

Innovation in service delivery:  
The expansion of general practice services for  
people with serious and ongoing mental illness

by

Katherine M Nelson

A thesis submitted to the Victoria University of Wellington  
in fulfilment of the requirements  
for the degree of  
Doctor of Philosophy  
in Social Policy

Victoria University of Wellington

2003

## Abstract

Over the past 50 years there have been many innovations in New Zealand's mental health services. Using case study methodology this research examined two innovations involving general practice – the Newtown Union Health Service (NUHS) mental health programme and the Hawke's Bay (HB) shared care pilot – targeted at people with serious and ongoing mental illness (SOMI). The intent of the research was to inform service delivery arrangements and to provide new knowledge concerning the development of innovative services. Four sources of data – programme documentation, evaluation reports, utilisation data and stakeholders' experiences acquired through questionnaires and interviews – were used in developing the case studies. While the history of these innovations was traced to specific actions, these innovations emerged because of the national and clinical context. The NUHS programme was a bottom-up development – the innovation occurring because NUHS needed to find a way of meeting the needs of the people with SOMI who were registered there. NUHS practitioners in consultation with the community made decisions concerning the programme's development. The HB pilot was a top-down development that was purchased because new money became available. Primary and secondary service practitioners, managers, researchers and the purchaser made decisions concerning the pilot's initial development. The factors that shaped the innovations included: funding, staffing, clinical and financial risk management and time. Similarities in the innovations included the range of arrangements for mental health care for individual people (from GPs being the sole providers through to GPs providing only physical health care, with the mental health service providing the mental health care), issues of trust and poor communication between the primary and specialist services and the frequency and length of consultations. Differences included the payment arrangements, access issues, the formalisation of co-ordination arrangements and the role of the nurse. The research found that to be adopted for routine use these innovations needed to develop effective service delivery arrangements. The NUHS programme was more successful than the HB pilot at delivering accessible, acceptable, co-ordinated, comprehensive, efficient and effective services. The findings regarding targeting, funding mechanisms, practitioner roles and the time it takes for trust to develop so that innovative services can become established have implications for Primary Health Organisation development. Research is needed on other innovative services to establish whether evaluating the effectiveness of the service delivery arrangements provides a useful framework to monitor and guide the implementation of an innovation in service delivery.

## **Dedication**

Dedicated to the memory of Keith Truman (my Dad), Adrienne Benson (my cousin) and Kim Larson (my American sister). I miss you all.

## Acknowledgements

To Paul, thank you for being there for Sarah and me, for keeping everything afloat and allowing me the time to work on this thesis, even when you have been so unwell.

To the people with SOMI, the staff at the Newtown Union Health Service, the health practitioners involved in the Hawke's Bay shared care pilot and other providers, thank you for sharing your experiences and being open to participate in these innovative services and in this research.

To my supervisors, Stephen Uttley, thank you for starting me on the journey, and for opening my eyes to the complexity of service delivery and introducing me to the concept of innovation. Dr Kevin Dew, a special thank you for taking over from Stephen, for providing the motivation, the critique, the challenges and seeing this through. Dr Ian Culpitt, thank you for giving your time and critical eye over the thesis in the closing months.

To my friends, Sheryl, Virginia and Joy who read and commented on drafts of the thesis, and Debbie who provided a listening ear, thank you.

To the Health Research Council of New Zealand thank you for the financial support received to train in health services research and to undertake the Hawke's Bay case study and Victoria University of Wellington thank you for the financial support towards conference attendances and undertaking the Newtown Union Health Service case study.

To colleagues from the Health Services Research Centre and the Graduate School of Nursing and Midwifery, thank you for your efforts, support and cajoling along this journey.

To my extended family, especially my Mum and sister Robyn who have always been there with encouragement and a listening ear, thank you for your love and support over the years.

Lastly, to my daughter Sarah, a special thank you for keeping life in perspective and providing the daily hugs, loves and chats.

## Table of contents

Abstract.....	ii
Dedication .....	iii
Acknowledgements .....	iv
Table of contents .....	v
List of figures.....	vii
List of tables .....	vii
List of abbreviations .....	viii
<b>Chapter 1 – An introduction to the research .....</b>	<b>1</b>
<i>General introduction.....</i>	<i>1</i>
<i>Terminology used in the thesis.....</i>	<i>5</i>
<i>Service delivery – a brief overview.....</i>	<i>8</i>
<i>The choice to use innovation as a lens to study the services .....</i>	<i>9</i>
<i>The research journey .....</i>	<i>13</i>
<b>Chapter 2 – The methodology.....</b>	<b>16</b>
<i>Case study methodology .....</i>	<i>16</i>
<i>The application of case study in this research.....</i>	<i>21</i>
<i>Methodological and ethical issues encountered.....</i>	<i>31</i>
<b>Chapter 3 – The framework developed to study the innovations.....</b>	<b>38</b>
<i>An overview of approaches used in studying service delivery.....</i>	<i>38</i>
<i>Researching innovation .....</i>	<i>41</i>
<i>Describing innovations in service delivery.....</i>	<i>49</i>
<i>Examining the effectiveness of an innovation in service delivery .....</i>	<i>49</i>
<i>Conclusion .....</i>	<i>58</i>
<b>Chapter 4 – The national context in which the innovations were located .....</b>	<b>59</b>
<i>Overarching government structures and strategies.....</i>	<i>61</i>
<i>Changes in the provision of welfare .....</i>	<i>72</i>
<i>Institution to community based services .....</i>	<i>79</i>
<i>No person input to some input.....</i>	<i>86</i>
<i>Acceptability of the mental health system waxes and wanes .....</i>	<i>94</i>
<i>Conclusion .....</i>	<i>96</i>
<b>Chapter 5 – The clinical context in which the innovations were located.....</b>	<b>97</b>
<i>The health needs of people with SOMI .....</i>	<i>97</i>
<i>Mental health services .....</i>	<i>99</i>
<i>General practice services .....</i>	<i>107</i>
<i>Models that combine general practice and mental health.....</i>	<i>115</i>
<i>Conclusion .....</i>	<i>120</i>
<b>Chapter 6 – The Newtown Union Health Service mental health programme .....</b>	<b>121</b>
<i>The development and organisation of NUHS 1987-2000.....</i>	<i>123</i>
<i>The mental health programme 1990-2000.....</i>	<i>134</i>
<i>The day-to-day activities of the NUHS mental health programme.....</i>	<i>142</i>
<i>The effectiveness of the NUHS programme .....</i>	<i>150</i>
<i>Conclusion .....</i>	<i>157</i>
<b>Chapter 7 – The Hawke’s Bay shared care pilot .....</b>	<b>159</b>
<i>The origins and development of the pilot.....</i>	<i>160</i>

<i>The pilot's initial arrangements</i> .....	167
<i>The changing shape of the pilot</i> .....	172
<i>The pilot operations day-to day</i> .....	183
<i>The effectiveness of the pilot</i> .....	188
<i>Conclusion</i> .....	194
<b>Chapter 8 – Innovation in service delivery</b> .....	<b>195</b>
<i>The increased role of general practice in mental health as an innovation</i> .....	195
<i>Why these innovations came about?</i> .....	196
<i>The shaping of the innovations</i> .....	200
<i>Decision-making</i> .....	209
<i>Sustainability as a goal</i> .....	215
<i>Conclusion</i> .....	220
<b>Chapter 9 – Developing primary health services for people with SOMI</b> .....	<b>222</b>
<i>The features of the innovations</i> .....	222
<i>Funding arrangements</i> .....	225
<i>Targeting people with SOMI</i> .....	232
<i>Services received as part of the innovations</i> .....	236
<i>Establishing effective primary mental health services</i> .....	240
<i>Conclusion</i> .....	246
<b>Chapter 10 – Developing and shaping innovations in service delivery</b> .....	<b>247</b>
<i>Reflection on the research</i> .....	247
<i>Innovations and local factors</i> .....	248
<i>Existing features, evaluations and risk management</i> .....	250
<i>New understandings regarding innovations in service delivery</i> .....	252
<i>Implications for policy, practice and research</i> .....	254
<b>Appendices</b> .....	<b>261</b>
<i>Appendix 1 – Contract with NUHS service</i> .....	261
<i>Appendix 2 – Example of baseline data on people with SOMI</i> .....	264
<i>Appendix 3 – Example of NUHS and Hawke's Bay utilisation review tools</i> .....	266
<i>Appendix 4 – Example of interview schedule used with people with SOMI</i> .....	268
<i>Appendix 5 – Example of interview schedule for GPs, CMHT and other providers</i> ....	270
<i>Appendix 6 – Hawke's Bay information sheet and consent for evaluation</i> .....	271
<i>Appendix 7 – Example of baseline data gathered on roles in the Hawke's Bay</i> .....	274
<i>Appendix 8 – NUHS information sheet</i> .....	276
<i>Appendix 9 – Letter and form requesting people at NUHS be interviewed</i> .....	278
<i>Appendix 10 – Letter to Wellington Ethics Committee</i> .....	280
<i>Appendix 11 – Response from Wellington Ethics Committee</i> .....	283
<i>Appendix 12 – Newtown Union Health Board Structure</i> .....	284
<i>Appendix 13 – Newtown Union Health Service Primary Mental Health Team</i> .....	285
<i>Appendix 14 – Hawke's Bay shared care pilot information sheet</i> .....	287
<b>References</b> .....	<b>289</b>

## List of figures

Figure 1. Map of the CRHA region .....	4
Figure 2. Service delivery principles and processes .....	10
Figure 3. Healy's questions for researching service delivery.....	39
Figure 4. S-shaped curve of research and rate of use of innovations over time .....	42
Figure 5. Schulz and Greenley's framework for examining innovation in mental health services.....	43
Figure 6. Goals of the NUHS mental health programme.....	137

## List of tables

Table 1. Timing of data collection for the evaluation of the HB pilot.....	26
Table 2. No. of stakeholders involved in the research in each case study .....	31
Table 3. Key events in mental health and primary health service development in New Zealand, 1960-1998 .....	60
Table 4. Key central and local government agencies involved in mental health, 1948-1998 ..	62
Table 5. Summary of changes in welfare provision that impacted on people with SOMI, 1948-1998 .....	73
Table 6. Providers specifically funded to deliver mental health services for people with SOMI, 1948-1998 .....	82
Table 7. Socio-demographic features of NUHS people with SOMI interviewed and whose records were audited .....	123
Table 8. People by socio-demographic features registered at NUHS 1989-1998 .....	126
Table 9. Numbers enrolled at NUHS by year .....	132
Table 10. Significant events in the history of the NUHS mental health programme .....	136
Table 11. Mental health ailment codes, 1993-1997 .....	141
Table 12. Findings from cover sheets on health prevention and monitoring strategies .....	155
Table 13. Socio-demographic features of people on the pilot in Napier 1998 .....	160
Table 14. Key dates in the history of the pilot.....	172
Table 15. GP consultation data for people on pilot 1998 .....	184
Table 16. Role description of health practitioners working with people with SOMI.....	185
Table 17. Pilot claims by Napier GP for 1998.....	187
Table 18. Similarities and differences in decision-making in the innovations .....	209
Table 19. Similarities and differences in the innovations.....	223
Table 20. Description of funding arrangements .....	226

## List of abbreviations

ACC - Accident Compensation Corporation  
AGM - Annual General Meeting  
AHB - Area Health Board  
CCH - Capital & Coast Health  
CCDHB - Capital & Coast District Health Board  
CHE - Crown Health Enterprise  
C-L - Consultant-Liaison  
CME - continuing medical education  
CMH - community mental health  
CMHT - community mental health team  
CRHA - Central Regional Health Authority  
CSC - community services card  
DA - Disability Allowance  
DHB - District Health Board  
DoH - Department of Health  
ECT - electro-convulsive therapy  
EEG - electro-encephalogram  
GP - general practitioner  
HB - Hawke's Bay  
HBd - Hospital Board  
HFA - Health Funding Authority  
HHS - Hospital and Health Service  
HSRC - Health Services Research Centre  
HUHC - high user health card  
IPA - independent practitioner association  
MHA - Mental Health Act  
MH(CA&T)A - Mental Health (Compulsory Assessment and Treatment) Act (1992)  
MHC - Mental Health Commission  
MoH - Ministry of Health  
MOSS - medical officer of special scale  
NGO - non-government organisation  
NHC - National Advisory Committee on Core Health Services  
NP - nurse practitioner  
NUHS - Newtown Union Health Service  
OPD - outpatients department  
PERT - psychiatric emergency response team  
PHC - Public Health Commission  
PHO - primary health organisation  
RHA - Regional Health Authority  
ToW - Treaty of Waitangi  
SOMI - serious and ongoing mental illness  
UK - United Kingdom  
USA - United States of America  
WHO - World Health Organisation  
WSM - Wellington School of Medicine



## **Chapter 1 – An introduction to the research**

Policies of community care over the past 50 years have led to many changes in mental health care. Since the mid-1950s services for people with ongoing needs from mental illness have gradually moved from mental hospitals to the community. One of the interesting aspects of this which led to this doctoral thesis is that despite this move, general practice, traditionally the focal point for primary health care, had, with the occasional exception, not played a major role in the care of many people with ongoing needs from mental illness. However, in New Zealand in the 1990s this started to change. The change in general practice involvement is considered in relation to health and welfare reform from a national and clinical perspective. The thesis concerns two initiatives in general practice that targeted people with serious and ongoing mental illness (SOMI). This thesis examines how these initiatives developed, how they changed, what services were provided, and investigates aspects of the effectiveness of the initiative's service delivery arrangements.

This chapter commences with an introduction to the research and the two cases that were studied to examine how innovative services develop to meet the needs of people with SOMI. This is followed by an introduction to the concepts of service delivery and innovation and a discussion of terminology used throughout this thesis. The chapter concludes with a description of the research journey and an outline of the remainder of the thesis.

### ***General introduction***

In 1990 as part of the World Health Organisation's (WHO) goal to achieve health for all by the year 2000, a publication was released titled *The Introduction of a Mental Health Component into Primary Health Care* (World Health Organisation (WHO), 1990). This emphasised that good mental health care involves both the management of mental illness and the promotion of mental health. The two innovations that form the core research focus of the thesis both strived to deliver good mental health care. The first involves an early innovation at the Newtown Union Health Service (NUHS). Even before this international focus on primary mental health care, staff at NUHS had commenced working closely with people with mental illness. In 1987, NUHS staff responded to an identified community need, by running health promotion sessions for people with 'chronic' mental illness ('Newtown Union', 1987). Three years later one nurse and one general practitioner (GP) developed a more targeted mental health programme to respond to the ongoing needs of people with a diagnosed mental

illness (Morten et al., 1992). This mental health programme (referred to hereinafter as the NUHS programme) is discussed in this research. The second innovation involved general practice in Hawke's Bay. In 1994 the Central Regional Health Authority (CRHA) had additional money to purchase more mental health services. Some of this money was used in 1996 to purchase the Hawke's Bay shared care pilot (referred to hereinafter as the HB pilot).

In line with the international focus on primary mental health the New Zealand Department of Health (DoH) released a discussion paper in 1993 that proposed a strategy for advancing primary mental health care that provided for choice, access, effectiveness, efficiency and co-ordination with other projects (Department of Health (DoH), 1993). In 1994 the Ministry of Health (MoH), which replaced the DoH in 1993, released a strategy document, *Looking Forward*, for mental health service development for the following six to ten years. One goal in this strategy was "to improve the provision of and access to primary health providers, by co-ordination between specialist mental health services and primary health providers" (Ministry of Health, (MoH) 1994, p.15). Funding to implement this strategy was used in 1996 to purchase the HB pilot.

Partly in response to the 1993 discussion paper (DoH, 1993), the MoH commissioned a group of researchers and academics to report on the "economic and other barriers to primary mental health services" and to develop a model to "facilitate the planning and development of mental health services in the community" (Mental Health Services Research Consortium, 1994, p.i). The Consortium's report concluded that what was needed was action, "a process of creative design rather than further analysis", and that there was a need "to move ahead towards desired objectives and to learn from the experience" (1994, p.i).

This doctoral research aimed:

- to inform the service providers about their mental health service;
- to inform policy, practice and processes regarding services for people with SOMI in a primary setting in New Zealand; and
- to increase the knowledge of how and why innovative services develop, and what influences their shape and trajectory.

In meeting these aims the research touches on many aspects of health service delivery including: the concept of mental health, the organisation and delivery of general practice regarding mental health services, the changing role of general practice, the roles and

responsibilities of stakeholders involved in general practice mental health services, and the funding of primary mental health services.

A case study methodology was used to investigate these innovations. An important consideration in choosing this research approach is the availability and preparedness of the case to be studied. The HB pilot was selected because the CRHA purchased a new service and wanted this to be evaluated. The Health Services Research Centre (HSRC) was engaged in this evaluation and because I was the principal researcher for this I subsequently became the project co-ordinator for the pilot. In agreeing to take on the twin roles of principal researcher and project co-ordinator I also negotiated permission that the evaluation of the pilot could be incorporated into my doctoral research. A NUHS doctor was at the meetings called by the CRHA to plan the HB pilot and the evaluation.

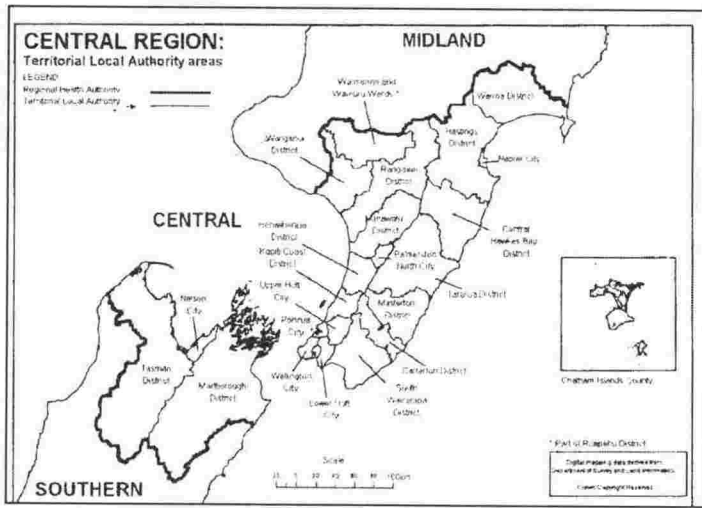
This NUHS doctor was keen to have an evaluation of the NUHS programme. When the CRHA declined to purchase an evaluation of the programme negotiation between HSRC staff and NUHS staff continued to see if a way could be found for an evaluation to be undertaken. These negotiations were made easier by my past association with the service. For example, I had been the public health nurse for Newtown when NUHS opened in 1987. NUHS gave permission for their involvement in this doctoral research on the understanding that they were partners to the research involving NUHS, and that NUHS also benefited from the research. A formal contract for the partnership was drawn up and signed by both parties (see Appendix 1) and a research team consisting of the GP and nurse working in the NUHS programme, the executive officer for NUHS and myself was formed.

### **The Newtown Union Health Service and general practice in Hawke's Bay**

While the local contexts are described in considerably greater depth in Chapters 6 (NUHS) and 7 (Hawke's Bay) an overview of the local context and structures within which the innovations occurred is provided here. This highlights the key differences between the settings of the NUHS programme and general practice in Hawke's Bay.

NUHS is based in Newtown, a southern suburb in Wellington, the capital city of New Zealand. The HB pilot began in Napier, one of two cities in the Hawke's Bay province, and two Wairoa GPs joined the pilot three months after the pilot started. As the Napier

stakeholders were the group involved in making the decisions, the pilot and the analysis focuses on Napier. Both services were within the jurisdiction of the CRHA (see Figure 1).



**Figure 1. Map of the CRHA region**

There were considerable differences in the demographic features of the Napier and NUHS catchment populations. NUHS's catchment population was ethnically diverse, with many Asian and Pacific peoples, and nearly one third of people were not born in New Zealand. Napier, on the other hand, had nearly twice as many Māori compared with the catchment area for NUHS. The NUHS catchment population also included a higher percentage of adults compared with Napier, and in Napier there were more elderly and young people than in the NUHS population.

The government funded the two services differently. The majority of funding for NUHS was paid using a capitation-based payment arrangement, whereas Hawke's Bay GPs were paid on a fee-for-service basis. Other differences between the two services involved practice sites, staffing and governance. NUHS was an urban-based practice that largely occupied one building. In contrast, the HB pilot involved 10 doctors from nine practices based in Napier and two doctors from one practice based in Wairoa. The difference in ownership and management of the two services was considerable. NUHS was community owned and managed. This involved a Policy Board, which in turn employed all staff including doctors and nurses. In Hawke's Bay, the general practices were owned by the individual GPs and the nurses were employees of the GP. The GPs in Hawke's Bay were profit driven, whereas NUHS was not-for-profit.

NUHS argued its philosophy was based on community development and primary care whereas Hawke's Bay was principally based on primary care. The community development focus of NUHS meant that the community was involved in making decisions about the service and was consulted by NUHS practitioners regarding the appropriateness and quality of the services offered. The NUHS programme developed from the bottom-up whereas the HB pilot was developed from the top-down. The polarised positions of top-down and bottom-up are extremes of how decisions can be made regarding services (Baldwin, 1993). The funding, ownership and governance of the services influenced their philosophies, staffing and the relationship I had as a researcher studying the two services. A particular value in studying how the two locations each developed services that targeted a similar group of people was the opportunity to learn about similarities and differences in the shaping of innovations such as when, what, why, how and where services originate from given their polarised positions. The analysis involved researching the cases separately, then working comparatively and reflectively with the findings.

### ***Terminology used in the thesis***

People and agencies use various terms when referring to people with a mental illness. The terminology used is often dependent on the context and who the speaker is. Although the terms are often used interchangeably, the terms differentiate on the person with mental illness role within the mental health services, and can influence the kind of relationship that a person has with the mental health service (Pilgrim & Rogers, 1999). Terminology used to label people with mental illness in the past included idiot, inmate, mental patient, and the insane (Truman, 1984). In the contractual climate of the 1990s mental health services increasingly called the person either a client (Keks et al., 1995) or a consumer (Crowson, 1993); while general practice retained the older terminology – patient (Hall, 1996), and researchers and policymakers referred to either mentally ill people (Wilson & Dunn, 1996) or service users (Healy, 1995). In New Zealand, a Māori phrase *Tangata whaiora*, meaning people who pursue wellness is also used (Mental Health Commission (MHC), c.2001). Embracing a particular political perspective mental health consumer movement advocates refer to those with mental illness as survivors and consumers (Pilgrim & Rogers, 1999). More recently the term people with a mental illness is being used (MHC, c.2001).

This thesis mainly uses the term people with serious and ongoing mental illness or people with SOMI because it reflects the criteria that were used to determine the eligibility for the innovations studied. It also clearly conveys the imperative that the services were first and

foremost for people. However the terms patient, client, consumer and service user used by the services studied in this research are also sometimes used to reflect a context. For example in referring to general practice the word patient is sometimes used, and with mental health services the term client is sometimes used. Consumer representative is used to describe people with SOMI who were consulted on aspects of this research.

In medical terms, mental illness consists of a group of illnesses that are diagnosable for a certain collection of symptoms. These diagnoses are derived from one of two classification systems, the American based diagnostic system (American Psychiatric Association, 1994) commonly referred to as DSM IV and the WHO's (1992) international classification of disease series 10 (ICD 10). Epidemiological evidence suggests that 3% of the adult population and 5% of people under 18 years have a severe mental illness at any one time. A further 5% of adults have moderate to severe illness and another 12% have a diagnosable mild to moderate illness (Wilson, 1997 p.10). The issue of how one defines who is in the serious compared with the moderate category of mental illness was one of the issues that had to be addressed in these innovations. How decisions were made concerning who was eligible for the innovations, and the implications of the decisions is presented in the findings, Chapters 6 and 7 and discussed further in Chapter 9.

The illnesses that most commonly fit into the category serious mental illness are schizophrenia, bipolar disorders and some depressive disorders. Although these disorders have different symptoms and require different treatment, at a service level many writers and service arrangements do not distinguish between these groups; rather they write and provide services as if they are one. I have also chosen this approach even though there is increasing focus in the literature and in service delivery to address the diagnostic groups separately. The reason for my choice is that in New Zealand most services, with the exception of some highly specialised areas such as early intervention psychosis, maternal mental health and eating disorders, are set up as generic services.

Health services can be grouped using the WHO (1990) framework of primary, secondary and tertiary levels of service. Within these levels, practitioners have different knowledge and skills (Pratt & Adamson, 1996). Primary practitioners are considered generalists, while secondary and tertiary practitioners are specialists. The levels of service differ in several ways – how people access or choose the services, where the services are located, the type of

problems for which they provide services, the level of expertise of the staff, and how the services are organised. Chapter 3 describes issues to be addressed when services from different levels work with the same group of people.

These innovations were located at the primary level and were based in general practice. The decision to use the term general practice is not meant to downplay the underlying differences in philosophy between NUHS and Hawke's Bay services. It was influenced by the fact that the funding formulas for these innovations were determined by payment for GP consultations. NUHS states that it is a primary health care service, not a general practice. Primary health care services tend to be more diverse in where and how they deliver services compared with general practice (Freeman et al., 1997). The Hawke's Bay GPs saw themselves as providing general practice services. The focus of these general practice activities are principally but not exclusively on the individual work of GPs, whereas the focus of primary health care is built around different health practitioners, including the GP. Chapter 9 considers the role of this difference in what services these innovations delivered.

The medical practitioners in both services are referred to as GPs or doctors. Locums are the doctors who provide temporary relief for the GPs when they are absent. Specialist doctors such as psychiatrists are referred to by the specialty medical qualification they have. The nurses in these innovations used different terminology to describe their positions. In Hawke's Bay the nurses were described as practice nurses while in NUHS they were called nurse practitioners. However, because the Health Competency Assurance Act, 2003 intends limiting the use of the title nurse practitioner to those nurses who have demonstrated certain competencies, I will not use the term. Generally speaking I will utilise the terminology nurse. Nurses working in the mental health service will be referred to as mental health nurses. When referring jointly to the doctors and nurses working in general practice the term primary practitioner is used.

Specialist mental health services, unless otherwise stated, refer to services that receive some or all of their funding through the public system. Specialist services range from those located and delivered through the District Health Boards (DHBs) such as inpatients and outpatients, community mental health teams (CMHTs) and Māori mental health services through to non-government organisation (NGO) and privately owned, but publicly funded services such as supported accommodation, personal supports, recreational and occupational services.

### ***Service delivery – a brief overview***

Service delivery is the activities involved in providing a service or delivering a programme to a client or client population. It is the process by which governments and organisations deliver on promised policy initiatives (Hogwood & Gunn, 1984). Services and programmes are made up of components. These components consist of products or tools (e.g. clozapine, electro-convulsive therapy) and processes or procedures (e.g. therapy as a day patient versus an inpatient). Uttley (1991) argues that product and process are similar; they both concern the technology of delivering health services. Uttley's view of technology as both systems and tools is shared by others who have studied medical science (Elston, 1997).

According to Gilbert et al. service delivery systems involve “organizational arrangements that exist among service providers and between service providers and consumers” (1993, p.26). Many aspects of our lives involve interaction with services such as those provided by the transport services, the retail and insurance industries, and welfare services. This thesis is concerned with welfare services. Health services are one of many welfare services. In this thesis health services are referred to conterminously with welfare services. This is because health is one of the basic requirements for living. Other basic welfare services are food, housing, education and economic security or income (Gilbert et al., 1993) and some suggest recreation (Gidlow et al., 1994). Many people are able to meet their own welfare needs. Where this is not possible because of age, income, health or level of expertise required, the state, private sector, charitable or voluntary agencies may provide a service to meet the need. Private organisations, charitable and voluntary sectors are often partially funded by government. The arrangement of the mix of state, private, charitable and voluntary organisations delivering welfare has changed over time. Most notably the change has been a move away from the state both funding and providing the service, to mainly funding services (Healy, 1998). Laugesen (1994) and Scott (2001) discuss this in the New Zealand health context, noting how new purchasing and provider structures were required as the state exited from the provision of services. The NUHS programme and HB pilot are two of many welfare services that are part-funded by the state and delivered by private or community-based providers.

Welfare services are shaped by multiple influences including values, policy, politics, knowledge, resources, demand and need (Hardy, 1981; Kennett, 2001; Mechanic, 1991; Sauber, 1983; Spicker, 1988). According to Uttley how these influences shape health



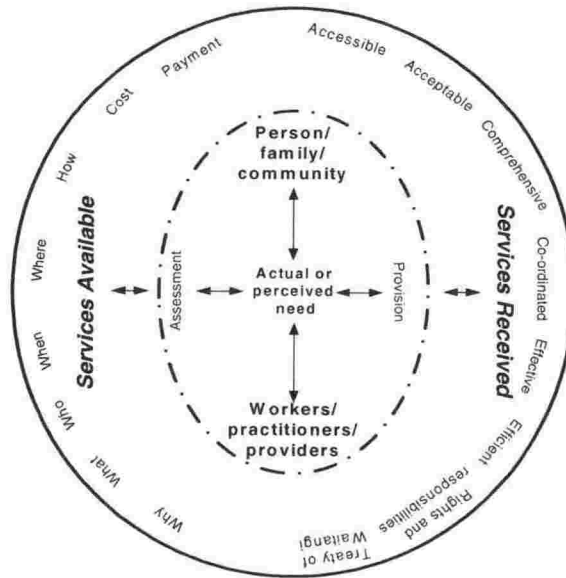
services is complex as health “straddles the boundaries between industrial, social, political and personal aspects of human life” (1991, p.10). Key stakeholders that influence welfare service provision are the users and potential users of the services; the family or personal supports of those who require welfare services, often referred to as informal carers; the workers, be they clerical or professional, who work in the services; the organisations that are responsible for delivering the service; the funders of the services; the regulators of services; and the community at large (Parsons, 1995). Each of these stakeholders has a different interest and emphasis regarding what is important when delivering welfare services. Stakeholders’ impact on policy and service delivery can be viewed internationally, nationally and at a service level. How this impact influences service delivery will be discussed further in Chapter 3 and then illustrated at the international and national level in Chapter 4 and in the clinical context in Chapter 5. It will be apparent from these chapters that over time there have been changes in who and what influences service delivery arrangements. Who and what influenced the development of these two innovative services is a central aspect to this thesis.

It is generally accepted by those providing and purchasing health services that the key principles for providing effective or quality services for people with SOMI are that services should be accessible, acceptable, accountable, comprehensive, co-ordinated, efficient, effective and equitable (Hansson, 1996; Huxley et al., 1990; Sauber, 1983). These principles were included in New Zealand’s mental health policy in 1990 (Abbott & Kemp, 1993). More recently, New Zealand has extended the principles to recognise obligations under the Treaty of Waitangi and the rights of users, carers and the community in service delivery (MoH, 1994). All of the above principles are considered important for service delivery and development (MHC, 1998a). These principles form the basis of the framework for this thesis. Figure 2 provides an illustration of how these principles interact with the process of service delivery. These principles and process will be expanded upon in Chapter 3.

### ***The choice to use innovation as a lens to study the services***

My decision to view the increased role of general practice working with people with SOMI in these two services as innovations was not made until after the data gathering for the research was completed. The term innovation was adopted as a means to describe and analyse the NUHS programme and the HB pilot. While the thesis explores what can be learnt from these services regarding innovation in service delivery, the research was not set up to explore innovation as such. For these reasons apart from a brief discussion in this chapter, the thesis

does not explore the theoretical underpinnings that define innovation<sup>1</sup>. Describing the case studies as innovations came out of developing the framework – how best to capture what could be learnt from these service initiatives.



**Figure 2. Service delivery principles and processes**

Critical to working with case study methodology is the theoretical or analytical framework that informs the analysis and definition of a particular case – if this is not developed then using case study can result in mere description. When the research question involves testing a theory or hypothesis the framework is well developed, posing precise questions before the data gathering commences, determining the nature and type of data gathered. This differs from when the research involves informing or creating theory, here the framework is less developed, guiding rather than directing the data gathering process – the theory itself being induced from the findings of the research. In this latter approach, one starts with broad questions, for example what is happening here, what are the important features and relationships that explain how this new funding is being used? “These questions are then refined and become more specific in the course of fieldwork and a parallel process of data analysis” (Keen & Packwood, 1995, p.445).

This research combines these approaches. In addressing the clinical issues stemming from these innovations, precise questions are addressed such as who was eligible for the

<sup>1</sup> Sklair (1970) and Wilson (1984) are two authors who have written on the theory of innovation.

innovations, who worked in them, what contribution did the innovations have in peoples' mental health care, how often did people access the innovations, what services did they receive when they accessed them, what skills did practitioners require to deliver the service, and how effective were the models of service delivery that developed? In addition, the research addressed social policy issues arising from such innovations. Broad areas of inquiry were followed such as how and why the two services developed and changed, and who and what influenced this development. During the journey of the research these questions were refined and added to. Healy argued that a question approach is the "traditional" format for understanding service delivery (1998, p.14). These refinements and additions mainly occurred during the data gathering and analysis phases as avenues for interpretation and theoretical exploration, emerged and were explored. This included understanding the role of risk, trust, the direction of decision-making, and sustainability in shaping these innovations.

According to Dingwall it is important to be clear regarding how "a case study fits into a body of theory or other findings. It is that background which makes for the intelligibility of the particular case" (1992, p.169). These initiatives are innovations because they were new models of providing services for people with SOMI. They needed to be reviewed for what they were, not in comparison with what had existed before<sup>2</sup>. Innovation means "something new, something different", something that "transmute(s) values" (Drucker, 1985, p.22). It is generally something that has not been seen before. An innovation involves more than an alteration or an adjustment to existing services, it involves the creation of something new. It is able to stand as a concept and a perception in its own right.

According to Wilson an innovation possesses "the sort of novelty that results from a restructuring and recombining of already existing properties and activities" it is "qualitatively new only in the sense that it is more than an addition of parts which yields mere quantitative variation" (1984, p.4). The outcome or expectation of an innovation embraces uncertainty (Pearson, 1991), it is something that an innovation aims for. Using the term innovation allowed a different energy, a freedom to explore and look at the services not in comparison with previous or other service arrangements, but for what the services achieved in their own right. This research involved examining why was it that in the 1990s two separate innovations involving general practice delivering mental health care developed and how and why they took the shape they did.

---

<sup>2</sup> The terms change and development were not seen as suitable as using these terms would involve an examination of the new services to establish how they differed or advanced existing services.

The product and process duality noted in the discussion of service delivery, is also present in regards to defining types of innovations (Moore, 1994). It is my view that product and process innovations are not mutually exclusive and do not necessarily occur in isolation from each other. Product innovations often lead to, or require, changes in service delivery arrangements to accommodate the new product. Although an innovation can be about a specific product, to actually use or produce the product can mean that services need to re-organise. Likewise process innovations may involve using a product differently, thereby leading to changes in the product.

Much of our understanding of the history of innovation in health services has come from the study of product innovations. This is possibly because since the 1930s there has been near constant growth in the number and diversity of products available (Uttley, 1991). Another reason is that products have a history that is easier to review in isolation from other factors. They generally have a traceable origin, a time when they were first produced, and a time when they were mass-produced. The tracing is also possible because products, unlike processes, often have to meet stringent regulations before they can be introduced. In addition, as part of selling the products, producers sponsor and share the development of innovations. Process innovations, on the other hand, have often been written up as a change process – the concept of innovation not always being recognised or acknowledged.

Innovation can occur at any point or part of a service delivery system. Innovation in how services are organised involves the introduction of new approaches to the structure and processes around delivery arrangements (see e.g. Butler's (1990) account of the introduction of day surgery). These new approaches can be planned or unplanned, and can occur gradually or suddenly. Innovations in where services are delivered are similar in that the new approach concerns only the location in which the service is delivered (e.g. the introduction of the cardio-thoracic unit). Innovation in who undertakes a service can involve existing workers taking on new activities, learning new skills or new workers taking on old or developing new activities (e.g. nurses prescribing medication). Sometimes when there are changes in who undertakes an activity or role, reference is made to up-skilling or down-skilling the workforce or service provided (Harvey, 1995). Innovations in who receives a service does not require a new approach to the services delivered, rather the change is in who is targeted for the service. Often this involves an expansion of the services (e.g. extending the age that people were

given hip surgery).

In NUHS and in Hawke's Bay there was nothing "clinically" new in general practice staff working with people with SOMI or in the care and treatment the people with SOMI received. What was new was the significant increase in the numbers of people with SOMI who were either able to, or expected to receive some or all of their mental health care and treatment in a general practice setting. The innovative services developed as both a consequence of (in the case of the NUHS programme), and a precursor to (in the case of the HB pilot) managing the increased numbers of people with a SOMI.

### ***The research journey***

How the journey was followed in the research was different for the two case studies. The fact that this research was being undertaken at the same time as the pilot commenced in Hawke's Bay, combined with my role in the pilot, enabled me to not only look at issues as they emerged, but also to influence how the pilot was shaped. In addition, I was regularly in the position of presenting the early developments and findings of the evaluation of the HB pilot. In the NUHS study my role was initially purely as researcher. The programme had been established seven years prior to this research commencing. It was not until I had been involved with the programme for nearly two years, when the analysis was underway, that I felt I was in a position to present, comment and critically review the programme with the staff. It was only then, that it was possible that the presence of the research and I as researcher may have had an impact on the programme's development. It was at this point that I contributed to NUHS's successful application for a mental health service award.

Due to circumstances outside my control, the fieldwork for the research was not completed in the proposed research timeline (1996-1998). As a consequence of this, decisions have had to be made about the cut off point for the cases under study. The interruptions impacted mostly on the NUHS study, where data gathering spanned a four-year period. Interviews with staff at NUHS were undertaken in 1997. The retrospective review of patient records was undertaken in 1997 and 1998 and the interviews with the people with SOMI were undertaken in 2000. Following the periods of absence from the research, every attempt was made to obtain information regarding any developments that had occurred in the services during my absence. By the nature of their development, the time period each case covers naturally differs both at the start and at the end. The HB pilot focused principally on the developments

to mid-1999. This was a natural cut-off point as the demise of the Health Funding Authority (HFA) in 2000 resulted in the responsibility for the pilot being transferred to the Hawke's Bay DHB. The NUHS case study by the nature of the interviews with people with SOMI needed to be extended to the year 2000.

### **The thesis outline**

The thesis is presented in 10 chapters. The layout is not in traditional thesis format in that there is not one chapter focusing on the literature. The reason for this is because the thesis draws on different sets of literature. These were used to background the question in this chapter, to explain and justify the methodology, to argue and present the framework, to present the national and clinical contexts, to discuss the findings, and to outline the implications of this research for theory, policy and practice.

This chapter has provided an introduction to the topic and how terms will be used throughout the thesis. It also poses the research question – how have two locations developed services involving general practice to meet the needs of people with SOMI? Chapter 2 describes and discusses case study methodology and how it was applied in this research. It also outlines the methods used in the case studies; the issues and tensions encountered using these; and how these issues and tensions were addressed during the research. Information is provided on ethical issues that the research encountered and how these issues were addressed.

Chapter 3 introduces the framework from which the cases were developed and studied. The framework focused on two aspects of service delivery, the first aspect concerns looking at how each of the cases developed as an innovative service, whilst the second aspect outlines the approach used to describe the innovations and examine aspects of their effectiveness as models of service delivery. Throughout the chapter key questions that the framework gave rise to in looking at the innovative services are raised.

Chapter 4 utilises the framework to provide a history of social institutional arrangements enabling these innovations to be viewed in the broader context of social institutional development. It covers the changing policy and practice in community mental health in New Zealand that has led to the development of general practice involvement in the mental health of people with SOMI. Chapter 5 looks at the clinical literature. This literature is the

literature that was read and used by the clinicians and myself, as the pilot project co-ordinator, to inform the establishment of these innovative services.

Chapter 6 presents the findings of the NUHS case study and Chapter 7 the findings of the Hawke's Bay case study. The case study presentations cover the origins and shaping of each innovation, how each innovation worked on a day-to-day basis and over time, and reports on what was established concerning the effectiveness of the innovations in providing a service for people with SOMI.

Chapter 8 discusses the findings from these case studies pertaining to innovation in service delivery. Chapter 9 discusses the implications of the findings for the New Zealand health and welfare services, focusing in particular on considerations for establishing services involving general practice targeting people with SOMI.

The final chapter, Chapter 10, concludes with the key contribution this research has made to understanding innovation in service delivery that involves increasing the role of general practice working with people with SOMI. It comments on the suitability of the approach used in this research to study innovation and identifies areas for future research. Finally the chapter considers the implications of the findings from the NUHS programme and the HB pilot case studies for primary health organisations that are currently forming in New Zealand.

## Chapter 2 – The methodology

There were two factors that shaped the selection of a case study methodology. The first was that it addresses the research aims of informing service delivery and advancing the understanding of innovation in service delivery. Secondly, given that the NUHS programme and the HB pilot provided services for people with SOMI in two quite different locations a case study approach was selected. It requires context to be taken into account and enables each innovation to be researched separately (Yin, 1994).

This chapter is divided into three sections. Section one describes the case study methodology and outlines the issues this methodology highlights including an assessment of the explicit limitations of such an approach. Section two describes how the methodology was utilised in this research, how the tools were developed, how the research was conducted, what ethical issues were encountered and sets out the 4-staged analytical approach that was used. The final section discusses the methodological issues encountered during the research and how these were managed to ensure rigour in the research.

### *Case study methodology*

Case studies require the researcher to set out the particular aspects of the unique settings and situation being studied. The framework used to examine and build the specific description guides the construction. This involves:

a detailed investigation, often with data collected over a period of time, of one or more organizations, or groups within organizations, with a view to providing an analysis of the context and processes involved in the phenomenon under study. (Hartley, 1994 p.208-9)

This research approach is most useful when the researcher has little control over events, when the phenomena under study involves real-life events, when little is known about a subject and where broad, complex questions have to be addressed in complex circumstances (Keen & Packwood, 1995; Yin, 1989). As such, it is particularly suitable for studying the origin and implementation of innovative services as it enables the identification of what facilitates shapes and obstructs the development of an innovation; and it describes how the services work. Because it can accommodate different stakeholders' (Vedung, 1997) interpretations of events such research designs enable specific processes of definitions and unique description of the unit studied can be developed. The interpretations of events thus comes from within



and between stakeholder groups. In addition, the analysis can be managed without giving one stakeholder's perspective more credence than another's (Stake, 1994), and it is important in studying such unique innovations to get the views of the different stakeholders involved.

Since one of the explicit aims of the research was to study each innovation separately a case study approach was ideal. Given that both innovations targeted people with SOMI, whilst starting from very different situations, this pattern of research provides an opportunity to explore the similarities and differences in how these separate innovative services developed.

Because of my involvement in the HB pilot consideration was given to using an action research approach (Dash, 1997). However, because of the different roles I had in both cases this was not considered appropriate. Another reason for not developing this approach was that the project co-ordination role in the pilot was initially thought to be of short duration. An action research methodology could have impacted on my objectivity as researcher, since the impact evaluation of the pilot was undertaken at the same time as this research. The other method deliberated about was to research the effectiveness of increasing GP involvement in people with SOMI's health status and service use. However, given the findings of the literature presented in Chapter 5, it was clear that designing a study to measure the clinical effectiveness of general practice in mental health would be problematic because of the difficulties in controlling for confounders. This view was subsequently supported in a paper by Gask et al. (1997) who also raised issues regarding which unit of randomisation (patient, GP or general practice) should be used in evaluating primary mental health care services. In the discussion on the life-cycle of an innovation presented in Chapter 3, it is revealed that effectiveness studies of an innovation often comes some time after a new technology has been developed.

### **Defining and choosing a case(s)**

A first step in case study research involves defining what is meant by the case area or project to be investigated. From such definitions flow the relevant priorities of how each case is examined and constructed. Consequently definitional dimensions are influenced by the aims of the research. Is the aim to understand phenomena, demonstrate an example of a difference, or test a theory or hypothesis in a specific setting? As I have mentioned, this research aimed to understand how two quite different general practices developed services for people with SOMI. Stake (1995), an authority on case study methodology, considers the most important criterion in choosing a case(s) is to maximise what can be learnt. To maximise what could be

learnt in this research, a decision needed to be made whether to consider the NUHS programme and the HB pilot as single or multiple cases.

Four constructs, each requiring a different focus of analysis, were considered. The first defined the case as an innovation in general practice working with people with SOMI, combining the data sets from each site as if there was only one innovation. In this construct each site would be an embedded case (Yin, 1994). Aspects of this option are used in the analysis pertaining to innovation in service delivery. The second construct, the one utilised for this research, saw each site as an innovation in its own right – defined by a purchasing agreement to provide mental health care in the general practice setting. In the NUHS programme the purchasing contract involved one general practice, whereas in the HB pilot 10 general practices were involved. Basing a case study on the purchasing contract enabled the Hawke's Bay general practices to be studied as a group, rather than as 10 separate cases. This approach enabled the development of the two models of service delivery to be explored from a purchasing, governance and operational angle. The third construct available was to study the NUHS programme and each Hawke's Bay practice separately. In this option the Hawke's Bay case would have been treated as an embedded case – providing for subunit analysis of each of the 10 practices. Aspects of individual practices' experience do feature in the analysis of the HB pilot. The fourth construct was to define a case as a stakeholder group; the case in this research approach would have been the people with SOMI, GP or nurses.

Studying single cases is considered most useful when they represent a critical test of a particular or significant theory, or when they are extreme or unique and where the study of the case provides an opportunity to see something previously inaccessible or new (i.e. it is a revelatory case) (Yin, 1994). A single case is warranted when the phenomena under study is unique (Stake, 1994). In contrast, studying multiple cases is most useful when one wants to see how the same phenomena are replicated in different settings. The number of cases required depends on whether the aim of the research is literal replication (predicting similar results from the different settings) or theoretical replication (predicting different results from the different settings). The type of replication being explored determines whether one should choose similar or different cases. Although this research treated each case as a single case the overall research design had features typical of a multiple design.

When the CRHA was making decisions about evaluating their purchase of primary mental health services, consideration was given to whether the CRHA should also purchase an evaluation of the NUHS programme. The CRHA chose not to do this because it considered the NUHS programme unique since the size of the programme (over 300 people with SOMI) was not replicated elsewhere in New Zealand. The CRHA considered that any findings arising out of an evaluation of the NUHS programme would not necessarily be generalisable, useful or applicable to other settings. Stake notes, "sometimes a 'typical' case works well but often an unusual case helps illustrate matters we overlook in typical cases" (1995, p.4). Studying the NUHS programme was of interest for this research because it reportedly developed from a community development approach and the programme was not only designed around the work of the doctor. The HB pilot was also unique because it was reportedly the first mental health funded primary mental health shared care service purchased in New Zealand.

While it is unusual to choose two unique cases for one research project, the NUHS programme and HB pilot were both chosen, as they were different on some important dimensions and similar on others. Similar cases are important if the aim is to find out if there are differences in how phenomena work under similar circumstances, whereas different cases are important if the aim is to find out what factors play a role in influencing how particular phenomena operate. The sites were similar in that they were both primary care providers that received funding from the CRHA to provide a service for people with SOMI. The sites differed in the type of funding they received, ownership, practice description, location, and their approach to providing primary care.

The final criterion in choosing a case study design is not only the availability of individual cases but also the preparedness of each case to be open to the required scrutiny. The services examined in this research had to be open to the possibility for the research funding to identify issues in performance. Those services also needed to ensure that the required research data was obtainable. In addition to obtaining agreement from each site to undertake the research, ethical approval from the Hawke's Bay Ethics Committee and the Wellington Ethics Committee was also required for the research to proceed. Particular issues addressed in the ethics applications related to how procedures for obtaining informed consent were implemented, how the research would ensure the confidentiality of the service users and stakeholders involved in the research. Other issues covered the safety of interviewees, access

by the researcher to service user's health data and the security of data. The applications proposed addressing interviewee safety by inviting interviewees to bring a support person with them to the interview. Confidentiality and security of data was indicated in the applications and was achieved in several ways. Material was kept, and continues to be kept in locked filing cabinets. In New Zealand such research data is now required to be stored for 10-years after the research is complete. At the time that ethics approval was obtained the time period was three years, but now this data will be stored to meet the 10-year requirement. In writing up the case studies every attempt has been made to ensure that any person's experiences are confidential and could not be linked back to any one individual.

### **Criticisms of case study**

Research using a case study approach has been criticised for lacking scientific rigour. This criticism is made because the findings are often only descriptive, the original question can no longer be answered by the case (as the latter has changed over time) or the research merely generates theory rather than tests hypotheses. Other criticisms are that the findings from case study research are not always generalisable, and the written reports are too long (Bryman, 1989; Datta, 1997).

These criticisms have all been answered and in some cases rejected by the proponents and analysts of case study methodology (Gummesson, 1991; Hartley, 1994; Stake, 1994; Yin, 1994). These proponents and analysts argue that there is an important place for description in research. Providing such descriptions involves both data gathering and an analytical component. Where such case studies merely describe, the methodology may not have been used correctly. Insufficient attention may have been given to the study of the particular. The question can no longer be answered because the researcher has generally made an incorrect choice in the number of cases to study, often choosing only a single case where multiple cases or an embedded case was required. However, not all research has to test hypotheses, there is a role for research to generate theory. Case studies provide for theoretical generalisation, and there are ways to limit the detail in reporting and discussing the findings of case study methodology.

Dingwall (1992) provides three practical solutions in order to avoid the difficulties that commonly lead to the criticisms. Firstly, he notes that a researcher needs to separate the data from analysis to allow the proper presentation of the data in the construction of the case.

Secondly, Dingwall advises researchers to look at their findings, and to ask, whether the findings demonstrate the search for contradictory or negative evidence? For example, does the case study test theories or does it challenge previously established findings? Thirdly, to avoid mere description Dingwall suggests that researchers check to see that the analysis is constructed using the multiple viewpoints and data sources used in examining the cases.

In summary, a case study design was chosen for this research because the methodology is able to capture similarities and differences in how the NUHS programme and the HB pilot developed services for people with SOMI. However, given the warnings of how easy it is when using a case study research methodology to contravene scientific rigour, particular attention was given to developing the framework and analysis for this research. I was, however, less concerned with the criticism regarding case studies being too descriptive, as this research concerned innovative services, and a comprehensive description was therefore considered important for others to understand how the services worked.

### *The application of case study in this research*

My approach, whilst treating each case study as an innovation in its own right, also used features of a multi-case design. This particular design was developed in response to two questions: how did the two innovative services develop in general practice to meet the needs of people with SOMI, and what influenced the shape the innovations took? Whilst the overall approach to the methodology was decided at the commencement of the research, and was used to guide the development of the tools, the specific framework for the analysis of the cases was not developed until the data collection was complete. It was at this point that the analytical framework outlined in Chapter 3 was developed. This approach is common in case study construction (Keen & Packwood, 1995).

An important issue in research design is whether a deductive or inductive approach will be used. When the research involves testing a theory or hypothesis the framework is well developed, posing precise questions before the data gathering commences, determining the nature and type of data gathered. This differs from research that critiques current theory or seeks some new theoretical explanation. Here the framework is less developed, being inherently more speculative and potentially controversial. Guiding rather than directing the data gathering process – the theory itself being induced from the findings of the research. In this latter approach one starts with broad questions, for example what is happening here, and

what are the important features and relationships that explain how this new funding is being used? "These questions are then refined and become more specific in the course of fieldwork and a parallel process of data analysis" (Keen & Packwood, 1995, p.445). In applying a case study methodology, it is not uncommon for theory testing and theory building to go hand-in-hand (Yin, 1994).

Investigating the development of the NUHS programme and the HB pilot, compared with what was known about the development of innovative services involved theory building. Throughout the research, most particularly during the data gathering and analysis phases, other avenues for interpretation and theoretical exploration were opened. This refining process raised issues of innovation development such as trust, risk, up-skilling, and the inter-relationship of funding and policy.

The multi-case design meant that each case was developed similarly. Each case study consisted of three separate, but interrelated components, including a history of development, a description of how the service worked, and the effectiveness of the service delivery arrangements. The history provided a developmental schema of how and why both the NUHS programme and the HB pilot developed and changed. The descriptions set out the manner in which these services operated, recorded the organisational patterns that were developed and how different stakeholders were affected. Developing these descriptions is similar to undertaking a process evaluation in that the focus was on how the innovations were working, who they were working for and the impact of events on the innovations (Walker, 1997). These descriptions included analysis of the roles of stakeholder groups such as people with SOMI, service user representatives, doctors, nurses, other providers and managers. A clinical audit was also included. This focused on two aspects; the utilisation rates of each service over a period of 12 months and defining a sample of respective service users and evaluating their patterns of care and service use. Evaluating the effectiveness of each innovation's service delivery arrangements involved assessing the provision of accessible, acceptable, co-ordinated, comprehensive, efficient services that improved health outcomes and met the obligations required under the Treaty of Waitangi and New Zealand's Code of Health and Disability Services Consumers' Rights (Health and Disability Commissioner, c.1996).

## **Research tools**

The particular tools and techniques used to obtain the data for each case study included a documentation review, utilisation review and interviews and questionnaires with stakeholders. A mixed-method approach as described earlier, is commonly applied to such case study designs (Bryman, 1989; Yin, 1994). While the process of completing the documentation review was similar for both case studies, the procedures applied to an analysis of utilisation and how stakeholders' experiences were obtained differed. However, one common factor was that consumer representatives on the NUHS Policy Board and involved with the HB pilot were consulted in the designing the interview schedules for use with the people with SOMI.

### *Documentation reviews:*

These reviews, involving an analysis of available documentation (e.g. programme documentation, minutes of meetings, letters) about the services, were undertaken from both a date sequence and a themes and issues perspective. This involved a consideration of what was and was not said, who said it, what assumptions were made, who was and was not involved, what and why particular decisions were taken, and what issues the innovations were addressing. Ongoing notes were written about changes to the services as the case studies progressed. The reviews described what was happening and established some of the factors in how the innovative services developed. Issues that were unclear from the documentation review were noted for inclusion in interviews.

### *Utilisation reviews:*

These reviews, involving an analysis of who, when and why someone uses a service, were useful in creating a picture of how such services work and for setting out a way to assess effectiveness as a model of service delivery. Specific criteria and tools were needed so that these reviews might ensure that all data were recorded and measured consistently. Developing an understanding of rates of utilisation involved reviewing records during 1997 for the NUHS programme and for 1998 in respect of the HB pilot. From the perspective of service delivery this meant developing an accurate record of who accessed the service, how often, what for, the output of the consultation, and whether there was continuity of care and complementary care. To achieve these multiple goals two parts of the review were developed. Particular data collected was influenced by what was found in the literature reported in Chapter 5, the clinical context. The Hawke's Bay tools were designed first and

were modified for use with the NUHS programme. The first part of the utilisation tool was aimed at providing a description of the socio-demographic and health features of people who used the innovative services (see e.g. Appendix 2). Personal details such as date of birth, sex, ethnicity, occupation (previous if unemployed), community service card status, and housing arrangement were included in this description. The specific health data included mental health diagnosis, summary of previous psychiatric history and treatment including (where possible) when first diagnosed with a mental illness, number and length of admissions, and which other mental health providers were involved. In order to capture a picture of the level of co-morbidity and to establish whether the NUHS programme had achieved high levels of health screening and completed immunisations, the NUHS study sought information on other major health diagnoses and the status of health prevention measures such as immunisation and cervical screening.

The second part of the utilisation review recorded what happened when a person with SOMI consulted general practice staff (see e.g. Appendix 3). The particular data gathered included date and place of consultation, who the consultation was with, the general reason for consultation and the output of the consultation. The latter included the type of care and treatment provided, what other liaisons and referrals were made. There were some differences in the data collected in each case study. For example, to accommodate the work of the nurse the NUHS schedule included a variable on supportive counselling, while in the HB pilot data was collected prospectively, which enabled data to be collected on the type and length of consultations.

#### *Interviews:*

These were conducted in order to describe, explain, and elaborate on the phenomena identified in the review. Interviews are usually with stakeholders who, according to Vedung (1997), can be anyone from the general community to those actually participating in the activity being studied. A set of stakeholders – people with SOMI, consumer representatives, CMHT staff, GPs, nurses, and other providers – were similarly identified in both sites. Two different types of interview schedules were developed. A semi-structured format was used for interviewing all people with SOMI (see e.g. Appendix 4) while for the other interviews schedules were developed for each practitioner group (GPs, CMHT, and other providers) (see e.g. Appendix 5). In the NUHS study staff interviewed included current and past staff members, and staff working within and alongside the mental health programme. In Hawke's



Bay it was only those staff currently involved with the pilot. The interviews with people with SOMI were designed to complement the utilisation review because one of the limitations of utilisation review is that while it can tell "the variety and quantity of care received by an individual ... [it] misses out the essential element of the appropriateness of providing him/her with these forms of care, and is measuring merely services rather than individual outcomes" (Huxley et al., 1990, p.16). The interviews aimed to establish the views of people with SOMI such as their care arrangements, why they registered at NUHS or joined the HB pilot, their understandings of the roles of different providers in their care, their experiences with the services and what they thought needed to be improved. According to Steele (1992) the best approach in looking at services is to ask people about the nature of their experience (thus encouraging them to talk about what they know best), rather than relying on satisfaction ratings along pre-determined dimensions.

Staff and other providers were interviewed to gain an understanding of how the services developed and worked, to find out about their and others' roles in the innovations and how the innovations impacted on the way they worked. It was also important to gain an understanding about what obstacles the services had encountered, how these were overcome and what the various stakeholders considered the main issues facing the service. With the NUHS programme it was also important to establish how it related to the rest of the NUHS services.

### **Procedures for collecting data for the HB pilot case study**

The documents examined for the Hawke's Bay case study included those documents developed especially for the pilot as well as the CRHA evaluation reports. Apart from some documentation provided by the Healthcare Hawke's Bay team leader and from personnel who developed the training programmes, most of the documentation had been developed by me in the role of project co-ordinator.

The tools used in the pilot were developed in consultation with the evaluation team since it was important that people were not needlessly approached. Advice regarding the content and language developed in the on-entry questionnaire to be completed by the people with SOMI was obtained from the Wellington Mental Health Consumers Union. Consultation about other tools used with consumers was held with the consumer representatives for the pilot. As Table 1 shows, the CRHA-purchased evaluation required that people with SOMI, CMHT,

GPs and other providers were approached for an interview or to complete a questionnaire on three occasions. On each of these occasions different stages of the pilot were evaluated.

**Table 1. Timing of data collection for the evaluation of the HB pilot**

<b>Phase of Hawke's Bay pilot evaluation</b>	<b>Time in relation to pilot commencing</b>	<b>Data collected</b>
<b>Start of pilot</b>	1996 - Commencement	*Interviews with CMHT and GPs *On-entry questionnaire and outcome tools as people with SOMI joined pilot
<b>Interim evaluation</b>	1997 - 9 months after the pilot started	*Interviews with CMHT, GPs and people with SOMI *Health status outcome tools
<b>Final evaluation</b>	1998 - 18 months after the pilot started	*Interviews with CMHT & GPs *People with SOMI either interviewed or completed questionnaires *Health status outcome tools

All service users who met the pilot criteria were provided with information about the pilot and how it would be evaluated and were invited to complete an informed consent form in which they then agreed to data being submitted for the evaluation (see Appendix 6). This consent covered data obtained in the utilisation review, completing outcome measurements<sup>3</sup> required for the impact evaluation, and consenting to be contacted for interviews. The CMHT staff approached people to explain the pilot and obtain this consent. The initial requirement that the consent process be witnessed posed particular problems for the CMHT as many of the people lived alone, or were alone during the day. This meant the CMHT members needed to travel in pairs in order to witness the consent process. This was very time consuming and the CMHT was concerned that having another CMHT member present as a witness added pressure to the consent process. The Hawke's Bay Ethics Committee was contacted about these difficulties and approved a revised consent process involving only one CMHT member. Obtaining consents from a group of people who joined the pilot via the GP posed particular problems. For example, some were on the pilot for over nine months without a consent being signed. GPs, who had been requested to obtain these consents, were advised that people would not be eligible to remain on the pilot if this documentation remained incomplete. All other stakeholders interviewed were required to give written consent prior to the interview<sup>4</sup>.

<sup>3</sup> The health status questionnaire, the SF-36 and the Health of Nations Outcome Scale (HoNOS) were both used to evaluate the impact of shared care on health status.

<sup>4</sup> While this consent was the same as that signed by the people with SOMI, a modified information sheet was used. The modification emphasised provider and practitioner issues.

The initial data collected in the Hawke's Bay study involved baseline data about the GPs involved in the pilot and how the services currently worked (see Appendix 7). Accordingly, a GP utilisation sheet was designed and pre-tested, and questionnaires were developed to obtain data from the service users who joined the pilot. Once people consented to participate in the evaluation they were required to complete the entry questionnaire providing baseline data (see e.g. Appendix 2). Subsequently, every time they went to the GP, the GPs were expected to complete a record of individual utilisation data (see e.g. Appendix 3) and also to submit these returns monthly to the pilot co-ordinator in order to receive payment for their services.

Interviews and questionnaires were then developed before each stage of the evaluation. Interim interviews focused on issues that arose in establishing shared care, for example, how consumers perceived their care to be working and what changes they had experienced in service arrangements. Final interviews focused on how people with SOMI viewed the effectiveness of the shared care arrangements and what impact ceasing the pilot would have on their care arrangements. Although the GPs and CMHT staff knew who could be approached for interviews they were not aware of who was actually interviewed, unless the people themselves informed them personally. Since the interviews covered consumers' experiences with their service arrangements it was important that their confidentiality was assured.

Two other researchers conducted some of the interviews. They were trained and, following the first interviews, the tapes were reviewed for consistency of approach in the questioning. The venue for interviews was negotiable and included people's homes, supported accommodation, the community mental health office, or other mental health settings. Where interviewees were not comfortable with the use of tape-recording notes were taken. Transcripts were not offered to Hawke's Bay participants because of the large numbers involved.

Arrangements were made for consumer support people to be employed if people did not have access to their own support person and wanted someone present at the time of interview. Two consumer representatives were trained to undertake this role. The support workers were paid on an hourly basis for their time. The procedures involved in the use of support workers was as follows:

- the support worker was briefed about the research and their role,

- they were then introduced to the person requesting their support and given five minutes to meet with the person privately to discuss the impending interview, and clarify the support the person wanted,
- the interview took place,
- following the interview a further five minutes was allowed for the person and support worker to discuss the interview, and
- at the end of a group of interviews the support worker was also debriefed.

The need for this latter phase had not been identified prior to the interviews commencing but was identified following the first interview when it was revealed by one support worker that they were concerned. The issues they identified as troubling included feeling uncomfortable with a venue because of previous experience with that venue, or having had an unpleasant experience with one of the health practitioners named during the interview.

### **Procedures for collecting data for the NUHS programme case study**

The documentation review of the NUHS programme involved examining letters and Minutes of the Management Committee meetings (later renamed the Policy Board); Annual Reports; and reports, talks and articles about NUHS. The tools and procedures used in the HB pilot were modified for use in the NUHS programme case study. This variation was made in consultation with NUHS staff. Consultation was also conducted with Policy Board representatives about the interview schedules to be used with the people with SOMI.

In the NUHS case study, initial data collection commenced in 1997. It involved preparing the documentation review and conducting the interviews with NUHS staff. The utilisation review spanned 1997, 1998 and 1999. In 1999 interviews with other providers were undertaken. Finally, in 2000, interviews (see Appendix 4) were held with service users. This time-span impacted on the research and is discussed further in the section on methodological issues.

While all NUHS staff and service users were required to give written informed consent<sup>5</sup> prior to the interviews, the clinical records were reviewed without consent. The reason for not obtaining individual consent before reviewing clinical records was that the focus was on understanding service delivery, rather than profiling a particular individual's clinical picture,

---

<sup>5</sup> The consent form was similar to that of the Hawke's Bay pilot (see Appendix 6). See Appendix 8 for the information sheet for the NUHS interviews.

and the data would be reported as group data. The ethics application also argued that as the researcher was also a registered nurse, she was bound by a professional code of ethics concerning the confidentiality of patient health data. It was also argued that requesting consent would impact on randomisation and would possibly cause needless distress for some people as only a sample of records were to be selected. NUHS staff did not know whose records were reviewed.

A random stratified sampling approach (Patton, 1990) was used to determine whose records were examined for the utilisation review. The size of the population of the programme was such that to obtain data on the whole population would not have been feasible. A computer print out of all eligible participants was obtained from NUHS. Nazareth, King, Haines, Rangel et al. (1993) found computer records to be sufficiently accurate in identifying who was enrolled in a service. Stratification was used as the research sought a representative picture of service use by years at NUHS and an understanding of the ailment code (NUHS had 4 mental health ailment codes). People with an alcohol and drug dependence problem only were excluded from the sampling as this group of people had their own programme (Kennedy, 1997). Although it was intended that 50 such records would be reviewed, in order to obtain minimum numbers in each stratified group, a total of 57 records were reviewed. The results of the stratification process are provided in Chapter 6. Once the records were obtained a retrospective review of service use was undertaken (see e.g. Appendix 2 and 3).

In addition, it was intended that 10% (n=30) of the service users with SOMI would be selected for interview from the mental health ailment code lists. This was achieved by selecting every 10th person on the computer print out. This overall number and selection technique provided an assessment of how long people had been enrolled at NUHS. People interviewed were not necessarily representative of the range of patients in the NUHS programme. It was assumed that by their mere presence in the programme a person would “either possess characteristics or live in circumstances relevant to the social phenomena being studied” (Mays & Pope, 1995, p.110). People were approached in writing and invited to participate (see Appendix 9). If anyone declined the 11th person on the list was approached. Due to the time delays only 22 people were interviewed. Interviews were conducted at a time and place that was convenient to both the interviewee and myself. Venues for the interviews included people’s homes (including supported accommodation), work support programme and the HSRC. NUHS staff did not know who was approached and who consented to

interviews. If the interviewee agreed the interviews were taped and later transcribed, otherwise notes were written. Interview transcripts were cleaned of names and identifying features and then returned to the interviewee for checking. A few people changed some details in the transcripts and notes at this point.

### **Analysis of the data**

The analysis of data obtained in this research involved a four-stage approach reflecting the advice given by Dingwall (1992) (see pp.20-21) to overcome the limitations of case study. Initially every dataset within each case was analysed separately. A dataset is all the data obtained using one method for each group of stakeholders.

The documentation review provided analysis of when events occurred, what the official record was of why and how things occurred, how the services changed over time and why the change occurred. In this analysis it was also important to establish who was speaking, and from what position or perspective. The analysis of the utilisation data was quantitative, descriptive statistics being used to outline the samples by age, gender, ethnicity, diagnosis and time enrolled with the service. The utilisation data was analysed by calculating measures of central tendency (mean, medians) and proportions (frequencies) for the year's utilisation. The consultations were then analysed for: who was present, type, location, reason and outcome.

Analysis of stakeholders' experience involved a mix of quantitative and qualitative techniques. Stakeholder interviews, with the exception of the people with SOMI, were examined in order to gain information regarding how the services developed, why they developed, and what was the stakeholder experience with the innovation. In the interviews with people with SOMI quantifiable data was analysed using descriptive statistics, and the qualitative data was analysed using an editing-analysis style (Miller & Crabtree, 1992). This involved compiling a list of experiences and issues arising from the interviews, reflecting on these, grouping them into themes and interpreting the themes. Subsequently, each interview was re-read in order to review these interpretations and to see if any information was left out. Table 2 provides the numbers by role of each type of stakeholder who participated in interviews or completed questionnaires.

The second stage involved analysing the datasets as a group to identify the different interpretations and experiences of the services. The third stage involved constructing each

case study, and involved converging and triangulating the results from the first two stages in order to create one picture. Triangulation enabled an analysis of the significance and implications of the findings of the datasets as a whole (Jick, 1979; Mays & Pope, 1995) and assisted with the construction of the case studies “by identifying different ways” the innovations were experienced (Stake, 1994, p.241). The analysis involved linking the data sets to establish the different stakeholders’ experiences of the innovative services (Sandelowski, 2000).

**Table 2. No. of stakeholders involved in the research in each case study**

	NUHS	Hawke’s Bay*
<b>Service users</b>	Interviews (22) Records Review (57)	Interviews or questionnaires (154)
<b>Service user representatives</b>	Policy Board members (4)	Consumer representatives (3)
<b>General practice staff</b>	GPs (1) Nurses (3)	GPs (13) Nurses (1)
<b>Mental health service staff</b>	CMHT members (1) Psychiatrists (1)	CMHT members (7) Psychiatrists (5)
<b>Other providers</b>	Maori health provider (1)	Supported house managers (4)
<b>TOTAL</b>	90	187

\*This number consists of all people who were interviewed or completed questionnaires for the pilot evaluation. An additional group of people joined the pilot without completing baseline data.

This final analysis involved using the cases comparatively and reflectively to ascertain what individually and jointly they could contribute to an understanding of how general practice staff worked with people with SOMI, as well as how such innovative services develop. This approach is similar to that used by researchers doing international comparative analysis of social policy development (Jones, 1985; Kennett, 2001; Rodgers et al., 1979). Reflection and comparison enabled questions to be raised that may not have otherwise occurred had one or other services be researched singly. The results of these analyses are presented in Chapter 6 (the NUHS programme) and Chapter 7 (the HB pilot). Working with each innovation as a case study in its own right, while also wanting to incorporate multi-site design features, meant several methodological issues were encountered that could impact on the rigour of the findings.

### ***Methodological and ethical issues encountered***

The nature of such case study design revealed both opportunities and constraints with the research process. The methodological issues addressed included differences in how the case studies were researched, issues arising out of working in a team and a partnership, and

interruptions in gathering the data. Addressing these as methodological issues enables the limitations of the research to be appreciated and standards of rigour to be applied.

### **Differences in how the two innovations were researched**

The first difference in how these case studies were developed grew out of the different relationship I had with each of the innovations. As project co-ordinator in the HB pilot, combined with that of researcher, I was able to look at issues as they emerged. However, as project co-ordinator I was not able to be a silent observer, since I was often involved in shaping the CRHA's response to the issues. However, I was never in a position of authority, my role rather was to identify and raise issues and discuss possible solutions. As researcher I needed to be open to other interpretations of how and why the pilot took on the shape it did and to be open to critiquing my contribution to the pilot's development.

Although I did not have a direct responsibility within the NUHS programme, because of my previous employment as a public health nurse working alongside NUHS (and through the partnership agreement signed for this research) I developed a close working relationship which strengthened over time. After I had been researching the NUHS programme for two years, I felt I could utilise early findings to present, comment and critically review the programme with the staff. It was only then that my presence as researcher might have impacted on the programme's development. The relationship was such that I was able to discuss what the analyses of the datasets were revealing, and have NUHS utilise this information for its benefit.

In evaluation research those who purchase the research are the main audience to whom the results are directed (Owen, 1993). Although NUHS did not purchase this research, they did enter into a research partnership on the understanding that they too would benefit<sup>6</sup>. Being physically close to the sites had the advantage on getting considerable detail of how the services worked on a daily basis and the issues encountered in developing innovative services. I was able to observe what was happening and use this information to inform the interviews. This added to the richness of the case studies.

---

<sup>6</sup> The results of the earlier analyses contributed to the NUHS programme being awarded an Australasian mental health services award in 1999. The manager of NUHS informed me that as a consequence of winning this award, NUHS was given a substantial grant towards the cost of their new premises.



Both sites sometimes used the results of the early analyses to share their work with other interested parties, and as principal researcher, I was often involved in this sharing. This included presenting findings from the first two stages of analysis at conferences, meeting with managers, clinicians and researchers from overseas, presenting findings to students of social policy, psychiatry and nursing. Ideas and findings were shared with policy staff of the Ministry of Health and the Mental Health Commission, and with other sites in New Zealand interested in the role of general practice in mental health. This sharing was important as the NUHS programme and the HB pilot were innovative services which others were considering replicating. Given the size of New Zealand, researchers involved in service delivery often take on such multiple roles as policy advisor, project management and researcher.

The literature on innovation in service delivery was not read until after the case study data collection was completed. The innovation literature therefore did not influence the data gathering process or my actions as co-ordinator in the HB pilot. The reason for reading the literature on innovation at this point was it was only after the broad questions of the research were refined that the NUHS programme and the HB pilot were interpreted by the researcher as innovations.

The timing of data gathering in relation to the origin of each innovation created a second difference in how the case studies were researched. Data for the HB pilot was collected as the service was developing. The research commenced very shortly after the first planning meetings for the pilot were held, and before the pilot commenced. Data for the NUHS programme however was gathered after the service was established and involved both a historical and a concurrent component.

The NUHS programme's origins were analysed using the documentation review and interview data, whereas the HB pilot's origins were analysed using the material developed at the time. Knowing the basis for such material means that as researcher, I can be more confident with the picture of why things happened in the pilot compared with NUHS. To overcome the potential bias of my involvement in Hawke's Bay and lack of involvement in NUHS, the drafts of both case studies were reviewed by at least one stakeholder involved in each innovation. This review resulted in some minor modifications to the case studies and added to the rigour of the research. It provided the researcher, and subsequently the reader, with a means to be more confident about the validity of the case studies as developed and reported in Chapters 6 and 7.

A third difference in how the case studies were undertaken was in the detail of the datasets used. In addition to the differences in documentation, there were differences in the utilisation review and in the interview process. The utilisation review for the NUHS study was done retrospectively, while the pilot review data was collected prospectively. It is possible that as the NUHS utilisation was based on data that was not established with a view to formal evaluation, not all patient records were necessarily complete (Nazareth, King, Haines, See Tai et al., 1993<sup>7</sup>; Ward et al., 1996). The analysis of service use and consultation outcomes is potentially limited by the quality of the record keeping. In comparison, a limitation of the prospective data is that the GPs may have completed the utilisation forms in a way to try to influence the outcome of the pilot. Throughout the data gathering process two GPs in the pilot were lax about completing their returns, requiring intermittent requests for data returns. In responding to these requests the two GPs reported that they reviewed patient's records and retrospectively completed the documentation. The data from these GPs has been treated in the same manner as that from other GPs, as it was considered the GPs would most probably be able to recall from their clinical notes the components of the consultations.

Another difference in the datasets was that people involved in the NUHS programme were only interviewed once, whereas those in the HB pilot were interviewed up to three times. The NUHS interview schedule (Appendix 4) was designed to capture this difference, and to find out during the interviews how, if at all, the service provided to them by NUHS had changed over time. As such the NUHS interviews required people to recall past service arrangements. As this can involve a comparison with existing arrangements, there is a risk that some detail regarding how things were may not be recalled, or arrangements may be recalled with some bias. These differences in datasets are not considered to impact on the quality of the research findings as this research was examining how innovative services involving general practice developed to meet the needs of people with SOMI. I also considered that it was people's current views of the service arrangements that were important.

### **Doing research with a team and in partnership**

A second methodological issue that arose out of this research was that of ownership of the researcher's contribution to the research. As already noted, a team was involved in evaluating the HB pilot and the NUHS study involved a partnership. Involving others raised an ethical issue concerning the confidentiality of research participant's data. During the analysis at no

---

<sup>7</sup> Referencing of three or more authors includes other surnames if the author has published more than once in the same year, otherwise et al. and year are used.

point in either case study were whole transcripts, notes from interviews, or an individual's utilisation data discussed with researchers or practitioners.

Members of the Hawke's Bay evaluation team, of which I was head, assisted in the development of the tools used in the pilot as the case study was conducted as part of a larger study. The other members in the team included an expert in research methods and one in health economics. The role of the expert in research methods was to assist in the quantitative analysis for the evaluations contracted by the CRHA. This research methods expert was also an adviser on mental health consumer issues. In this capacity she focused on language and ensuring the research did not reinforce the stereotypes of people with SOMI. The economist's role was to undertake a cost-benefit analysis of the HB pilot. However, this was never done due to lack of cost data being provided. In addition to these people, others, mainly student researchers in training, were occasionally involved in working on the pilot evaluation. None of the above researchers were involved in constructing the Hawke's Bay case study as developed for this research, or in the focus of the research on innovation. A different timeframe was analysed for the utilisation review for the thesis and the interviews were re-analysed from the perspective of the framework. A benefit of this research being part of a larger study was that it has been possible to analyse the role of the evaluation in the development of innovative services.

Ownership was also an issue with the NUHS study, as the NUHS research was developed in partnership with them. In this partnership NUHS had a role to play in the final shape of the case study, and in the findings reported. The partnership raised an issue regarding results. NUHS believed they had developed a very good service and wanted to receive the credit for this development. The researcher was initially conscious that NUHS staff might wish to block the release of unfavourable results. This factor was considered when negotiating the contract, as New Zealand health services were, at that time, purchased using a competitive model. NUHS has not vetoed any such findings, rather they have embraced the opportunity to have their service researched; they have trusted the process. Tones and Tilford consider trust develops because different partners to research bring different skills and knowledge. They argue evaluations that include a qualitative component, such as case study, impact positively on the working relationship between researcher and participants: "the ... relationship [is] predicated on mutual benefits among coequal partners" (1994, p.55).

### **Interruption in the data gathering process**

Due to a series of personal crises involving several members of my family experiencing serious health problems the fieldwork for the research was not completed in the proposed timeline (1996-1998). The fieldwork was not completed until 2000. As a consequence, decisions had to be made about the cut off point for studying each case. Using a case study methodology meant that I could revisit the proposed timelines and extend the periods under study. Each crisis impacted on my ability to undertake fieldwork for between three and six months. Following the periods of absence from the research, every attempt was made to obtain information regarding any developments that had occurred in the services during my absence.

Researcher safety in regards to the content of the interviews was addressed in the ethics application. However, it was the content of the interviews that was addressed in the ethics application, and not the researcher's safety to conduct the interviews. What I experienced when these family problems arose was that it was not safe for me, as researcher, to interview people, while dealing personally with such trauma. Interviewing was discontinued until it was safe to resume. This delay raised another ethical dilemma, how to meet the ethical obligations of the research.

The delays impacted on the time period covered in each case study. The HB pilot case study ended in mid-1999 before data gathering for an extension to the evaluation of the pilot took place. The NUHS case study needed to be extended from 1998 to 2000 in order to complete the interviews with the people with SOMI. Accepting the realities that the international, national and local context impacts on experience and service delivery arrangements interruption in data gathering had to be built into the analysis. The time delays also meant that fewer people were interviewed at NUHS than intended. The richness of the interviews was such that the reduced numbers did not impact on the quality of the findings from this dataset.

As part of the ethics applications and consent procedures a researcher proposes what they consider is a feasible timeline for study completion. The delay in not meeting the proposed timeline raised particular issues; should the research be abandoned, and if not, how should one address the issue. In this research the decision was made to continue. The ethics committees were advised and letters sent to participants advising them that due to personal

circumstances the research findings were delayed. Once this thesis has met examination requirements, a final report will be sent to the participants, again acknowledging the delays. Some people will not receive this acknowledgement as some have moved with no forwarding address, while others are known to be deceased. In one situation, a non-governmental provider (NGO) opened a letter regarding the research delays, because the person had committed suicide. A delay in providing research feedback has the potential to cause distress to people who open the mail of people who have died. Other ethical issues encountered during the research were raised with the appropriate ethics committee (see Appendix 10 and 11).

### **Ensuring rigorous research**

Another impact of the time delay was the time between collecting information and writing up the research. Record keeping, documentation and notes kept by the researcher made this process easier, and helped ensure the rigour of the research was maintained (Mays & Pope, 1995). In addition to sending draft case studies to each of the sites for review, the final check for the rigour of the research was to use a checklist developed by Datta (1997) for reviewing case study research. Datta's checklist includes being transparent regarding data collection, database information and analysis techniques. Datta's checklist along with Yin's (1994) criteria for exemplary case studies will be revisited in Chapter 10 in reflecting on the research. One of Yin's criteria for an exemplary case study is that the cases "are unusual (or) nationally important in theoretical terms or in policy and practical terms" (1994, p.147). Given that the NUHS programme and the HB pilot were both unique services this research has the potential to meet Yin's first criteria. His other criteria of the cases having to be complete, to consider alternatives, to provide sufficient evidence and to be composed in an engaging manner will be evident in the presentation of the findings in Chapter 6 and 7. These findings were constructed using the theoretical framework developed to study the innovations. This framework is presented in the following chapter.

### **Chapter 3 – The framework developed to study the innovations**

This chapter outlines the framework used to examine the NUHS programme and the HB pilot as innovations in service delivery and the effectiveness of the service delivery arrangements. The framework has been influenced by two factors: a desire to extend what is known about how such innovative services develop and change; and to contribute to service development for people with SOMI not only in respect of these two case studies, but also throughout New Zealand. Making a contribution to policy development, of which service delivery is one facet, has long been an important aspect of social policy research (Hammersley, 1995; Majone, 1989; Weiss, 1979). To make this contribution Majone argued “policy makers need retrospective [post decision] analysis at least as much as they need prospective [or pre decision] analysis, and probably more” (1989, p.33). This research utilised a retrospective design in looking at the development of these innovations that included exploring the pre-decision analysis that took place in establishing the innovations.

The chapter commences with a brief overview of approaches used in studying service delivery and an outline of what influenced the development of the research framework. The framework is then presented and positioned in relation to the literature on innovation and service delivery. The framework is divided into three parts: the origin and development of these innovations, a description of the respective analyses of innovative services, and analysis of the effectiveness of each site’s service delivery arrangements.

#### ***An overview of approaches used in studying service delivery***

Many authors have developed analytical frameworks to look at service delivery (Gilbert et al., 1993; Hadley & McGrath, 1984; Healy, 1998). Some have been developed to examine general social policies (Gilbert et al., 1993). Others focused on particular aspects of welfare policy such as rationing (Foster, 1983); while others limited their focus to service delivery (Healy, 1998). The frameworks differ in their purpose, be it to evaluate, explain, understand, critique, analyse, deconstruct or describe (Ham, 1980). Some, such as that developed by Hogwood and Gunn (1984) combine both a prescriptive consideration of how policy should be made as well as a descriptive consideration of how policy is actually constructed. They also differ in that some focus on a particular sector such as health, while others focus on welfare per se (McCarthy, 1989). Most frameworks utilise either a life-cycle approach examining the total policy-making cycle or they focus only on one aspect of the cycle such as implementation. Although the frameworks differ in relation to what is involved, they

essentially point to policy making having four phases. These involve establishing the problem to be examined, determining the intervention, implementation and evaluation.

According to Kettner et al. (1990) framing the problem “correctly” is essential to finding the most effective solution. Having established the problem Gilbert et al. (1993) consider the emphasis should be on determining the solution including looking at alternatives whereas others do not see that decision-making is always inherently rational. Ginsberg, for example, considers that there are many “nonrational factors that have an impact on policy; the roles played by emotion, sentiments, prejudices, and power” (1994, p.166). Gilbert et al. also believe it is important to understand the values that underpin and shape a service. To understand how a policy is implemented there is a need to look at what is actually being done, to whom, what strategies are used for delivering the service, how the service is financed and what are the outcomes of the services offered. Healy (1998) expanding on the work of Gilbert et al. identified 11 questions (see Figure 3) as the basis for researching service delivery. According to Healy all 11 questions do not have to be considered in the examination of a particular service development. Ginsberg provides a similar framework to Healy, differing mainly in his emphasis on the financing arrangements around services. Kettner et al. (1990) used similar questions to Healy, but grouped them as inputs (e.g. who attends, who works there and what equipment is provided), throughputs (e.g. what happens in the service) and outputs (e.g. number of visits, number discharged). The evaluation or analysis of the policy once implemented involves understanding how a service balances meeting the needs of the individual, with providing a service for a population (Seed & Kaye, 1994). Ginsberg argued it is important that such evaluations include a cost-benefit analysis and identify the “unintended consequences” of a service.

1. Why should a service be provided?
2. What should be done?
3. To who should the service be provided?
4. What type of service?
5. Which sector?
6. What will it cost?
7. Who pays?
8. Who provides?
9. Where should the service be delivered?
10. When should the service be delivered?
11. How should the service be provided?

**Figure 3. Healy's questions for researching service delivery**

## **Requirements for the framework for this research**

As there is no standardised approach to studying innovation in service delivery choices had to be made when developing the framework. In making these I was mindful of Schram's (1995) argument that research similar to this project can lack autonomy. Schram considers that some projects achieve "credibility not by ... [their] objectivity, but by ... [their] consistency with the prevailing biases of welfare policy discourse" (1995, p.6).

The framework for this research needed to be specific to its intention – that of studying innovation in services provided for people with SOMI. The framework therefore took cognisance of the features of innovation, service delivery and what was understood about delivering services to people with SOMI. The framework needed to capture the dynamic nature of service delivery, and to demonstrate in a systematic fashion the interactive factors that impact on service delivery. To do this, it needed to locate the development of the innovations within the broader context of service development, thereby positioning them in the New Zealand health system and the related political and economic environment (Walt, 1996). Contexts can vary; they can be geographical, sector-based, historical and cultural or a combination of these or other features. The context for this research combined geographical and historical features with the health and welfare sector. Contextual features of specific relevance within New Zealand also include a consideration of the obligations of health and welfare services under the Treaty of Waitangi. It was also essential that the framework be applicable to both of the cases studied and sufficiently flexible to capture the uniqueness of each innovation while providing findings that would be useful for comparative purposes. The framework had to bridge the micro-level of service delivery, namely the inputs, throughputs and outputs, and the macro-level of social systems, namely the organisational, national and international context.

The framework was shaped by the literature and personal experience. Critical to this personal experience was the need to position the person who the services were for as central to the framework and the research. According to Schram positioning the person involves understanding "the subject matter in terms of the subjective experience of those being studied" (1995, p.40). My experience – as a public health nurse, a community worker and a user of health services – was that for services to be utilised well, they needed to be accessible, acceptable and appropriate for the people who used them. Without these aspects even if they were available or clinically effective they would not necessarily be used.



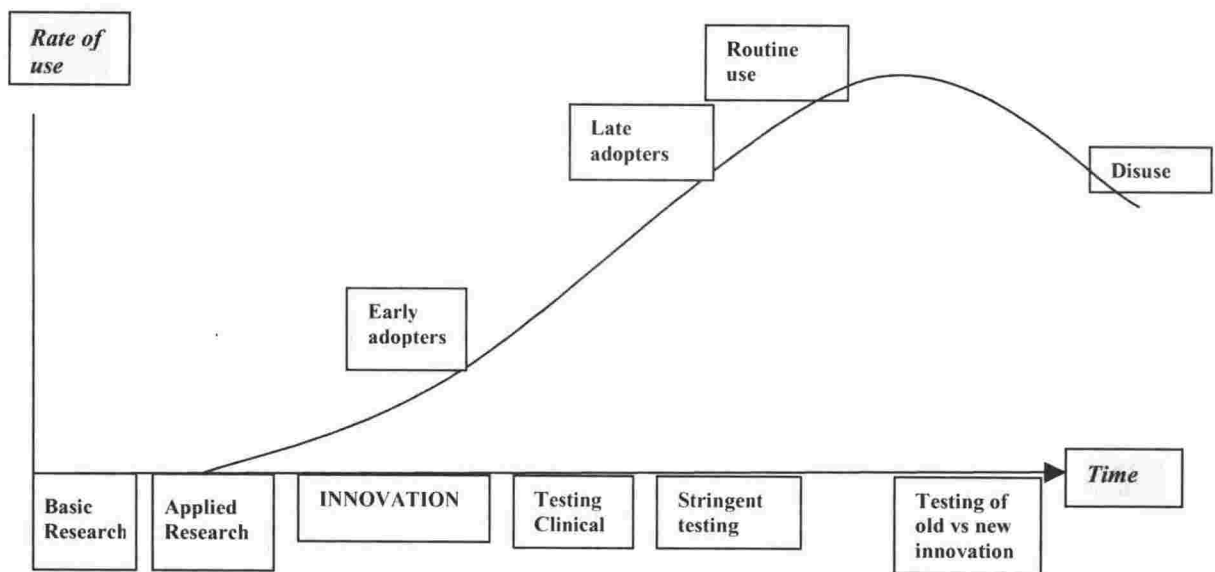
### ***Researching innovation***

Innovations in health services have been researched from two general approaches: first, the pattern of their development, and second understanding their unique ability to deliver services. In the former, researchers have generally used a life-cycle framework to examine the life of innovations (McKinlay, 1981; Rogers, 1995). While in the latter, researchers have utilised a descriptive approach to understand how an innovation has been shaped or implemented (Schulz & Greenley, 1995; Taft & Seitz, 1994). Nonetheless, in both approaches, case study has often been the methodology of choice (McKinlay, n.d.; Schulz & Greenley, 1995; Stocking & Morrison, 1978), hence my approach in this thesis.

While it was argued by McKinley (1981) (in his seminal work on this topic) that innovations in health technologies do not necessarily follow a "career" sequentially, it is generally accepted within the life-cycle approach that innovations pass through a series of stages. These include a beginning or origin phase, a shaping or development phase, adoption and diffusion, and then ultimately a discontinuation in the use of the innovation. These stages have been captured diagrammatically using the "S-curve". For writers such as McKinlay, features of the S-curve are research focused while for others such as Banta (1981), the concentration has been on adoption and diffusion, the S-curve represents when the innovation emerged and the rate of early and late adoption. Figure 4 combines these approaches. The life-cycle approach is very linear and can lead to a simplification of what was involved in the development of an innovation. It implies there is a very definite starting point for an innovation, and that the innovation takes on a similar form throughout its life. A major focus of the approach has been on establishing what influences the rate of adoption and diffusion (Rogers, 1995). Less is understood concerning the decision-making in the Basic and Applied Research stages and also in the shape an innovation takes. It is these stages that this research focuses on.

The descriptive approach has tended to use a multi-factorial framework to capture the components, features and operations of an innovation. Specific frameworks are developed for each study of innovative services. Schulz and Greenley (1995) included four factors – environmental factors, the innovation or change, change agents and the organisation in which the innovation is occurring – in their framework to look at innovations in mental health services (see Figure 5). A strength of this approach is that it puts the innovation into a broader context. However, a limitation is that the study of each innovation is dependent on

capturing the appropriate factors for consideration in the framework. This diversity of different conceptual frameworks (and methodologies) can limit the contribution research can make to policy development (Rist, 1994). A second limitation is that although a framework may capture how and why an innovation developed and changed, description generally does not capture the dimension of time and the dynamic nature of social systems. For example, although Schulz and Greenley's model has the innovation as part of the framework, they do not see that the innovation impacts on other components of their framework, rather it is only shaped by these. The descriptive approach is often used to celebrate the trial or introduction of an innovation. In that the tenor of many articles that utilise this approach, indicate actual or perceived benefits of the innovation (see e.g. Taft & Seitz, 1994), the descriptive approach may provide some of the evidence required in the 'promising report/applied research' stage in the life of an innovation.



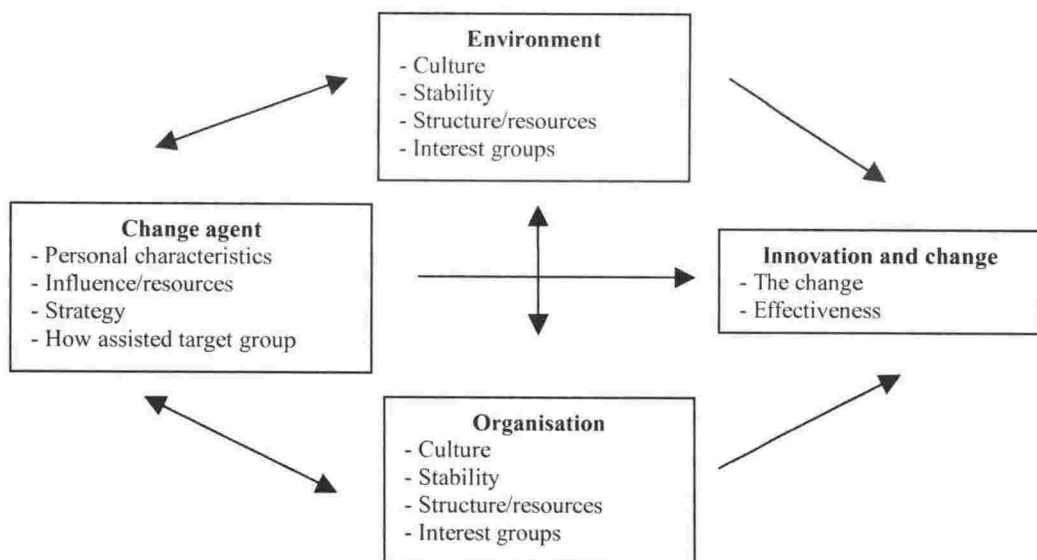
**Figure 4. S-shaped curve of research and rate of use of innovations over time**

Adapted from: Banta (1981). Public policy and medical technology. In C. Altenstetter (Ed.) *Innovation in health policy and service delivery*. West Germany: Oelgeschlager, Gunn & Hain, Publishers Inc.

This research has combined the life-cycle approach with the descriptive approach, as neither approach was considered sufficient on its own. The framework builds on what is known about the different steps concerning the development of innovative services. The focus is on what influences how innovations arise; what influences, informs and directs the shape of an innovation; and the framework also provides a means of assessing an innovation in service delivery for its effectiveness.

## The origin and shaping of innovations

McKinlay's (1981) view of innovations originating from basic research is only one view concerning the 'origin'. Other researchers argue that innovations come about because of factors internal (e.g. a crisis, staff change) or external (e.g. changes in population demographics, the state of the economy) to a service or system (Drucker, 1985; Uttley, 1991). For Mays it is the interaction overtime of "science-push" and "market-pull" forces that lead to the development of new technology to the promising report stage (1993, p.107). Market forces result in innovations "where jobs are dull, repetitive and sometimes dangerous" or emerge to "harness and maximise the potential for labour" in order to accumulate capital (Uttley, 1994, p.186). Innovations may also arise in response to a change in the industry structure or market structure (e.g. as a result of the 1993 health reforms, IPAs emerged) or to address a particular need (e.g. the introduction of blister packs for medicines to reduce the risk of overdose). Thus the emergence of an innovation may be planned or unplanned.



**Figure 5. Schulz and Greenley's framework for examining innovation in mental health services**

Source: *Innovating in community mental health: international perspectives*, Schulz, R. & Greenley, J. (Eds). Copyright © 1995 by Rockwell Schulz and James R Greenley, J. Reproduced with permission of Greenwood Publishing Group, Inc., Westport, CT.

Planned innovation consists of "the purposeful and organised search for changes" and "the systematic analysis of the opportunities such changes might offer" (Drucker, 1985, p.35). Planned innovations often develop incrementally (Stocking & Morrison, 1978); the innovation usually arising to address a particular problem (Drucker, 1991). For example, publicly funded health services have not been able to meet all the community's health needs,

therefore systems such as the introduction of the formalised waiting list for non-urgent procedures have had to be developed to address the shortfall, and develop a more sustainable model. Unplanned innovation is a more random activity – an opportunity suddenly seen or seized upon. This opportunity can occur because of the success or failure of a system or because of an outside event. For example, the emergence of the Mental Health Commission arose because of the failures of the existing health organisations to lead mental health service development. Whether planned or unplanned, innovations are part of a wider social system or socio-political context (Heirich, 1998; Mechanic, 2002; Schulz & Greenley, 1995; Walt, 1996). While considerable attention has been placed on understanding technology management, less is understood regarding the socio-cultural context.

In health services there are three interrelated aspects to the wider social system – the national context, clinical context and the local context. Innovations emerge, and are shaped as a result of interaction among and between these contexts resulting in change in how particular services are delivered in a local setting (Hill, 1997). The interaction happens continuously and can be seen as both following a sequence, yet being spontaneous. The influence can be instantaneous or delayed, simple or complex and can involve one aspect of service provision (e.g. eligibility for welfare or a new form of medication) or can involve service provision generally (e.g. changes in community attitudes and values).

The national context includes the macro-level of service delivery and is located in the international, acknowledging that New Zealand is part of a wider social system (Manning & Shaw, 2000). Ginsberg considers that "the roots of all current programs and services ... can be found in ... history" (1994, p.16). Government reforms and critical incidents either originate from within or outside the welfare system and sometimes the direction of a government's policy results in innovations in welfare. For example, what the community understands about mental illness generally, can impact on the acceptance of people with mental illness by themselves, their family and the community at large. In turn, this influences how services are made available to people, what policy decisions are taken and how providers work with them. Society's understanding of and attitudes regarding rights to receive welfare and how welfare works are also influenced by policy decisions and debates, media content, one off events, personal knowledge or experience and therapeutic advances. The developments in New Zealand's health and welfare system that contributed to the emergence of the role of general practice working with people with SOMI are presented in Chapter 4.

The sector specific context concerns the understanding of best practice and its application that guides service delivery. Knowledge and ways of practising undergo near constant change in response to ongoing research and internal review. It is also derived from insights gained from the literature, failures of the existing system, crises, public scrutiny, or a person's (or groups) particular interests. The clinical context for this research concerned the day-to-day operation of the services and what was known about the best ways to deliver services in general practice for people with SOMI at the same time that these innovative services were developing. Chapter 5 presents this clinical context.

Understanding the local context involves establishing who are the local stakeholders, how they worked prior to the innovation, and how decisions were made regarding service delivery arrangements. The aim is to establish 'What was 'unique' in the settings to trigger or enable an innovation to originate?' Some of the differences in the local context of the NUHS and Hawke's Bay settings were introduced in Chapter 1 (see pp.3-5). The local context is revisited in Chapters 6 and 7, the respective presentation of the case studies.

Although why innovations arise in particular settings and what influences their shape is not well understood, research has established some factors that influence the rate of adoption and diffusion (the uptake by others of an innovation which results in its growth of use) of an innovation. One set of factors relate to the innovation, namely its relative advantage or the degree to which it advances practice; its compatibility or the degree to which the ideas are attuned to existing values and beliefs; observability, namely the degree to which others can see the innovation; the complexity of introducing the change; trialability or the degree to which the innovation can be tried before implemented; adaptability, the degree to which the innovation can be modified to fit the local setting; and cost (Cockerill & Barnsley, 1997; Mays, 1994; Rogers, 1995). Another set of factors relate to the individuals involved. Rogers proposes five "ideal types" to categorise when individuals become involved in innovations. These are innovators, early adopters, early majority, late majority and laggards. The people in these types differ in the ability to accept uncertainty and take risks, leadership skills, social-economic status and their immersion in society (Davis, 1991; Rogers, 1995).

Adoption and diffusion for many technologies such as pharmaceuticals and advanced surgical techniques cannot occur until the innovative technology passes very strict safety and clinical testing. This testing can result in changes to the technology. Innovations in health service

delivery do not necessarily go through a testing stage, instead their adoption is influenced “not [by] the wider climate of opinion, but [by] the characteristic of the change itself” (Mays, 1994, p.104). Other factors known to shape service development are: contracting, technology and resources (personnel and equipment), critical incidents, need and demand, knowledge, and politics and values (Abbott, 1988; Baldwin, 1993; Gordon & Plamping, 1996; Hardy, 1981; Kennett, 2001; Mechanic, 1991; Norris, 1993; Sauber, 1983; Shaw, 2000; Spicker, 1988). Mechanic, for example, considers that mental health service “development depends on the level of financing ... and the incentives that shape professional and institutional behaviour” (1991, p.801).

Understanding how and why innovations develop and change involves looking at decision-making. This involves finding out about which stakeholders and what factors influence the decisions that shape an innovation. Chapter 1 (p.9) listed the key stakeholders in welfare service provision. Not all stakeholders are necessarily involved in all innovations. Stakeholders in these innovations whose decision-making could be explored included: the consumer representatives, the GPs and practice nurses, the CHE-based community mental health service, the CRHA, and my role. Other groups that may have had an influence include for example the general practice organisations (e.g. New Zealand Royal College of General Practitioners, City Medical, the IPA Paradigm, and Health Care Aotearoa), mental health consumers’ movement, and government agencies (e.g. Work and Income New Zealand<sup>8</sup>, the MHC and MoH).

### **Decision-making**

I consider there are three important components – type, direction and nature – of decision-making to be understood in service delivery. These components of decision-making are not mutually exclusive, they overlap. No one theory of decision-making captures all these or is able to explain all the decisions pertaining to a particular policy or service. The aim of the framework is to provide a basis from which the most “plausible account” of the decision-making process used in the development of the innovations can be made (Parsons, 1995, p.247).

Types of decision-making differ in relation to the stakeholders, structures and processes that influence particular decisions and in the level of analysis applied to the decisions taken (Lewis & Boldy, 2002; Parsons, 1995). Finding out which type of decision-making shapes a

---

<sup>8</sup> Renamed the Department of Work and Income in 2000.

particular innovation involves understanding who the stakeholders are, how they are involved, and where the locus of power and control in decision-making is?

The direction of decision-making concerns the origin of decisions. The polarised positions of top-down or bottom-up are the extremes of how the direction of decisions can be made regarding services (Baldwin, 1993; Sabatier, 1986). Top-down services are those that are directed by an authority higher than the service where it is delivered. One way that is often used to bring about top-down change is that of a pilot or trial service (Stocking, 1997). Bottom-up services are those that develop out of the “need” of the community or people served as opposed to satisfying “management and administrative requests” (Baldwin, 1993, p.40). Their development requires hearing and working with “local voices” (Flynn et al., 1996, p.63). According to Baldwin the top-down approach is used more often where larger populations are involved (i.e. a whole community) whereas bottom-up decision-making occurs where small populations (i.e. neighbourhoods) are involved. Webster (1995) considers that the effectiveness of community-based services requires both top-down and bottom-up activities to occur.

Bottom-up services locate the power in the community, those who are users of the service, whereas top-down services have the decision-making located at the contracting level. If the innovations model the polarised positions the role of the people with SOMI would be different in the two services. While the two innovations studied appear to have originated from polarised positions – the HB pilot as “top-down” and the NUHS programme “bottom-up” – the question that needed to be considered in the research was who drove the developments? In the HB pilot was it really the CRHA and in the NUHS programme was it the community?

The level of influence of the stakeholders depends on whether they are “insiders” or “outsiders” in regards to the locus of decision-making (Flynn et al., 1996; Maloney et al., 1994). Groups known to influence policy development are pressure groups, political elites and government officials (Hill, 1997). Decisions on service-delivery are ultimately made depending on who has the power and what is their interest and emphasis. For example, Flynn et al. argue that within the community health services the purchasers controlled service provision through the contracting process.

The nature of decision-making concerns the pace and influence of decisions, that is whether

the process is rationally or incrementally based. Rational decision-making “holds that decision-making can and should be carried out in an orderly fashion starting with assessment”. The goal of the decision-making is to find the ideal solution that is “unbiased and based on knowledge and information” (Foltz, 1996, p.210). Rational decision-making originates from economic rationality that has its roots in capitalism and from bureaucratic rationality with its roots in organisational or administrative systems (Etzioni, 1964). Simon (1957) introduced the notion of “bounded rationality”, that is there are limits, because of human nature and organizational environment factors, to the range of options that can be considered. Lindblom (1959) contested the rational approach to decision-making, declaring that decision-making was not rational, that there was never an ideal decision. He argued that decision-making was incremental it involved “muddling through”. The incrementalist model posits the decision maker as starting not with some ideal goal but with the policies currently in force. Decision making entails considering only incremental change, or change at the margins. Only a rather restricted number of policy alternatives is reviewed and only a limited number of consequences is envisaged and evaluated for any given alternative. (Smith & May, 1980, p.150)

Lindblom and Cohen (1979) argued that incrementalism could take three forms. The first involved a simple analysis of alternative policies. The second a strategic analysis utilising tools of trial and error learning; systems analysis; operations research; management by objectives; programme evaluation; and review techniques. The aim with the strategic analysis is to employ these tools to guide and direct. The third form was disjointed incrementalism. This form is similar to strategic analysis with the exception that it intertwines values and policy goals and problem solving of “ills”. That is, what is planned for tomorrow does not differ radically from today. Decision-making starts with “what exists and where one can go from here” (Foltz, 1996, p.210). This form offers a very localised view of decision-making, where a comprehensive understanding of theoretical issues is not required; rather the decision makers confine themselves to the “variables, values and possible consequences that are of immediate concern” (Gregory, 1989, p.140). More recently, Lindblom (1990, 1993) has acknowledged that other factors such as the influence of legislators, interest groups, government employees and broad social factors such as power and socio-economic and political inequality also affect decisions. Hudson (1992) in an analysis of the introduction of community care planning in the UK found that it is not an either or approach. He reported that the earlier changes to community planning had been incremental,



but the proposed changes were quite rationalist in their basis, concerning the type of decision-making and the basis and pace of changes within the innovations. Depending on its origin, the implementation of an innovation can be “incremental or radical, evolutionary or revolutionary, enabling or disruptive” (Pearson, 1991, p.18).

### ***Describing innovations in service delivery***

To describe an innovation requires knowledge of its goals and characteristics (Cockerill & Barnsley, 1997; Drucker, 1991). Understanding goals involves examining an innovation’s objectives to establish if these aim for excellence, leadership, control or whether they are to fill a niche market or meet a general or special need? Understanding the characteristics initially involves establishing the components of an innovation’s service delivery arrangements such as who the stakeholders are and what goods and services are delivered and received. Stakeholders can include funders through to the community at large. Goods and services vary depending on context. They are visible on an organisational and individual level. Goods and services can be equipment, procedure or processes. While there are several ways one can establish the goods and services an innovation provides, an approach that fits with service delivery involves answering Healy’s (1998) 11 questions regarding service delivery that were presented in Figure 3 (p.39).

Within a service, stakeholders can have different roles and responsibilities. These roles and responsibilities change depending on the context, the stakeholders having different levels of influence at different times. The term “role” captures the functions and activities provided by a stakeholder. Responsibilities can be developed out of practice, be administratively decided or determined by regulation or legislation. Stakeholders’ roles and responsibilities act as a guide for how services operate, shaping what goods and services people are expected to receive. In reality, people may not receive these goods and services; they may even receive other services that are not specified in the descriptions of the roles and responsibilities. Describing the characteristics involves more than describing the components; it requires one to consider the innovation for what it is. For example, were these innovations about general practice staff wanting to target people with SOMI or were they about a new model of community mental health care?

### ***Examining the effectiveness of an innovation in service delivery***

There are different opinions on how one measures the effectiveness of innovative service arrangements. These differences arise because of the different sectors in which innovations

are located and because of differing levels of analysis. For example, McKinlay (1981) argues the effectiveness of innovations in healthcare are evaluated through clinical testing, whereas Moore et al. considers the effectiveness of welfare reform is measured by assessing whether “those who are on public assistance are able and willing to pursue the goal of self-sufficiency” (1998, p.1). Neither of these approaches is applicable to examining the effectiveness of these innovations. McKinley’s model would need to address significant methodological issues (e.g. randomisation and contamination) which are known to be problematic when evaluating mental health and primary care innovative services (Gask et al., 1997). And, Moore et al.’s focus is inappropriate when considering people who have ongoing needs from enduring disorders who for these reasons may never be able to live independently of the welfare system. In these scenarios measures of effectiveness are therefore concerned with service arrangements.

The approach for examining the effectiveness of these innovations to meet the needs of people with SOMI combines many of the principles of service delivery proposed by Healy (1998) with the qualities necessary to develop a successful primary health service (Gordon & Plamping, 1996). A successful primary care strategy supports the work of generalists, both doctors and nurses; manages chronic illness as an emergent condition and not a series of events; maintains the scale appropriate to a personal care organisation; and incorporates the managing of networks and boundaries as part of the core business. Significantly for this thesis, the principles identified by Healy, are the same features Huxley et al. (1990) consider are required in providing effective community mental health services. These features are that services should be accessible, acceptable, accountable, comprehensive, co-ordinated, efficient and improve health outcomes.

### **Accessible and acceptable services**

An accessible service is a service that is available to those who need it. “Gaining access to health ... service programs is seldom easy, and the process is rarely simple – for either the prospective participants seeking help or for the human service staff who are trying to help them” (Kraus & Pillsbury, 1994, p.1). Accessibility involves the availability of a service in the right place, at the right time, which can meet the needs of those who require it. Access to a service or welfare good is either universal or targeted. Universal provision entitles everyone access to a service. Targeting or selective provision entitles only those who meet pre-set criteria to be eligible to receive a service. The NUHS programme and HB pilot both used a

targeted approach. Eligibility is usually based on an assessment of need. Categories of need include normative, perceived, expressed or relative need (Kettner et al., 1990). The decision on what “specific characteristic” to target is based on a nation’s values, beliefs, structures, availability of resources, technology and the aim of current policy (Abrahamson, 2000; Kettner et al., 1990). In New Zealand income, age and health status are criteria that are commonly used to determine welfare eligibility (Boston & St John, 1999).

Once criteria are established, someone is then required to assess and decide whether a particular person is eligible for the welfare good. As demand for services is almost always greater than the supply, there will be people who have unmet needs (Salter, 1995). Cornwell considers that the gap created by demand and unmet need creates a “reliance on professional assessments to legitimate bureaucratic decisions” (1992, p.51). Targeting and prioritising are techniques used by systems and organisations to facilitate people with the greatest needs getting services first. Assessment thus involves an “exercise in power” and can result in the rationing of services (Oliver, 1996). In addition to rationing because of resource availability, rationing arises out of the process of how need is assessed.

Receiving services concerns access, take-up and reach. Access and take-up of welfare provision refers to the ability to obtain and receive the provision, whereas reach refers to who actually receives the provision; that is ‘who’ gets ‘how much’ of ‘what’. Barriers to accessibility can be internal (a result of the organisation) or external (a result of society’s beliefs, values and policies). Three key factors – structural and administrative factors and claimant behaviour influence take-up and reach of welfare provision by both limiting and facilitating access to welfare (Craig, 1991; Huby, 1992; Huby & Whyley, 1996; Moore et al., 1998; Noble et al., 1997).

Components of the structural design of welfare that are important include the complexity of the scheme and guidelines; the lack of specificity of entitlement criteria; the basis and aim of the welfare provision; whether the provision is aimed at groups in society against whom there are prejudices; and whether the initiative to start the claiming process is largely with the applicants (Daly & Noble, 1996; Huby, 1992). Administrative factors affecting take-up include the quality of decision-making by administrators; the sufficiency of advice and information concerning welfare provision for potential applicants; the complexity of the application forms and process such as requiring a third party to sign papers; co-operation with other

administrations; and ways of handling applications which are perceived as humiliating; and budget limits of funds available (Craig, 1991).

Considerable attention has been focused on the role of third parties as gate-keepers to both facilitating and restricting access, reach and take-up of welfare goods (Foster, 1983). Administrative arrangements include the organisation of services on a day-to-day basis, involving the location, hours of operation, organisational processes such as appointment procedures, waiting times, cost to attend the service, cultural beliefs and attitudes of staff, and the appropriateness of the range of services offered for the targeted group.

Claimant behaviour is also important in determining take-up (Klein & Millar, 1995). Kerr (as cited in Huby, 1996) argued that an individual considers sequentially six concepts before they will actually take-up a service. The concepts are perceived need, basic knowledge, perceived eligibility, perceived utility, beliefs and feelings and perceived stability. A number of researchers suggest decision-making may be better conceived as a series of trade-offs between the concepts, that is, where the likely benefits are traded-off against the likely costs and where the concepts interact with each other (Craig, 1991; Huby & Whyley, 1996). Research also suggests that the beliefs and feeling concept is extremely important in determining take-up (Corden 1987 cited in Huby & Whyley, 1996), where expectations of success, feelings towards means-testing and welfare services, and stigmatisation are all important factors in the decision process. Perceptions of need and eligibility – feelings about whether people can get by without a service and who could and should receive a service have also been found to be important (Huby & Whyley, 1996). The uptake and implementation of a new service is not only attributable to the actual care or treatment received, but is also affected by an organisation's structure and the health care system in which the service is being delivered (Mays, 1993).

Acceptable services are services that are considered by the people they are designed for as being appealing and appropriate (Huxley et al., 1990). The perspective of those, whom these services target, is critical. If those who the services are designed for do not value, like or find the services accessible and acceptable, they will not use them. Utilisation is therefore one measure of viewing whether services are acceptable. Utilisation, however, is problematic as a measure of acceptability because it can be interpreted and analysed in many different ways and is influenced by many factors such as availability, and personal supports (Gilbody &

House, 1999; Wing, 1996). To be acceptable a service not only has to meet the needs of the people it is set up for, it also has to meet the needs of other stakeholders such as those who work in them (Saltman et al., 1993). If a service is not acceptable to providers or practitioners, they may not work in them, or refer people to them.

### **Comprehensive and co-ordinated services**

A second set of principles is that services are comprehensive and co-ordinated. When services are working well at the systems, organisation or provider, and individual levels, a person should receive a comprehensive package of care, which is well co-ordinated. At the systems level, policy provides the continuity (Majone, 1989). When comprehensive services to meet the range and variety of health and welfare needs of a person or population are not available there can be gaps or discontinuation in service arrangements (Rein, 1983). Sometimes an innovation addresses a gap so that services can become comprehensive (Drucker, 1985). However, new services or innovations may duplicate existing services. Although duplication can lead to inefficiency at a provider and systems level, at an individual level it has the benefit of choice.

Co-ordinated service means care and treatment is not delivered in isolation. This term is used interchangeably with that of continuity of care and more recently, integrated care. It is about “the relatedness between past and present care” (Bass & Windle, 1972, p.111) and shared understandings with all involved in the existing care (Rein, 1983). These shared understandings should result in the work of health providers being synchronised when working with people to address needs. People have many of their needs met through services in the health and welfare system. Determining what people’s needs are involves an assessment.

The basis of needs assessment is that needs are not heterogeneous, they can be complex and are often changing. As Huxley et al. observed, at “any one time, a client may need help with any or all of the following areas: psychological, social, welfare, financial, housing or health” (1990, p.8). Assessment generally aims to identify areas whereby through welfare provision one can prevent deterioration or secure improvement and/or reduce costs (Davies, 1994). It involves identifying the appropriate resources available for the level of need, as well as providing a mechanism for the efficient use of resources. Determining what a person’s needs are can be influenced by their diagnosis, personal characteristics, the prevailing treatment

modalities, assessment process, and the availability of resources. There is some debate as to whether services should develop to meet needs (needs-led), demands (demand-led) or from the perspective of services that are available (service-led) (Flynn et al., 1996; Fries et al., 1998; Gillam et al., 1994; Glennerster, 1993; Haggard, 1997). There is no uniform agreement on what, and in what quantity needs should be met (O'Grady, 1996).

Once a needs assessment is complete, people with SOMI often get involved with more than one organisation or practitioner (Lang et al., 1997). Different countries have different institutional arrangements for delivering services. In the UK for example, illness needs are provided by health services and social needs by social services (Pearson, 1995), whereas in New Zealand the services available to meet the illness and social needs of people with SOMI are mainly located in the health system. According to Gilbert et al. (1993) different system arrangements require different strategies (e.g. centralised or decentralised, federation, collaborative) to achieve co-ordination. Case-management is one approach commonly used by organisations in planning and delivering services for an individual. Chapter 5 includes a description of commonly used approaches to care and treatment in mental health.

Known barriers to developing comprehensive and co-ordinated services include organisational barriers (e.g. contracting, structures and processes); professional barriers (e.g. orientation, role conflict, confusion and overlap, and 'patch protection'); legal barriers (e.g. who has responsibility); technical barriers (e.g. who is funded to provide a service); political barriers (e.g. bureaucracy) and; ideological barriers (e.g. values and beliefs about concepts such as individualism, stigma and dependency (Healy, 1998; Jennings Jr. & Krane, 1994). To overcome these barriers, organisations, practitioners and people with SOMI need to work together to match services to meet individuals' needs. This requires that stakeholders appreciate and work within the boundaries of their roles and responsibilities otherwise there can be confusion, duplication and gaps in service arrangements.

Boundaries divide roles and responsibilities. According to Pratt and Adamson the "position of the boundary is usually the result of a historical process reflecting organizational and professional attitudes, availability of resources and public opinion" (1996, p.22). It has long been appreciated that "the boundaries of social services are not easy to define" or to work within (Rein, 1970, p.104). Boundaries can be rigid or fuzzy. An innovation can involve shifts in boundaries as a result of stakeholders changing their roles and responsibilities.

Co-ordination at the service level should enable movement of people between services as their needs dictate and should provide greater accessibility for the patient and increased accountability (Muijen, 1993). For this to happen there needs to be clear lines of accountability so as service users and the services know who is responsible for the different components of care (Pratt & Adamson, 1996). Care becomes fragmented when services are not co-ordinated (Rein, 1983) and often results in the services provided being ineffective (Jennings Jr. & Krane, 1994). Co-ordination is essential for smooth interfaces between services. This generally happens when service deliverers understand, value and respect the roles, functions and service delivery arrangements of the “other” organisation as well as their “own” organisation and where there is a mutual respect for skills, a common knowledge base and a willingness to communicate (Pratt & Adamson, 1996, p.21). At times working together results in conflict (Pearson, 1995) as services work at cross-purposes (Rein, 1983).

### **Rights and obligations in the delivery of services**

Citizens generally have rights and responsibilities when they live in a particular country (Salter, 1995). Some rights, such as the right to life are “theoretically” seen as universal, whereas others, such as the right to health and to healthcare are contested, embedded in a country’s social and historical context (Montgomery, 1992). Rights and the accompanying responsibilities are determined by a country’s social and political system. The purpose of rights and responsibilities are for order and accountability (Emanuel & Emanuel, 1996). People who use services also have rights and responsibilities associated with service use. In New Zealand some of these rights are specified in the *Code of Health and Disability Services Consumers’ Rights* that became law in 1996 (Health and Disability Commissioner, c.1996). Huxley et al. in talking about mental health services considered that people have the right to have “care options which are not damaging, which offer the least restrictive care in terms of curtailment of liberty, and which promote self determination on the part of clients” (1990, p.9). The users of mental health services also have rights to choose who is involved in their care “to the extent that ... [their choice] does not impose a serious risk to the consumer or other person/s” (MoH, 1997b, p.11). Providing rights for one person can thus curtail the rights of others such as family and community members. According to Klein and Millar the UK government, and the same could be said of the New Zealand government, “puts more emphasis on the control of total expenditure than on maximising choice” (1995, p.313). An aspect of providing rights encompasses the adequacy of resources. One facet of working towards resources being adequate concerns the efficient use of available resources.

Meeting people's rights and obligations pertains to accountability. Accountability addresses the issue of how people, who give authority and property in trust to someone else, can ensure that their rights are responsibly exercised in a way that follows the interests of the owner of those rights (Bares & Linder-Pelz, 1990). Systems, organisations, practitioners and people with SOMI are all accountable for their actions in various ways. An issue to address regarding accountability involves understanding the different levels for assessing accountability (Wall, 1996). Practitioners, in providing services, need to be accountable to a range of stakeholders: their users and their users' carers, their organisation and their profession, their funders, and the community as a whole. Developing services that are accountable involves operating within rules and regulations and developing a service delivery arrangement that is traceable. Individual services manage accountability via administrative systems. Administration concerns the operation of the service. One aspect of administration is how the criteria of accessibility are met. Mechanisms for guiding and ensuring accountability are regulations and legislation. Regulatory and legislative requirements can be at an individual, provider or systems level. Failure to meet consumer rights can be caused by organisational, structural, or discrimination factors (Kraft, 1998).

### **Efficient and effective services**

Efficiency and effectiveness concern the performance of a service (Allen et al., 1987). Although these are important criteria for the adoption of innovations they receive only limited attention in this thesis because to answer many of the questions raised by these criteria requires research using economic analysis and clinical testing using outcome measurement. Oliver (1997) argues that a multi-disciplinary team should develop such research. The team involved in evaluating the HB pilot undertook a limited cost analysis and conducted some clinical testing (Nelson, Cumming, & Peterson, 1998).

In an efficient service "resource decisions give value for money" (Scott, 2001, p.9). There are two main types of efficiency: allocative and technical. Allocative efficiency pertains to the level and mix of goods and services required. Debates occur regarding "what should or should not be spent and on where it should be spent" (Jones, 1994, p.507). Achieving efficiency involves "making value judgements concerning the relative desirability about efficiency versus diversity" (Gilbert et al., 1993, p.143). According to Healy achieving efficiency should also involve the "principle of parsimony", that is services "should be delivered in the most direct and simple way" (1998, p.13). Technical efficiency pertains to



which services yield “the best result at least cost” (Spicker, 1988, p.11). In mental health “the most efficient combinations of forms of care [are not known]; very few services are technically efficient; many are not targeted properly; and cost data used in efficiency studies are often inadequate” (Huxley et al., 1990, p.9).

Efficiency is required at all levels of the system including the administrative arrangements of running the service; the system of eligibility and entry to the service (Kraus & Pillsbury, 1994); the services provided; the level and skill of those delivering the service; and the system of funding and of communication. A limitation of achieving efficiency is that “the constraint of cost means that something less than the maximum goal may be achieved” (Spicker, 1988, p.11). Mechanisms such as payment, competition and targeting impact on efficiency.

When comparing models of service delivery, more than one model can be found to be effective (Sainsbury Centre for Mental Health (Sainsbury Centre), 2001). How effective an innovation is concerns the impact of outcomes. In health services, outcomes are complex and multidimensional (Horowitz, 2002; Mirowsky & Ross, 2002; Oliver, 1997); and can be grouped into three sets of measurement. These measurements are health status, health service and consumer or carer outcomes. Health status outcomes measure an individual’s state of health (Andrews et al., 1994). In addition to tools such as the SF-36 and the HoNOS which have been developed internationally to measure health status, a key mental health outcome in New Zealand is that of recovery. Health service outcomes measures the performance of the health services (Allen et al., 1987). Consumer outcomes are measures consumers have identified make a difference for them. In mental health, choice and independence have been identified as consumer outcome measures (Nocon & Qureshi, 1996).

Criticisms of outcome studies include that they often use very different outcome measures; there is a lack of clarity in defining the ‘population’ under study; they often involve only one type of outcome measure; and not all key stakeholders are consulted (Pope & Mays, 1995; Saltman et al., 1993; Spicker, 1988; Wykes, 1995). In writing about community care, Wykes argued that not only must one understand the effectiveness of an individual treatment, but also one should know the best method of service delivery to enable a treatment to take place. This means that in evaluating the effectiveness of an innovation it is important not only to

look at the innovation itself, but also to consider how the innovation is integrated and applied as part of the service delivery system.

### ***Conclusion***

The framework for the analysis of the NUHS programme and the HB pilot case studies combines the life-cycle and descriptive approaches to studying innovation with that of models of decision-making and the principles of service delivery. In the analysis undertaken for this thesis the basic and applied research phases of the life-cycle approach have been replaced with the national/international, clinical and local contexts in which the innovations were located. This leads to the innovations being viewed as having their origins in and being shaped by an interactive process between the various contextual factors. Through the addition of an analysis of decision-making and of the principles of service delivery (namely services should be accessible, acceptable, accountable, comprehensive, co-ordinated, efficient and effective and meet the rights of users and the obligations under the Treaty of Waitangi) the framework specifically directs the researcher in the writing of the case studies to examine particular aspects of roles, relationships, and activities in the innovative services development and operation. Yet, in providing this direction, the framework provides sufficient flexibility to capture both the similarities and differences in the two innovations so some conclusions can be made about the influences on the developments, the shape of the services provided and their effectiveness for meeting the needs of people with SOMI.

The next two chapters show how in using this framework increased attention has been focused on developing efficient and effective services so as to limit the escalation of the cost of providing health services and to contribute to evidence-based policy-making. These chapters draw on a range of sources to describe the national and clinical contexts in which the NUHS programme and Hawkes Bay pilot were located.

## **Chapter 4 – The national context in which the innovations were located**

This chapter examines changes in the overall patterns of New Zealand's health administration and service delivery systems. These include the move from universal to targeted provision, the closing of institutions and the focus on community-based services<sup>9</sup>. All of these structural changes in service delivery patterns have been accompanied by similar structural changes in the health workforce from a narrowly focused workforce to a diverse workforce. Changes in legislative and regulatory processes demonstrate a move to outcome focused contract accountability. This national context that emphasised new systems of agency theory and accountability shaped the climate within which both the NUHS programme and the HB pilot developed. Even though this national context was shared by both innovations, it will become apparent that the origin of each of the innovations, and the shape they took, were influenced by different policies and events. The chapter also shows how the public perception of mental health services has waxed and waned and how the users of these services have experienced considerable fluctuation in public levels of support for the services they need.

Although much of the context is considered from the perspective of mental health and primary health service provision, the shifts that took place in the area of service provision were reflected in other areas of welfare such as education or child services. Sometimes the overall direction of the government's programme resulted in changes in mental health even though the intent of the policy was not necessarily targeted at the welfare system, and on other occasions the origin and intent of the programme was very specific to mental health. The chapter does not follow chronologically, rather it is written around the headings of the principles of service delivery. This approach was chosen to reflect the multiple environmental factors that influenced the development of these innovative services. A chronological list of events covered is however provided in Table 3. This chapter focuses on the more recent changes, the earlier period having been well documented elsewhere (Laugesen & Salmond, 1994; New Zealand Government, 1974; Truman, 1984).

Three years (1948, 1978 and 1998) are used in tables to demonstrate changes over time. These landmark years represent turning points where a new agency had taken over the administration and control of mental health services. The year 1948 was the first year that the mental hospitals were administered as a Division of the Department of Health rather than

---

<sup>9</sup> For other versions of a history of New Zealand health services see Gauld (2001b) or Davis and Ashton (2001) and of welfare see Davey (2001) or Spoonley et al. (1994).

being a department in their own right; 1978 was the first year that Hospital Boards (HBds) had complete control over how the funding was spent on mental health services<sup>10</sup>; 1998 marks the combination of the four previous RHAs into one HFA, thus returning the main purchasing arm of the health service to a single central agency.

**Table 3. Key events in mental health and primary health service development in New Zealand, 1960-1998**

Year	Legislation	Policy changes impacting on mental health and general practice services
1961	Amendment to Mental Health Act	
1969	New Mental Health Act	
1970		Subsidies for practice nurses introduced
1972	Equal Pay Act	Psychiatric hospitals move from Department of Health control to Hospital Board control
1973	Domestic Purposes Act	Moratorium placed on new psychiatric beds
1975	Treaty of Waitangi Act	Mental health policy review
1982	Official Information Act	
1987		New money available for primary health services
1988	State Sector Act	
1989		Primary health care scheme introduced to reduced co-payment costs to see GP
1990	Bill of Rights Nurses' Amendment Act	
1991	Numerous legislation to reform the economic and welfare systems announced in the 1991 budget*	Changes to benefits and housing subsidies
1992	Mental Health (Compulsory Assessment and Treatment) Act	Closure of last hospital-based nursing programme
1993	Privacy Act Human Rights Act	Primary mental health discussion paper released by DoH; Mental Health identified as one of four health gain areas; RHAs; CHEs; PHC; NHC and MoH formed; Introduction of community services card
1994	Health and Disability Commissioner Act	National Mental Health Strategy released
1996		Mason et al. Report released Formation of Mental Health Commission; Increased funding for mental health services; Code of Health and Disability Consumers' Rights
1997		Formation of Health Funding Authority; Mental Health Commission Blueprint for mental health services; New Zealand Mental Health Standards released; Revised National Mental Health Strategy; Increased subsidy for children under 6 years when see the GP
1998		HFA document - <i>The next five years in general practice</i>

\*The 1991 budget by the Honourable Ruth Richardson was, and still is commonly referred to as the "mother of all budgets" because of the radical nature of many of the reforms proposed.

<sup>10</sup> Although funding had been transferred to HBds in 1972, it was ring-fenced for five years.

### ***Overarching government structures and strategies***

The second half of the 20<sup>th</sup> century saw two distinct periods of new overarching government structures and strategic direction. In the first the emphasis was not so much on how money was allocated, or whether it was spent appropriately, but that it could be accounted for as being spent (Truman, 1984). The focus was on administrative systems to ensure the equitable use of bulk funding arrangements. With new information systems that enabled information to be recorded more accurately, and filed in a timely manner, evidence accrued that there were inefficiencies with how taxpayer money was being spent. The passing of the Official Information Act (1982) provided the public with a way to access financial and policy information that had previously been unavailable. By the mid-1980s, awareness of these inefficiencies culminated in the emergence of the second period, that of economic rationalism (Kelsey, 1995; Scott, 2001). This belief, regarding inefficiencies, extended to welfare where it was considered that welfare had "become a burden, both on the state in the form of public expenditure and on the market economy in that welfare had a depressing effect on incentives" (Shirley, 1994, p.136). There was also a perception that New Zealand was heading towards a financial crisis.

Economic rationalism involved the government in divesting itself of what were perceived as unnecessary assets or staff in order to make savings and efficiency gains. This involved selling off some state activities (e.g. State Insurance, the telephone system) and corporatising other activities previously owned and managed by the government (e.g. housing, health). Corporatisation resulted in services being expected to deliver a profit. The government's intent was to get better value for taxpayer's money, and to address perceived failures of the existing system. Contracts for health services moved from being just input focused to include an input and output focus. There was a move to market ideologies in the search for increased competitiveness and an emphasis on responsiveness to consumer needs, self-reliance and accountability (Cumming & Salmond, 1998). It was believed that transparent management structures would result in increased accountability and more efficient services (Boston, 1995b).

The move to market ideologies was reflected in the passing of the State Sector Act in 1988. This Act required government departments and hospital boards to manage using the principles of general management and its implementation escalated the move from "managerial, rather than medical, control over the organisation of health services" (Samson, 1995, p.246). This was accompanied by moves to increase the responsibility of the individual and the family and

decrease that of the state (Armstrong, 1994; Swain, 1994). Over time, in response to and supporting the increased accountability, there was a move for organisations and individuals to become more risk averse (Mead & Bradley, n.d.).

The development of economic rationalism resulted in changes in many components of welfare (Kelsey, 1995) and the establishment of new structures. Table 4 illustrates some of the structural changes at central and local government in the agencies that had direct involvement with people with SOMI over the period 1948-1998.

**Table 4. Key central and local government agencies involved in mental health, 1948-1998**

	1948	1978	1998
<i>Central Government Agencies</i>	Division of Mental Hygiene, Dept of Health	Dept of Health Dept of Social Welfare Dept of Justice Dept of Housing	Ministry of Health Dept of Social Welfare Work and Income New Zealand Dept of Corrections Ministry of Justice The Treasury
<i>National Agencies regulated by central government</i>	Public Trust	Accident Compensation Corporation Public Trust	Accident Compensation Corporation Mental Health Commission Health & Disability Commissioner Privacy Commissioner Regional Health Authorities Housing New Zealand Public Trust
<i>Local Government Agencies</i>	Hospital Board	Area Health Boards	Hospital & Health Services Local Authorities

### **From centralised to decentralised to mixed control of administrative systems**

The overarching decisions about how the welfare system was managed and organised and what the state would provide varied depending on the nature of the 'welfare good'. Over the last 50 years, the distribution of welfare income for example, has remained centralised, whereas state housing has had a mix of central and local control. Publicly funded health services, on the other hand, have had several significant changes in relation to who makes decisions, how services are funded, and who is responsible for the general direction of service delivery.

In 1948, the DoH and the publicly elected HBds were the agencies responsible for overseeing the expenditure of health funding. The DoH oversaw the funding and regulatory arrangements for the health system including general practice. The HBds had the responsibility to administer and provide general hospital services. Mental hospitals along

with District Health Offices (DHOs) were administered centrally by the DoH. The HBds, DoH and GPs were funded through Vote Health. In addition, GPs could claim a co-payment from people at the time of a consultation. Funding for the HBds and DoH including mental hospitals was based on the previous year's expenditure with increments. Funding for additional projects required approval through the government's annual budget process. GPs had access to uncapped funding that they claimed on a fee-for-service basis. As the mental hospitals were under a government department, they were subjected to departmental policy and procedures. The hospitals were expected to be economically viable and self-sufficient (Truman, 1984).

A bi-partisan approach to health policy meant that very little changed until the 1970s. In 1972 the control of all the psychiatric and psychopaedic hospitals (hospitals for people with an intellectual disability) moved from the DoH to the HBds where they were located. Prior to the HBds taking over the psychiatric hospitals many of them were upgraded so they would be in a condition that was acceptable to the HBds (Truman, 1984). At this time a moratorium was placed on establishing more psychiatric beds (Abbott & Kemp, 1993). Other funding became available through ACC<sup>11</sup>. ACC had an important role in funding counselling sessions for people who had been victims of traumatic events.

A significant change to the health system was signalled in 1974 when the government proposed to create 14 Health Regions with a view to integrating primary health care, specialist care and community health (New Zealand Government, 1974). While this particular proposal did not proceed, a proposal to create Area Health Boards (AHBs) by combining public health services such as health education and prevention (provided by the DHOs) with the provision of health services provided by the HBds did succeed. This latter integration effort was first piloted in Northland (Crompton, 1981; DoH, 1982). However, a change in government resulted in the AHB proposals being shelved until 1983 when legislation was passed enabling them to be set up. The first AHBs were formed in 1985 and 14 were in place by 1989 (Laugesen & Salmond, 1994).

As part of a rethink on overall government expenditure, the government commissioned several reviews of the health system. The first of these, *Choices for Health Care* reviewed

---

<sup>11</sup> Another major reform of 1972 was the passing of the Accident Compensation Corporation Act. This legislation, which came into effect in 1974, introduced an employer levy to cover the healthcare costs and income needs of work-accident victims. The Act included a no fault cover and removed the right for people to sue because of an accident.

health benefits (Scott et al., 1986). This review indicated five possible options, from minimal to total participation, for the state's involvement in funding primary care. In that same year, the government also announced a package of funding for innovative models of primary care. The Newtown service was set up in 1987 with some of this funding (Crampton & Brown, 1998; McGrath, 1989). The second major review, *Unshackling the Hospitals* (Gibbs, 1988) reported on a review of the hospital system and concluded hospitals would do better if competition were introduced. No reference to mental health services was made in this report. From the information provided it would appear that only three people (2 psychiatrists and a doctor from Carrington Hospital's management group) involved in the mental health sector were interviewed or sent in submissions. The government responded to these reports by proposing changes that it hoped would improve the level of co-ordination and stop the "buck-passing and recrimination" amongst the key health players (Caygill, c.1988, p.12).

Although the system was decentralised, decisions on which health services were provided were, in the main, made by central government. The AHBs were funded on a population-based formula that included supplements for long-stay mental illness/mental handicap patients, training of health professionals and for special units (DoH, c.1984). The AHBs' contracts of 1987 specified the need to deliver some specific health goals and targets. According to the then Minister of Health, this was the "first time" health goals and targets had been set in health service contracts (Caygill, c.1988, p.18). Mental health was excluded from these goals and targets because of its perceived complexity, lack of target setting, and the belief that it was not possible to measure mental health. Disley argues that this failure to include mental health goals and targets worked against mental health in that it "reinforced the health service orientation toward physical aspects of illness" as opposed to both physical and mental health (1990, p.20). In 1989 the DoH released guidelines for the AHBs that "while not binding provided a framework for mental health service development" (Abbott & Kemp, 1993, p.224).

### **The reforms of the 1990s**

The 1990s commenced with the major health providers, the AHBs, experiencing major funding crises. To address this "critical mismatch" of funding to demand for services, the Wellington AHB proposed an innovative scheme called "Wellbank" which would separate the funder from provider activities carried out by the AHB (Bowie & Shirley, 1994). This innovative model was never implemented as the government reforms announced in 1991 for



the health sector led to the separation of the funding, purchasing and provider roles in health and to the formation of the National Advisory Committee on Core Health Services (NHC) and the Public Health Commission (PHC) (Upton, 1991). The initial role of the NHC was to determine which health services should be publicly funded. Its focus changed shortly after it was set up to address areas of high cost healthcare such as caring for low birth weight babies. The PHC's key function was to "advise the Minister of Health on measures that could be taken to improve and protect the health of New Zealanders" (Skegg, 1994, p.i). Mental health did not originally feature as part of the PHC's purchase brief. The government was also intent on no longer funding the AHBs based on the previous year's costs plus increments.

The restructuring that commenced in 1991 replaced elected representatives of the AHBs with government appointed commissioners. Later, the 14 AHBs became 23 Crown Health Enterprises (CHEs), four regional health authorities (RHAs) were established, and the DoH became the MoH. The MoH had the policy and funding function; while the purchasing function for all publicly funded health services, with the exception of public health, was given to newly formed regional health authorities. ACC was also a purchaser of health services. CHEs were registered as limited liability companies under the Commerce Act and were expected to make a profit. The policy and purchasing role for public health was to be undertaken by the PHC. The RHAs had a major responsibility in that they were "able to purchase all social care for the elderly, physically disabled and those with learning disabilities, providing an opportunity to switch resources between health and social care according to local need" (Coster & McAvoy, 1996, p.391).

These reforms were part of an international trend in re-organising health services in order to get better integration between primary and secondary health services and to achieve wide-ranging efficiencies (Ashton et al., 1991). It was argued that this change would contain the rising costs of healthcare, as health services were now required to shift their focus towards keeping people well, rather than providing for them when they were sick. It was also expected that these changes would result in a health service better able to meet community needs by being "less centralised and less politicised" (Upton, 1991, p.1). The reforms were based on the premise that increased competition would provide improved access, choice, and more efficient services could be targeted to those with greatest need. Others considered that to make any real cost savings there needed to be a reduction in hospital beds with a concomitant transfer of funding to community based services (Glennie, 1992).

The government also indicated its intention to introduce managed care (Upton, 1991). Exactly how managed care was to be implemented was widely debated (Ashton, 1994). The government had proposed that integration would occur through the development of health care plans for a defined population of people. Some wanted to see the desired integration go through to total merging of the funding arrangements in a geographical area, while others saw it as partial integration (MoH, 1996a; Te Puni Kokiri, 1995). Very early in the discussion about managed care it was argued that “mental health users may have special needs when it comes to managed care, and that what was needed was a separate mental health managed care organisation” (St John, 1996). The concept of a separate mental health managed care organisation was not new. In the USA mental health was both available within managed care organisations and also in separate organisations (Sederer & Bennett, 1996; Wells et al., 1995). Although the idea of health plans was later dropped because of problems of risk-rating health care premiums (Cumming & Salmond, 1998), the drive for integration continued.

In 1993 the government revisited health goals and targets and identified child health, Māori health, mental health and physical environmental health as health gain priority areas for particular attention. These areas were identified as “needing improvement due either to poor performance compared with other countries or a need to reduce disparity within New Zealand” (Shipley, c.1996, p.11). Disley (1996) argued that mental health was signalled to be a priority area as a consequence of effective lobbying. In addition to the extra funding the government provided for the priority areas, it was expected that the RHAs and CHes would “re-prioritise funding towards mental health services from efficiency gains in other services” (Wilson, 1997, p.8).

The government identified key and strategic result areas (KRAs and SRAs) in order for the public sector to achieve its overall goals of “building stronger communities” and “strong economic growth” (Signpost, 1996, p.3). In health, this involved the contracting process moving to an “output-based system of appropriation”. This meant that service delivery needed to be defined and described in components, that is “unbundled”. The increased specification involved “itemising” the components of care that could then be purchased separately. Publicly funded services could also be provided by both public and private providers (Boston, 1995a)<sup>12</sup>. Underpinning the change was a growing belief by politicians, policy analysts and many in the community that when “government builds facilities and staffs

---

<sup>12</sup> The increased involvement of private providers was also influenced by the belief that “private care is often ... more humane and ... less costly than public care” (Ginsberg, 1994, p.141).

them with permanent employees it takes on fiscal obligations that continue indefinitely and often expensively” (Ginsberg, 1994, p.141).

Predictably these general health reforms did not provide all the success that was hoped for. The government was plagued by criticism and public condemnation of how the health services were functioning. Many of the CHEs ran at a financial loss, and there was a belief by the public that the services were no longer able to meet basic health needs. In addition, the purchasers had not been able to ensure that what was purchased was provided. There was a growing critique that health was different from other products in regard to choice, competition, production and how efficiencies could be gained (Bowie & Shirley, 1994). It was also argued that in health organisations there needed to be both clinical and managerial input at the management level (Egger, 2001). High administrative costs and evidence of regional variance in service provision led to the four RHAs being combined into a transitional authority, and subsequently in 1998, into the HFA. The CHEs were renamed Hospital and Health Services (HHS). Although the HHSs had to continue to be efficient, they were no longer expected to make a profit. Population-based funding of HHSs was reinstated as important with considerable efforts being put in place to have the funds more accurately reflect the actual populations. This reallocation of funds resulted in the southern HHSs losing funds to the northern HHSs.

### **Changes in the 1990s to mental health structures**

In mental health services unbundling resulted in further separation<sup>13</sup> of the social (e.g. accommodation) and health aspects of mental health (Wilson, 1997). Social needs were conceived of as disability costs whereas health needs were treatment. The unbundling did not just happen within health, it also happened between health and other sections of government. For example, prior to the funder/purchaser/provider split, the Department of Social Welfare funded supported housing. With the reforms this responsibility was returned (along with the budget) to health.

This ... gave the RHAs the ability, not just to purchase support and residential services for those with psychiatric disability, but to integrate their purchase of both the clinical services and the support service, to get a greater continuum of care for people with mental illnesses. (Wilson, 1997, p.8)

---

<sup>13</sup> Some NGO organisations had increased their role in mental health during the 1980s.

The move throughout the western world to integrate care better, led to a review of the potential for general practice to deliver mental health services. The process of unbundling led to organisations identifying their “core” business with the result that aspects of care not seen as part of the core were often taken over by other groups or were just left not done. For example, supportive accommodation provided by CHE-mental health services was taken over by NGOs. The CRHA only purchased services from CHEs and mental health providers for those with serious mental health needs, that is, there was a focus on secondary and tertiary services. The changed contracting environment also enabled the RHAs to use the contracts to trial initiatives, and one such initiative was the HB pilot.

In 1994 the government, aware of the ongoing criticism of mental health services, released a 10-year strategic plan *Looking Forward* (MoH, 1994). This plan was accompanied by additional funding. The strategy although impressive in its goals, provided no overview as to how the plan might be achieved or measured, though documents produced by the RHAs provided a clearer direction of how the strategy could be achieved (Central Regional Health Authority, (CRHA) 1994). The mental health services however, continued to cause concern as the public was made aware of individual incidents that either put individuals or the public at risk. General disquiet about mental health service delivery resulted in a major inquiry into mental health services being ordered by the government in 1995. The main conclusions of this inquiry (referred to hereinafter as the Mason Report), the second to be conducted by Judge Ken Mason, were the historical nature of problems in the mental health services (an earlier report (Mason et al., 1988) had identified many of these). The problems identified were a lack of national direction; a lack of funding; structural problems due to the deliberate separation of provision of services from policy; and poor integration and co-ordination of services (Mason et al., 1996).

The government’s response to the Mason Report was to provide additional funds for new mental health services; to require involvement of consumers and their representatives in mental health; and to establish the Mental Health Commission as a monitoring body. New Zealand was not the only country that needed to direct additional money into mental health. Measures were also put in place in the UK to “force commissioning agencies, including fund-holding GPs, to make purchasing services for this previously neglected group a priority” (Gournay, 1994, p.40).

In 1996 there were three key bodies – the MoH, RHAs and MHC – involved in mental health. However, they were not set up with defined complementary roles and responsibilities. There was duplication and each body had different sets of information requests, for and from the providers. Fifteen months after the Mason Report Henare, a Mental Health Commissioner, expressed concern that “money intended to be distributed urgently has still not been fully dispersed to providers” (Ross, 1997, p.18). The money was apparently tied up because of contracting difficulties. In addition, staff shortages forced delays in establishing new services. Nonetheless, there was some reconfiguration of existing services to take the opportunity of getting some of the new money. For example, in Wellington a number of new specialist initiatives such as the early psychosis intervention and maternal mental health service were set up using “Mason money”. The HHS had previously provided such services as part of the range of services available. The new initiatives were staffed by people who had previously worked with people with a range of mental health needs.

The MHC presence was most obvious in its consultation and advocacy role where it challenged mental health providers and government to do better. Part of this challenge was presented in the MHC *Blueprint for Mental Health Services* released in 1997 (MHC, 1997) and updated in 1998 (MHC, 1998a). Integral to these documents was the need for services to adopt a philosophy of recovery in their approach to service delivery. The *Blueprints* set a national framework for the future of mental health services. In 1997 the MoH also released an important document, New Zealand’s first ever, mental health standards (MoH, 1997b). The purpose of these standards was to “upgrade the quality of our mental health services and ensure consistency” in the services delivered throughout New Zealand (English, 1997, p.iii)<sup>14</sup>. These standards were to be met by all mental health providers by 1999.

In 1997 the 1994 strategic plan was superseded by another plan, *Moving Forward*, which was the government’s response “to address the inadequacy of mental health services after they had been reconfigured” (Wilson, 1997, p.7). The strategy was based on several assumptions including that more services result in better access, and that “mental health is not the sole responsibility of health services - there are intersectoral responsibilities - social, education, employment etc”. A fundamental component of the strategy was the adoption of benchmarks (using epidemiological and service utilisation data) for purchasing and measuring the

---

<sup>14</sup> The standards were developed to be consistent with the principles of *Te Tiriti o Waitangi* signed in 1840 and to complement the *Health and Disability Services Code of Consumer Rights* (Health and Disability Commissioner, n.d.). Although not stated specifically in the standards, an assessment of them suggests that the values underpinning the standards are equity, autonomy and justice.

adequacy of services. The benchmark was that in any one-month period, specialist mental health services should serve the 3% of the adult population (excluding drug and alcohol) and 5% of the child population who were seriously mentally ill. The benchmarks were to form the basis for the funding allocation to provide adequate mental health services.

### **Changes in the 1990s to primary health structures**

The first significant change that impacted on general practice in the 1990s was the passing of the Nurses Amendment Act in 1990. While this Act is not particularly relevant to people with SOMI, it was for general practice as it paved the way for midwives to be independent practitioners, thereby creating competition in primary care. General practice responded to the main health reforms of the 1990s by setting up new organisational structures, IPAs to facilitate contracting arrangements. These associations involved GPs grouping together into collectives (Jacobs, 1997), effectively changing general practice from a collection of individual small businesses to becoming several large businesses that employed managerial and other staff to oversee their operations.

Once general practices were aligned into bigger organisations they were more easily able to contract to provide services (Malcolm, 1996). Contracting for an increase in their share of the health market was important for GPs whose incomes were reputedly falling in comparison to their specialist colleagues. In 1992 6% of GPs were involved in IPAs, in 1995 35%, in 1996 60% (Preamble & Fountain, 1996) and by 1999 83% (Gribben & Coster, 1999). Under the IPAs, individual practices still differed on a number of features: the number of GPs and other practitioners present, whether they received capitation funding for specific activities or fee-for-service funding, the range of services they provided and whether they were privately owned or owned by a collective. Concern by other providers was expressed over the potential power that IPAs could have.

IPAs are creatures of competition - they are ... "free to choose" in ways that would gladden any businessman's heart. .... IPAs do not operate under the funder/provider split. There is no requirement that IPAs be either 'providers' or 'funders'. They can be both. (Oliver & Francis, 1995, p.5-6)

Some GPs chose not to join an IPA forming their own organisation CareNet (Gribben & Coster, 1999). Similarly, third-sector organisations (e.g. union health clinics) that had been established to work with "vulnerable" populations formed an umbrella organisation Health

Care Aotearoa (HCA). This umbrella organisation appeared to differ from that of the IPAs in how it was set up, in the level of Māori representation and in its philosophy. It used a community development approach similar to the organisations that it incorporated (Crampton, Dowell, & Bowers, 2000).

As part of the reforms, the GPs in IPAs were able to expand their market share of health services. Some IPAs were awarded contracts to pilot the managing of budgets (commonly referred to as budget-holding) for services such as radiology, pharmaceuticals, laboratory, maternity, public health and dermatology. The incentive involved in managing budgets was that GPs could keep some of the savings. However, with these arrangements the GP did “not have to operate within the budget. If the budget ... [was] overspent then the RHA ... [would] pay the excess amount” (Oliver & Francis, 1995, p.4). An evaluation of budget-holding for laboratory services questioned the significance of cost savings and raised questions about the assumption that underpinned budget-holding (Kerr, Malcolm, Schousboe, & Pimm, 1996). It was not known, for example if doctors were over prescribing on laboratory tests, what the optimum level of the budget should be, or what the impact of budget holding would be on total health care. Similarly, Malcolm (1996) argued that budget-holding happened even though there were doubts as to whether such purchasing was in the best interests of New Zealand's health services<sup>15</sup>. Berringer (1996) observed that the four RHAs differed in their response to general practice: North Health being rather mistrusting of GPs, while Midland was ready to proceed with total budget holding, Central not yet sure, and the Southern RHA showed little development. How to reform primary care remained problematic. The HFA released a discussion document *The Next Five Years of General Practice* (1998) which argued the need to change the funding arrangements for general practice to capitation. This discussion document came at a time when there was evidence of growing support for capitation-based payment for general practice (Malcolm, 1998). The HFA hoped that if changes to primary health care came about, there would be improvements in the state of health of New Zealanders.

The chapter to this point has outlined key reforms and changes in the structures and agencies involved at the national level of the health system and what has happened to mental health and primary care structures. These structures, agencies and reforms will be revisited in the remainder of this chapter as they impacted on what was provided, who provided the services,

---

<sup>15</sup> Although not purchased using a budget-holding formula, the HB pilot and the NUHS programme were both purchased using special contractual arrangements with general practice.

the rights and responsibilities that people had and the public views about the effectiveness of the mental health system.

### *Changes in the provision of welfare*

Table 5 summarises how the delivery of welfare goods changed between 1948 and 1998. One aspect of this was that the state moved from being the dominant, and for some people with SOMI, the only provider of welfare goods in 1948 to a sharing of this responsibility in 1998. In 1948 people with SOMI were generally hospitalised for long periods. In hospital they received welfare benefits including free healthcare, housing (albeit hospital care), employment, some income and recreation. When they were hospitalised people had very limited rights, and the level of income was very small, more like “pocket-money”, whereas those in the community were eligible to receive a full income-related benefit, if they met pre-set criteria. By 1998 employment had been removed from the list. This was because the government no longer directly funded employment schemes and the mental hospitals that had been a major employer of many people who were hospitalised (patients worked in laundries, kitchens and gardens), existed in a much-reduced size. People were still eligible for income, housing, education and health goods and services.

In 1994 when the NUHS programme received targeted funding, welfare goods were paid for out of a mix of the individual providing some or all of their needs. Personal supports, community organisations and state funding often provided services when individuals were not able to provide for themselves. For example, individuals made co-payments for GP visits; peoples’ personal supports provided time and accommodation. The community via philanthropic trusts and Iwi-based organisations provided accommodation and recreation, and voluntary agencies such as churches provided emergency food and shelter. There was a growing expectation in service provision that the individual would be more self-reliant and that the family would have a greater role in providing care (Cheyne et al., 1997). Where the family was not available, formal institutions such as trusts sometimes took over the role of family.

During the 1980s and 1990s there had been major changes in who provided welfare and what welfare was provided. These changes, with the exception of health, are not discussed in detail. In the 1980s housing was accepted as something that everyone should have. When people were not in a position to provide their own housing, the state often provided this. In 1991 the state proposed to change its role from being a landlord (providing people access to



state-owned houses) to providing an accommodation supplement (a discretionary benefit) that people could use to offset their accommodation costs (Luxton, 1991). This change was similar to the separation of the purchaser provider split experienced in health and was one of a number of changes announced in the 1991 National government budget. However, the state proposed that it would still have a role in providing housing for people, such as “ex-psychiatric patients” who required additional care (Luxton, 1991, p.17). Some people requiring long-term care were eligible to apply for a subsidy. If this care was in a rest home such as an old people’s home, access to the subsidy became income and asset-tested, whereas if care was in hospital people did not have to directly contribute to cost except for the amount removed from their income benefit. There was considerable variability in the number of hospital beds available in each region of New Zealand.

**Table 5. Summary of changes in welfare provision that impacted on people with SOMI, 1948-1998**

	<b>1948</b>	<b>1978</b>	<b>1998</b>
<b>Administration site (Centralisation to mixed control)</b>	Centrally funded and centrally managed	Centrally funded and locally managed	Centrally funded, locally managed and contracted
<b>Types of welfare goods funded</b>	Healthcare, Housing, Income, Employment & Recreation	Healthcare, Housing, Income, Employment & Recreation	Healthcare; Housing; Income & Recreation
<b>Psychiatric service eligibility (Universalism to targeting)</b>	Universal – everyone who presented was admitted	Universal – most people who presented were seen	Targeted to the 3% with serious mental illness
<b>Site of services (Institution to community)</b>	Large institution called a mental hospital	Trans-institutional - Mainly psychiatric and general hospital with some services located in community	Majority of services community-based, hospital care limited to acute episodes
<b>Providers of services (One to many providers)</b>	Mainly one provider, plus a few voluntary organisations  Limited range of largely unskilled practitioners	Several providers, but one provider (mental hospital) involved with everyone Very specialised workforce	Many different providers, no one involved with everyone Move to introduce lesser skilled workforce
<b>Rights and responsibilities (No regulation to highly regulated)</b>	People – no rights Regular reporting No real auditing No accountability* In-house complaints process	People – limited rights Regular reporting Occasional auditing Some accountability Informal complaints process	People – extensive rights Highly regulated Regular audited Extensively accountable Formal complaints system
<b>Community interest and acceptance (No interest to intense interest)</b>	Not really interested in quality of service provision Keep people with mental illness behind closed doors	Interested in quality of service provision Some acceptance of people with mental illness living in less restricted environments	Highly critical of the quality of services Call to re-confine some people with mental illness to closed environments

\*Not only did the level of accountability change over time, so too did the form of accountability. In 1948 the form was management and statutory accountability, while in 1998 it was predominantly contractual.

People who were in subsidised long-term care such as supported housing or who were hospitalised for more than 12 weeks had the majority of their income diverted to the service

provider, with the person receiving the balance for personal needs, usually around \$15.00 per week. This 12-week hospital stay before penalty meant that some people were discharged in the 11<sup>th</sup> week only to be readmitted in the 13<sup>th</sup> week to get around the penalty being imposed. The rationale for this was people would lose their place in supported accommodation if their funding was diverted to a hospital. People, who because of health or disability needs were unable to procure an independent income, were eligible to apply for a Sickness (for illness of short-term duration) or Invalids' (for illness of long-term duration) benefit. These benefits were income, but not asset-tested. The Invalids benefit was paid at a higher rate than the Sickness benefit because it targeted those who were dependent on income support for a lengthy period.

In 1991 there were reductions ranging from 3.1% to 24.7% in the amount of income many income beneficiaries received (Cheyne et al., 1997, p.187). The one group that did not have their income reduced was those on the Invalids benefit. Disley raised the concern that the new differentiation in payment rates between the Sickness and Invalids benefit would "encourage people to seek classification as an 'invalid' ... [implying] long term illness or the inability to regain health to a point where employment is a possibility" (1991, p.21). A concern was also expressed that if those who are on permanent and semi-permanent benefits had insufficient income to enable a degree of 'quality of life' such as meeting their personal and recreational needs, there may be difficulties in the mental health services making improvements in health outcomes for the mentally ill.

Attention also moved to introduce a work for benefit scheme. It was proposed that people who were on the Unemployment, Sickness and Invalids benefits would be assessed for their suitability for work. Such had been the change in emphasis that unemployed people who declined work opportunities by refusing to go for job interviews (without "just" cause) were threatened with the loss of their entitlement to a benefit. So keen was the state in encouraging people to obtain an income independently that in the early 1990s it provided no penalty against the benefit for the first \$80 dollars earned (Green, 1996).

Before describing the details of the targeting strategies used in health, it is worth noting a change that occurred in the discourse surrounding welfare. In the 1980s the discourse was one of general acceptance that people who obtained welfare-provided income, deserved welfare. However, by the 1990s although it was still accepted that welfare was needed, the

discourse changed. It was argued welfare was not only being given to those who needed it, but it was also going to some people who did not need or deserve help. It was also thought that welfare did not usually work for the good of those who received it (Green, 1996). One basis for these claims was evidence that some people could obtain more from welfare than they could earn in paid employment. This higher payment from welfare than other sources broke an 'unwritten rule' in welfare that welfare should be a last resort. This rule was able to be broken because the 1991 Employment Contracts Act had resulted in the average wage for low-income workers spiralling downwards. There was also concern that there was a dependency cycle regarding welfare provision, there were families of more than one generation who were all on income-related benefits. Kelsey (1995) asserts that inaccuracies about the actual picture of who received benefits and why were presented to New Zealanders to gather support for radical reductions in payment rates.

Health as a welfare good was available to everyone in New Zealand until the 1990s. The shape and funding of the health system for most of the last century was determined by the 1938 Social Security legislation (Salmond et al., 1994). This legislation provided for a mix of welfare entitlements regarding health and supported the provision of both private and public hospitals. The former received tax incentives to offset their costs, people then paid directly (either by insurance or out of pocket) for any services received while the latter were fully funded by the state allowing for universal access to these services based on health need. No specifications were in place to define health need. Although the government had intended that primary health would be fully funded with GPs on a salary, this did not happen because of opposition led by the New Zealand Branch of the British Medical Association (Hay, 1989; Ward & Asher, 1984). This opposition resulted in GPs being able to charge patients a consultation fee or co-payment, as well as receive a government funded fee-for-service subsidy, the general medical subsidy (GMS). Pregnant women were excluded from this co-payment charge due to GPs being paid a higher subsidy. Pharmaceuticals obtainable on prescription were also available free of charge with the state fully funding the pharmacist for the costs. One significant change to funding of general practice that occurred in the 1970s was the introduction of the practice nurse scheme enabling nurses to be fully employed in general practice (McLennan, 1981). Since 2000 the move to introduce PHOs has paved the way for primary care to build upon the skills of a range of health practitioners, not just the GP.

## **Universal to targeted provision of health services**

Not only have there been changes to the welfare goods provided, but there have also been changes to who was eligible for health, mental health and welfare services. These changes have mainly been from universal to selective provision, a move from welfare being based on rights to that based on individual need (Oliver, 1996). Until the 1980s, there had only been a small increase in the payment rate of the GMS paid to GPs. As a result of inflation, the value of the subsidy had declined significantly, and GPs had offset this by increasing the amount of co-payment people were expected to pay. The co-payment rose to the point that it became a significant barrier for some people to access general practice. There were two main consequences of people not accessing general practice. People either got sicker than necessary, sometimes requiring secondary care or they were retained by secondary services where no co-payment was required. Lack of restrictions on medications resulted in much wastage as people were readily given prescriptions, some of which has since been shown to be unnecessary. In 1989 increased subsidies were introduced for all people accessing primary health care. The subsidies were greatest for children, beneficiaries and those people who were "chronically ill" (Caygill, c.1988, p.19). Prescription co-payment charges were introduced for children (\$2 an item) and were increased from \$1 to \$5 per item for adults. The one-dollar surcharge on pharmaceuticals had first been introduced in 1985.

A contract scheme that would increase the government subsidy to GPs "in exchange for a limit on fees charged to patients, data gathering, and participation in quality assurance programmes" was also introduced (Matheson, 1992a, p.35). NUHS signed up for this scheme. Similar to the resistance witnessed with the 1938 Social Security Act, the contract scheme was opposed by many GPs. The scheme was discontinued in March 1991, ultimately being replaced by another targeted approach (Jacobs, 1990, 1997).

In 1990 the newly elected National government introduced further reforms to move from universality in health provision to targeting "those most in need" (Holloway, 1994, p.82). The reasoning behind the reforms was the need to offset the escalating costs of healthcare; to put deterrents on the use of secondary services; and to put a process in place to overcome the failure of the system to deliver care to those most in need. User part charges were required for nearly all aspects of health care including hospital services, primary care and pharmaceuticals. Targeted subsidies to offset these charges were also introduced. People on a pre-determined maximum annual income were eligible for a subsidy once they had obtained

a community services card (CSC)<sup>16</sup>. Having a CSC meant hospital costs were free, and the co-payment expected from people to consult with their GP and pay for pharmaceuticals was less than for those who did not have a card. People on higher incomes were eligible for increased subsidies once they obtained a high user health card (HUHC) that they could acquire when they exceeded a pre-set rate of service use. All people were eligible for a prescription subsidy card (PSC) to offset the cost of pharmaceuticals once they had exceeded paying for a pre-set number of prescriptions. People who required hospital assistance for mental health and maternity care, were exempted from paying hospital user payment costs (DoH, n.d.). The rationale for the mental health exemption was that people requiring psychiatric assistance needed the least barriers possible to consult services (Mellsop et al., 1993).

Immense public pressure resulted in the government dropping the inpatient charges soon after they were introduced, and the outpatient user charges a short time later. The CSC, HUHC and PSC system remained for primary care and pharmaceuticals. People on low incomes with a disability or illness which lasted at least six months, were also able to apply for an income-tested discretionary benefit, the Disability Allowance (DA) (Income Support, 1997). The purpose of the DA was to provide financial assistance to offset some of the ongoing costs incurred (e.g. the co-payment cost of GP visits, special medicines or food) because of a person's disability or health need. Supported accommodation providers were also funded using the maximised rate of the DA to cover the ongoing costs of disability and illness<sup>17</sup>.

By the mid-1990s evidence was mounting that the targeted subsidies were not working for all groups of people. Problem areas were that the uptake of the CSC was estimated to reach to only 75% of those eligible (Crampton, 2001), and that even if people had the CSC they still could not necessarily afford the co-payment cost of a GP visit or the cost of pharmaceuticals (Linkage, c.2000). Structural and administrative reasons were identified as influencing the take-up and reach of the CSC. Accessing general practice was compounded by the minimal incomes of many welfare recipients.

---

<sup>16</sup> The original subsidy approach was based on three levels, but was changed to two levels soon after it was introduced.

<sup>17</sup> As an aside, while undertaking this research, I found that supported houses managed and utilised this funding differently: some gave it directly to consumers, some repaid consumers on an as-used basis and a third group utilised the funds on the consumers' behalf.

Other approaches to increase the targeting in primary care health were introduced later in the 1990s. These approaches were largely incremental, altering aspects of provision for some people, rather than the structure as such. Because of the regional structure of purchasing health services, each region could also introduce its own targeting approaches. The CRHA used such an approach in purchasing the two innovations discussed in this thesis. This targeting approach was supported by the GPs involved. On a national level an increased subsidy was introduced in 1997 for all GPs when they saw children under the age of six years for a consultation (MoH, c.1997). As had happened before, the terms that governed this subsidy were contested and shaped by the GPs who won the right to continue to charge a co-payment fee (Crampton, 2001). Many pharmaceuticals, particularly new and expensive drugs, were restricted, often a cap being placed on how many people at any one time could have the drug via the subsidy arrangements. Attention was also focused on restricting funded “access to those conditions where the new drug” would clearly deliver therapeutic benefit (Tait, 1996, p.3).

The lack of defining health need posed major problems for the health system in relation to hospital-based services. In the hospital services there were increasing numbers of people on the waiting list and some people were able to ‘jump the queue’. It was thought that the latter happened as surgeons generally managed their own lists. What was reputed to occur was that people would be seen privately and then be entered high on the public hospital list, displacing others who had been waiting or had a greater health need. There were no set criteria, other than acutely ill patients having priority, as to which patients’ need was greatest. In 1997 the government introduced a booking system so that people with greatest need would have priority for certain elected surgical procedures (e.g. the removal of cataracts, cardiac surgery). Tools were developed to manage this (Gauld, 2001a). A targeted approach was also applied to mental health. One consequence of this was that the people who were not in the 3% of people with serious mental illness were no longer eligible for mental health services delivered by the mental health system. The definition of who was seriously mentally ill was a clinician’s decision. How to target people with SOMI was one of the issues for which these innovations had to develop criteria.

How people accessed health services did not really change over the period, 1948-1998. GPs were the “gate-keepers” to most secondary healthcare, with the exceptions of mental health and maternity care. There was a general belief by policymakers that there should be no

barriers in access to mental health services. This meant that people and their families were able to self-refer. GPs also had a major role regarding eligibility for income. Although the eligibility criteria for the Sickness and Invalids benefit and the DA were determined by the Department of Social Welfare, a person required a medical assessment and documentation to receive these. An individual's eligibility to continue to receive these benefits was reviewed annually in the case of the DA, 6-monthly for the Invalids benefit, and 3-monthly for the Sickness benefit. Long-term access to the Invalids benefit and ACC payments sometimes required an assessment by another practitioner.

In summary, the move to targeted provision of welfare involved an ongoing realignment of how welfare was provided, and a mixed economy of welfare provision emerged. The state increasingly moved to only providing a safety net (if that) until people were in a position to become economically self-sufficient. For those people with SOMI, the safety net came in the form of income, housing and healthcare subsidies. Occurring almost simultaneously with the change to targeting was a move from institutional to community-based care.

### ***Institution to community based services***

The period 1948 to 1998 saw a major shift in the delivery of mental health services. In 1948 there were three kinds of services: large mental hospitals (Porirua Hospital housed 1,380 people), observation beds in general hospitals and a small number of community agencies providing recreational and post discharge support (e.g. Aftercare in Wellington). Inpatient numbers were reduced during this period and New Zealand was the first to report this decline in the western world (Abbott & Kemp, 1993). The reduction in inpatient numbers was due to the success of innovative therapies such as electro-convulsive therapy (ECT) in the 1940s, new medications in the 1950s and an accompanying more humanistic approach to care (Truman, 1984). Lobotomy and ECT, for example, require hospitalisation, psychotherapy a clinic setting, but almost all medications can be administered anywhere.

The advent of psychotropic medications impacted on community attitudes and understandings of mental illness. It resulted in increasing numbers of people volunteering to enter the mental hospitals, as mental illness was considered treatable. Between 1976 and 1981 there was a 23.7% increase in the number of people who had been resident in psychiatric hospitals for less than a year, and a decrease of 6.2% for the one to four year period (DoH, 1983, p.8). People who left hospital sometimes had to return - this process of coming and going was

referred to as the revolving door syndrome (Woogh, 1986). People's living conditions in hospital improved as smaller villas that housed approximately 40 people replaced the wards that had earlier housed over 100 people. Initially the turnover of patients was confined to those newly admitted however, from the 1970s people who had been in hospital for a long stay started moving from the hospitals to live in the community (Kemp, 1990; Truman, 1984). This movement is commonly referred to as deinstitutionalisation (Croll, 1995).

In 1973, in response to concerns that there were too many people as inpatients in psychiatric and psychopaedic hospitals, the DoH undertook a review of all people in inpatient settings to determine their appropriateness for living in the community (Brunton, 2001). This review identified that 26% of mental health patients could be rehabilitated to the community. It also highlighted that a large number of people with an intellectual handicap were living in psychiatric hospitals. Other research agreed that the psychiatric hospital had become a home for many people (Dowland & McKinlay, 1985).

From 1977 to 1982 additional funds were made available for HBs to apply to the DoH for community mental health-orientated projects (Disley, 1990). Some of these funds were a result of new taxation on alcohol and tobacco (the beer and baccy tax) that was introduced in 1977 (de Lacey, 1984). One of the new services funded involved "the secondment of social workers to general practices". In two of the four practices that introduced this new service it was found that the appointment of the social worker contributed to a "significant decrease in the prescribing of antidepressants and in referrals to psychiatric services" (p.18). These new services, and the advances obtained with the introduction of long-acting medications, resulted in increasing numbers of people with mental illness living in the community. In 1981 the number of people resident (on census night) in psychiatric (and some psychopaedic) hospitals was 8,047, in psychiatric units in general hospitals it was 939, in private psychiatric care it was 643 (DoH, 1983, p.27). A further 12,079 people were counted as being part of the mental health service. There was a general concern that New Zealand had too many mental health beds available. Research by Malcolm (1989) that found people were more likely to be committed and have longer hospital stays in areas with higher numbers of mental health beds per population, provided further evidence for the need to reduce the number of beds available. De-institutionalisation occurred at different rates in different parts of the country.

The example of Carrington Hospital illustrates the impact of deinstitutionalisation. In 1967



there were in excess of 1,300 people resident in the hospital, in 1977 there were 800, and in 1987 between 250 and 300 (Kydd & Simpson, 1997)<sup>18</sup>. The hospital closed in 1992 with care being provided in psychiatric wards in general hospitals, outpatients and other services shifting to the community. The reduction in bed numbers resulted in the focus of the inpatient unit changing from rehabilitation to "stabilisation" (Nurcombe, 1997). Stabilisation involved the management of acute episodes of illness. Rehabilitation however, remained a focus of the regionally located forensic units.

A difficulty that emerged with community care was that the funds did not follow the services. For example, in Auckland over 80% of the psychiatric budget was still being spent on hospital care in 1989, even though less than 5% of the patient caseload was being cared for in hospital. This changed fairly rapidly and by 1992, only 42% of the budget was being spent on hospital care (McGeorge, 1993, p.53). The community's support of deinstitutionalisation was generally positive when it was managed on a one-on-one basis. However, the movement of increased numbers of people into community-based housing from institutions such as Porirua Hospital was often accompanied by public fear. As with the care of the elderly, the move to the community was accompanied by an expansion in the number of providers delivering services (Minichiello, 1995). There was also an expectation that the community would become more involved in supporting people with SOMI.

### **Expansion in the number of providers**

Community-based care resulted in a gradual realignment of services from the hospital to the community. The realignment resulted in community-based services, including general practice, responding to meet the needs of people with mental illness living in the community. The change to community care was not simply the result of treatment advances, other factors were involved. These included significant attitude changes regarding recovery in mental illness, a growing acceptance of the failures of the current system and economic imperatives. There was also a genuine belief that "discharged psychiatric patients ... [would] inevitably receive a better standard of care in the community" than that available in hospitals (Chapman et al., 1991 p.8). Table 6 shows the shifts in who was specifically funded to provide services to people with SOMI from 1948-1998.

---

<sup>18</sup> Although the authors refer to Carrington Hospital, it is assumed that the 1967 reference is to the Oakley population; Carrington was not formed until 1973 (W. Brunton, personal communication, 23 July 2004).

Amendments to the Mental Health Act in 1961 (which allowed for informal admissions in general hospitals) paved the way for an increase in the number of psychiatric units being built in general hospitals. These units impacted on the patient population of the mental hospitals as many people with voluntary status were now cared for in the general units. Mental hospitals became more focused on those with enduring mental health needs, and those who were committed to hospital under the Mental Health Act (MHA).

**Table 6. Providers specifically funded to deliver mental health services for people with SOMI, 1948-1998**

	1948	1978	1998
<b>Psychiatric hospitals*</b>	<i>Long (often near life) term care in large mental hospitals</i>	<i>Short-long term care in medium sized hospitals</i>	<i>A few remaining beds Specialist forensic services</i>
<b>General hospitals</b>	<i>Observation wards in some metropolitan hospitals</i>	<i>Psychiatric Units in some hospitals</i>	<i>Psychiatric Units in most hospitals, psychiatric liaison service in some hospitals. Specialist HHS based services e.g. early intervention</i>
<b>Community based services of hospitals</b>	<i>Limited outpatient services</i>	<i>Community mental health nurses and social workers Day programmes Residential services Outpatient services</i>	<i>Community mental health teams Specialist programme teams Day programmes Residential services Outpatient services Health promotion and advocacy</i>
<b>Non-government providers*</b>	<i>Recreation and social support</i>	<i>Advocacy role and support for people after discharge Health promotion Emergency welfare</i>	<i>Accommodation providers Rehabilitation day programmes Employment programmes Recreation programmes Home-help service Health promotion and advocacy Emergency welfare Voluntary role</i>
<b>GP Groups</b>			<i>Some funded to provide a mix of general and mental health care</i>
<b>Consumer groups</b>		<i>Support role</i>	<i>Health promotion and advocacy Support role Provider role Voluntary role</i>
<b>Carer groups</b>			<i>Health promotion and advocacy Support role Provider role Voluntary role</i>

\* Ashburn Hall a non-government owned psychiatric hospital had also operated since 1882, but because it provided a private service has not been included here.

During the 1970s and 1980s psychiatric hospitals established regular outpatient clinics including specialised medication (moderate) clinics; opened community hostels and houses for people who were discharged (HBs were able to obtain affordable housing from the Housing Corporation) and introduced domiciliary nurses to visit people in the community. These services were established to meet the increased numbers of new patients and the needs

of those discharged from hospital. Community services partly expanded to offset the increasing cost of hospital care, though difficulties emerged. These concerns were that the community services were too institutionalised, some people were lost to follow-up (they had 'fallen through the cracks'), care was not sufficiently co-ordinated and care and living conditions for some people were substandard (Chapman et al., 1991). Although New Zealand experienced problems with community care these were not considered by some to be as great as some other countries experienced (Haines, 1988). This was probably because of the state's role in housing, the size of New Zealand, and that the health services often responded to unmet need before major problems were encountered. New Zealand also only had one main agency – health – involved, whereas the UK had to address inter-agency collaboration at a national level, because two agencies health and social services were generally involved in providing services to people with SOMI (Leonard, 1994). However, as occurred in the UK, one of the problems encountered with community care was that the community was not a structure or organisation that could be contracted with. The consequence of this lack of community structure according to Abrams (1987) cited in Chapman et al. was that in "the typical social settings ... community care is typically volatile, spasmodic and unreliable" (1991, p.10).

Providing outpatient services for the large number of people who had moved to the community was a problem. Many people who required appointments with psychiatrists were collected and transported to these by domiciliary nurses. General practice was not generally involved in the care of people who were discharged from psychiatric hospitals; rather the mental health staff managed all health/medication requirements. The presence of the NGOs as a provider of services, especially accommodation, expanded considerably. They were able to obtain funding for this through Vote Social Welfare (Green et al., 1992). Despite this funding arrangement, people were principally still under the care of the mental health services. Many patients were defined as being on leave from the services rather than discharged. As Baldwin and Parker observed this was "care in the community". The 1990s saw a move to "care by the community" (1988/9, p.144).

When the purchasing arrangements changed in 1992 and providers were contracted to provide specific services, many CHEs reconsidered what mental health services they could or needed to provide. The RHAs were able to purchase services by sub-contracting with organisations to accept responsibility for providing (either themselves or through further subcontracting) a

set of specified services for a specified population (Ashton, 1994). This resulted in the components of care being unbundled. Unbundling led to a rapid rise in the number of different providers, particularly NGOs, becoming involved in mental health as providers could contract for a component of care such as accommodation, recreation, or therapy. The CRHA reported that the number of separate organisations that it contracted to provide mental health services rose from 20 to 70 within the first four years of its existence (Hefford, 1998). New NGOs with a particular focus on mental health emerged and there was a marked increase in the number of Māori health providers and services available (Dyall, 1997). As part of the unbundling agencies (e.g. Schizophrenia Fellowship) that had had provided advocacy and support services on a voluntary basis were contracted to provide such services. Meeting voluntary needs such as emergency assistance were taken over by churches. The combination of providers involved changed to reflect a similar pattern to that found in the UK where Gilbert et al. had found that in "today's world, public, voluntary, and for-profit forms of social welfare are substantially interdependent" (1993, p.13).

Problems emerged with the reforms. Contracts meant that services only had to deliver what they had been contracted to and at times there were gaps and overlaps in service provision. On a national level it was appreciated that there was a need to set up a mental health information system that better reflected community care, as there was no way of knowing whether a comprehensive range of services was available. In 1995 a stock take found that "The increases ... in ... community mental health services, was above what was expected to occur within the strategy framework" (Wilson, 1997, p.9). The rise in number of services available raised concern about how to ensure comprehensive and co-ordinated services were provided. There could be six or seven providers involved with an individual. Wilson observed that there were "also significant difficulties with consumer and Māori participation and partnership ... as well as the involvement of caregivers" (1997, p.9).

As some CHEs had insufficient funds to pay for the services they were expected to provide they cut services (Gauld, 2001b). Cuts in mental health included further reductions in inpatient bed numbers and a reduction in providing staff training. By 1998 the picture of mental health services was very different. The dominance of the hospital-based services as the main provider had lessened, it was now shared with new NGO provider organisations. Accompanying the change in providers and where services were delivered was a change in the workforce.

## **Changes in the workforce**

Prior to the 1950s there were limited employment options in mental health. The staff were mainly nurses and attendants (later named male nurses), assisted by a few doctors and support staff (e.g. farm hands, laundry workers, cooks). During World War Two the chronic shortage of trained staff was so bad that people were “manpowered” to work in the service (Truman, 1984). The staffing picture started to change when the new mental health therapies emerged. Occupational therapists were introduced to provide recreational and occupational training, social workers to facilitate discharge and recreation officers to entertain.

By 1960 the impact of the new treatments forced changes in the psychiatric hospitals. Male and female nursing staff were no longer available to undertake farming duties. To overcome this unavailability, work was redefined as therapy and there was the expectation because of this that patients had to be supervised as they worked. The concept of rehabilitation was adopted throughout the service. Staff numbers increased and there was ongoing diversification; psychologists were now being employed. Staff shortages continued, largely because of negative community attitudes, limited training opportunities, and the availability of other employment.

The transfer of nursing education from health to the education sector in 1973 contributed to the loss of a nursing workforce (Ministerial Taskforce on Nursing, 1998). The last of the hospital-based training schools in psychiatric nursing closed in 1992. The change in nursing education also involved a change to the registration required of nurses from the individual “specialities” of psychiatric, psychopaedic, and general and obstetric nursing to a comprehensive registration that covered all of these. It was later found that the education sector did not provide the workforce either in numbers or with the skills that the mental health services needed (Matheson, 2002). This gave rise to a debate in nursing as to whether mental health was a specialist area that required its own education programme (Prebble, 2001).

Doctors’ numbers in mental health were increased through the inclusion of psychiatric experience into the specialties where training doctors (usually house surgeons) could get the necessary experience for registration as a medical practitioner. Psychiatry or psychological medicine also became part of the undergraduate medical curriculum. Some hospitals employed GPs as Medical Officers of Special Scale (MOSS) to cover the psychiatrist shortfall and to provide after-hours work and some routine clinic work. The use of the GP to

cover specialist shortages was not limited to mental health. The MOSSs were often highly skilled in mental health, having worked in the service when the specialist qualification meant little. Overseas doctors were also recruited. Increasing the involvement of GPs was identified as a way the health system could improve the care of people with ongoing needs for mental health services (DoH, 1993). This was influenced by the fact that the majority of people with mental illness now lived in the community, accessing mental health services was therefore more difficult.

The rise in the number of specialised providers, such as supported accommodation, led to the need for more staff and the requirement to find staff with new skills. The division of labour in mental health, like other areas of health had "become increasingly complex, with an apparent diffusion of authority and responsibility" (May & Purkis, 1997, p.1). Some of the larger providers such as the HHS and Pathways (an NGO) addressed this need by establishing internal training programmes and by supporting educational institutions to set up programmes. Consequently, a new group of workers, the mental health support worker, emerged. Support workers mainly worked in supported accommodation and with people in their own homes. Both the support worker and the GP were less skilled in providing mental health care than those who had typically worked in mental health services. A working party set up in 1996 to address workforce issues noted that there was a poor understanding of the skill mix needed. The short term nature of many mental health provider contracts created uncertainty, funding did not provide for human resource development and there continued to be a pattern of significant staff shortages and high turnover (MoH, 1996b).

In summary, over the period 1948 – 1998 mental health services previously located in large hospitals were now located in the community. With this move came a change in who was considered a provider of mental health services. Non-governmental provider groups emerged, as did the need to expand the role of general practice in mental health. Reasons why the latter role emerged were that mental health services had become increasingly specialised; increasingly targeting their work to those people who were acutely unwell and people with SOMI, now nearly always living in the community.

### ***No person input to some input***

Input by those with SOMI about the decisions concerning what happens to them on entry to the mental health system is almost taken for granted today, but this has not always been the

case. In the 1940s those diagnosed with a mental illness had limited rights relating to the management of their illness and, in many cases, the decision that resulted in their hospitalisation. Many people admitted to the mental hospitals were committed patients under the MHA. The closed community of the mental hospital, large numbers of patients in the villas and wards, and the belief that people generally did not recover from mental illness worked against any patient input.

New mental health treatments such as ECT were readily adopted in New Zealand (Truman, 1984). Treatments paved the way for a change in approach; straight jackets that had been used to restrain patients were no longer required. The therapeutic advances started a move that saw mental illness change from being considered as a deviance to being an illness, which sometimes could be cured. With this change came the acceptance that as patients, people with SOMI deserved better living conditions.

Changes in how mental health services were delivered were also influenced by the release of books such as Goffman's (1961) *Asylums* that provided an insightful view into what mental hospitals did and did not do, and Szasz's (1971) book *The Myth of Mental Illness* that questioned definitions of mental illness. The content of these books challenged the basis of how services were delivered and highlighted the lack of rights that those with mental illness had within mental hospitals (Ginsberg, 1994). This new information contributed to a wave of mental health legislation reform throughout the western world. In New Zealand, a new MHA that enabled for example "committed patients [to] be placed on trial leave in the community for up to two years with the possibility of indefinite yearly renewals" was passed (Abbott & Kemp, 1993, p.222). This Act meant that people could, at any point, be compulsorily readmitted to inpatient care. The lack of rights and review were challenged as part of the rights and consumer movements.

In 1975 in very significant legislation, the Treaty of Waitangi Act, re-acknowledged the Crown's relationship with Māori. This ToW Act involved a restatement and revisiting of the rights of Māori and the responsibility of the Crown to see that these rights were met. Despite this legislation there was evidence that although policy did not provide for discrimination, practice did (Pomare et al., 1995). By the late-1980s, previous unacknowledged disparity between Māori and non-Māori entered the public arena. One of the reasons this disparity may have become obvious was because the membership and secretariat of the 1988 committee of inquiry included people who were of Māori descent (Mason, 1988). What became apparent

was that Māori were over represented in many welfare statistics such as people admitted to hospital, prison, unemployed, on income related benefits and with poor education status (Te Puni Kokiri, 1998). In mental health it was reported that while Māori had considerably lower rates of admission than non-Māori in the 1960s, they had considerably higher rates by 1990 (Te Puni Kokiri, 1993). The over-representation was even more dramatic when committals under the MHA were reported by ethnicity (Dyall, 1997).

Prior to the introduction of the equal pay for equal work provision of the Equal Pay Act in 1972, the Domestic Purposes Benefit in 1973, and the Protection of Personal and Property Rights Act in 1988 women had limited rights and opportunities to meet their own welfare needs or to make decisions regarding their health. People with a disability such as those with SOMI had even fewer rights. Once the larger groups who had experienced discrimination, such as women and ethnic minorities, obtained increased rights, the focus of society moved to reduce discrimination against other groups of people who were disadvantaged such as those with a disability, including those with mental illness.

The social rights movement argued that people with disabilities should aim for “normalisation” (Mandiberg, 1999). The key principle was that people “should be given the opportunity to live a life as close in nature to that of others, with the same rights and responsibilities” (Carson et al., 1993, p.261). The push for normalisation was not limited to mental health; it crossed many sectors that targeted people who were conceivably different. Terminology such as “mainstreaming” was common. Central to this was the belief that services should enhance people and that the best way to do this was through integrating them into the mainstream of the community or health service (Croll, 1995). Some believed that “the time has come to stop segregating mental health problems and policies from the more general run of medical and health problems. Full integration of the mental and physical domains ... is both necessary and possible” (Callahan, 1994, p.453). Others argued that using mainly specialist services for those with mental illness was not always cost effective or efficient (Arya & North, 1999) and that general practice was an integral part of mental health services (Disley, 1990). The debate regarding general services and specialist services was wider than mental health. Wagner et al. (1996) considered that people with ongoing illness needed largely specialist input with general practice being involved on a needs basis only.

### **The 1990s legislative support for rights and responsibilities**

During the 1990s people’s rights were directly addressed in several pieces of legislation (Bell



& Brookbanks, 1998; Oliver, 1996). In 1990 the Bill of Rights Act was passed which provided for civil and political rights. This was followed in 1992 by new mental health legislation. There were several key aspects to the MH(CA&T)A including: a staged committal process that had to be completed within a set time, a time limit on how long people could be detained under the Act without review and a complaints process that allowed people to challenge the decisions made along the way. People with mental illness could be committed to either an institution or into community and professionals other than the medical profession were able to make the decision to detain people under the Act (Mellsop et al., 1993). This Act was much criticised by the community and health professionals. The community, as represented in the media, was concerned that the Act's definition of mental disorder meant that some people who could previously be detained under the 1969 MHA no longer met the criteria to be detained (Bridgman, 1994). The clinicians were critical of the time it took to complete the documentation and assessment criteria of the 1992 Act (Street & Walsh, 1996).

In 1993 the Privacy Act and the Human Rights Act were passed. The Privacy Act ensured the privacy of all personal information and enforced the right not to have this information disclosed to anyone without personal agreement. The Human Rights Act provided for rights against discrimination and established complaints-based jurisdiction. In 1994 the Health and Disability Commissioner Act (HDCA) established a commission for health and disability services. Although a statutory body it was supposed to be independent of ministerial/political influence. The HDCA provided for the rights and responsibilities of informed consent for both treatment and the conduct of research and set up a structure whereby people who had a "complaint" with the service could have it investigated. The need for the HDCA had arisen as a result of recommendations made by Judge Cartwright following her inquiry into the research and management surrounding a group of women with cervical cancer (Cartwright, 1988). Ethics Committees for assessing research proposals were set up as a result of Cartwright's recommendations. The Health and Disability Commission released a Code of Health and Disability Consumers' Rights in 1996 (Health and Disability Commissioner, c.1996). This Code established the rights of people entering health services and the obligations of service providers in regard to meeting these rights.

Difficulties arose with the implementation of the Privacy Act. A family, who before this Act was passed could easily access information regarding a family member from health

professionals, now faced difficulties unless the person concerned consented. This posed a dilemma, families were being expected to be involved in people's care once they were home, but providers were not allowed to share information about a person without the person's permission to do so. Some providers also considered they could not share information with other providers without the person's permission. The lack of sharing created considerable tension as practitioners, families and people with SOMI had to balance short-term needs with longer-term needs and individual rights with family and community rights. To overcome the conflicts specific guidelines were developed for mental health services in relation to the Privacy Act (MHC, 1998b). These guidelines aimed to address the balance between individual rights, family rights and responsibility and community good.

Not only was there recognition of the rights of users, carers and the community and the need to aim for quality standards in service delivery, but there was also recognition that more appropriate services for Māori were needed (MoH, 1994). As part of the increased awareness of the needs of Māori evidence mounted that the type of services provided and how they were provided were mono-culturally oriented. Specific steps were taken to purchase services that were *for Māori by Māori* and then later *for Pacific Peoples by Pacific Peoples*. Providing mental health services that met the needs of ethnic and other groups with special needs had been identified as generally problematic as people valued different things in illness and sometimes required different interventions (Huxley et al., 1990).

### **Mental health consumer movement**

As part of the international movement to increase rights in mental health, service user or consumer movements surfaced in New Zealand in the mid-1980s and expanded through the 1990s (Hinds, 1998). This movement challenged providers, policy makers and practitioners about the absence of service users at mental health planning meetings and conferences (O'Hagan, 1986). A major aim of the movement was to overcome the discrimination experienced by people with SOMI because

Once applied to a person, a diagnosis of serious mental illness develops a life of its own, staying with the person throughout life and creating a societal reaction of stigma, stereotyping, and humiliation ... the diagnosis is seldom revisited or validated with patients on a periodic basis ... [and] leads to care ... that is disempowering, dehumanizing, and controlling, often over many years, resulting in long-term damage to identity. (Hall, 1996, p.17)

In 1991 a World Federation of Psychiatric Users was established enabling the development of a worldwide network and power base for the users of psychiatric services (Allott & Holmes, 1993). Mechanic (1991) argues the movement came about as a consequence of the therapeutic process that saw empowerment and structuring people's activities as important. The movement initially commenced as a human rights movement. Once rights were secured, in principle, it expanded its focus for consumer representation on policy, planning and service provider organisations. This representation of consumers paralleled a similar requirement for Māori representation (and in some areas Pacific Peoples). It was also in line with a move internationally that saw increased public participation in healthcare (Webster, 1995). Providers needed to improve their services to make them more accessible and acceptable to those who were using them (MoH, 1995).

The movement also started to redefine the notion of effectiveness in mental health. Initially, the consumer movement led the criticism of the failures of the mental health system. Freedom from symptoms was no longer enough; choice and independence in treatment, living arrangements and employment were also considered important outcomes by consumers (Nocon & Qureshi, 1996). Employment was defined as not necessarily just concerning work for income, but could also apply to spending time "meaningfully". The consumer movement argued that the users of services had the right and ability "to adjudicate over treatment decisions and the quality of professional care" (May & Purkis, 1997, p.1). There were sentiments of anti-professionalism. One of the areas that the movement challenged was the need for services to balance individual rights with community rights (Belmartino, 1994).

In New Zealand, during the 1990s, consumer movement personnel sometimes took on paid provider roles. For example, the Wellington Mental Health Consumers Union was contracted to run recreational and support programmes and provide consultation services. A consequence of becoming providers was that the consumer movement lost some critical voice, as it was now often working with other providers and government agencies to facilitate and support change. The movement was involved in creating self-help alternatives, campaigning against abuse, critiquing the system and working within the system to improve and influence the system (Lefley, 1996; O'Hagan, 1993). In theory, with the rights reforms and the number of providers available, the mid-1990s should have been a period when consumers would have had considerable choice. However, the Director of Mental Health reported that this was not the case, that the consumers lacked knowledge about their choices

and were more confused than they were prior to the major reforms and expansion of service options (Wilson, 1997).

Even though the consumer movement had been very successful in improving rights, discrimination by society against those with mental illness continued. In 1997 the MoH, Transitional Funding Authority and MHC initiated a 3-year programme to campaign against stigma and discrimination associated with mental illness (Rikihana, 1997). This project aimed to "guide people on the journeys towards equality, respect and rights for people who experience mental illness" (MHC, 1998c, p.1). One of the issues that this project had to contend with was the concern that people with SOMI were dangerous and violent (Peterson & Thompson, 1999). New Zealand had experienced a number of incidents where a person with a history of mental illness had run "amok", sometimes causing injury or death to innocent people and to themselves.

The consumer movement was followed by the carer movement; carer in this context referring to family, friends and neighbours (Lefley, 1996). Prior to the 1980s family were rarely invited or expected to be involved in decisions regarding a family member's care. However, with the move to community care and the change of focus of the services to mainly work with people who were acutely unwell, family were expected to not only be involved in decision-making, but also to contribute to care. This involvement of carers was a challenge for some workers who felt their roles and responsibilities were under threat due to family presence (Bachrach, 1992). The expectation for carer involvement was problematic for many families and the community at large. The HB pilot recognised the role of the family, permitting them free consultations in specified situations.

### **Accountability and regulatory activities increase**

Throughout this chapter many changes in the welfare delivery system have been described. Accompanying these changes have been new accountability measures. There was an increasing requirement by policymakers, funders and users of services that the health services needed to be effective and of high quality. Accountability measures were put in place via contracts, policies and procedures, regulatory systems and legislation. The new measures impacted on mental health services in that providers were expected to deliver services to specific standards and to account for the money they spent. Practitioners became increasingly accountable for the care they provided. The purchasers of health services such as the RHAs

and PHC were instructed in the government's policy guidelines "to identify and analyse risks and develop risk management strategies" (Shipley, 1995/6, p.14). New Zealand generally had become more risk-aware.

The changed accountability measures impacted on general practice in many ways. General practitioners were expected to obtain continuing medical education (CME) credits to maintain their practising certificate. There was increased monitoring, usually via an audit of payment arrangement by Health Benefits Ltd and ACC for the claims GPs made. Social welfare and ACC focused on GPs' practices by requiring some people to have their eligibility for an Invalids benefit or ACC benefit to be re-assessed by a practitioner other than the person's own GP (NZMA Newsletter, 1996). Membership of an IPA also required a commitment to the IPAs' internal requirements (Jacobs, 1997). Some GPs in New Zealand and the UK found the additional accountability requirements problematic. As Onyett et al. reported "Many practitioners remain unused to operating within roles that have been shaped by a strategic commissioning process and general management. They still expect to determine their own practice on the basis of the presenting need as they perceive it" (1997, p.41). Having only an internal professional review process was considered by the New Zealand Medical Association (NZMA) to damage the "good standing and integrity of the medical profession" (NZMA Newsletter, 1996, p.4).

As part of evidenced-based medicine processes were put in place to develop and disseminate rules about practice, for example guidelines were developed for the treatment of depression by primary healthcare professionals (National Health Committee, 1996). Before new drugs were added to the Preferred Medicines List they were subject to rigorous review and were often rationed, becoming initially available for those who would benefit most. The difficulty of such decisions was that often only a fixed number of people were able to receive the drug under the publicly funded system resulting in some people who could have benefited from a drug having to pay in full, if they wished to have the drug.

In addition to guidelines to address problems and minimise exposure to risks from the reforms such as the Privacy Act 1993, guidelines were developed as a way of improving efficiencies in the health system. The government also developed a series of reports and discussion documents and introduced staff policies and quality assurance programmes (Mellsop et al., 1993). As with other changes that occurred in the 1990s there were also many regulations

that were designed to protect the users of the health system. These regulations stemmed from the Privacy Act and the 1996 Code of Health and Disability Rights. In addition, the mental health standards provided consumers with the right to choose who could be involved in their care "to the extent that ... [the consumer's choice did] not impose a serious risk to the consumer or other person/s" (MoH, 1997b, p.11). The expectation was that people with SOMI would fully provide input into decisions regarding their service arrangements.

In summary, many changes in people's rights and providers and practitioners responsibilities and accountabilities occurred between 1948 and 1998. These changes provided people with SOMI the right to choose who was involved in their care and resulted in providers and practitioners becoming much more risk-averse. Changes were sometimes influenced by the community perception of mental health services.

### *Acceptability of the mental health system waxes and wanes*

Throughout the period 1948-1998 the mental health service providers, as a group, were regularly criticised in reports and inquiries, and by the public and the media. This section will highlight only the key aspects of this criticism. The 1960s were characterised by considerable unrest in mental health. Such was the community voice that mental health became a major political issue. This culminated in the 1971 "Oakley Inquiry" (Truman, 1984). Although largely focused on Oakley Hospital where there were opposing views between prison and hospital staff towards the care of mentally disordered offenders, the inquiry highlighted many issues that mental health services faced at that time. Namely, "the lack of suitable psychiatric services, inadequate patient treatment, serious staff deficiencies and the generally unsuitable treatment environment which ... existed" (Mason et al., 1988, p.3). In 1983 the Gallen Inquiry highlighted problems between the criminal justice and psychiatric hospital system. This report was requested following the death of a person who had been administered ECT at Oakley Hospital. The report identified major problems with the care provided.

Although a debate continued over what services should be provided for people, by whom and where there was a sense that once deinstitutionalisation was complete that the mental health service problems would be manageable. In 1985 the DoH undertook research which recommended that there was a need for the hospitals to move from the strongly custodial-controlling approach that was present to one with more emphasis on therapy, reflecting a

caring model (Dowland & McKinlay, 1985). Such was the concern about what was happening at the psychiatric hospitals that in 1986 a special report was undertaken by the DoH to try to better understand the issues that the mental health services were facing (Board of Health, 1987).

This Board of Health report identified areas where hospital practice needed improvement. The report found that although conditions were better, hospital conditions were still characterised by staff shortages, over-reliance on drugs, under use of psychotherapies, lack of continuity of care, and an over use of seclusion and restraint. The report recommended that "goal-setting, staff recruitment and training and ... extra funds for the development of community based services" be adopted as ways of addressing the problems (Bichan & Mellsop, 1987, p.710). About the same time, the Mental Health Foundation released the results of a survey it had undertaken looking at community-based services. This survey identified a lack of community-based resources; lack of consultation with community groups; and a lack of liaison and coordination between primary and secondary service (Disley, 1990).

In 1988 a highly critical report on the mental health system was released (Mason et al., 1988). This *Psychiatric Report 1988* had been commissioned by the DoH in response to an incident where a person with a psychiatric history injured three people and killed a fourth. The inquiry was initially to be focused on forensic services and criminal justice issues; however it was extended to general psychiatric services most notably focusing on decision making in mental health. The report identified six key problems with the mental health services: a lack of the notion of co-ordination, a lack of co-ordination between government departments, particularly health and justice, a lack of funding, a lack of consultation, inappropriate management structures, and a lack of liaison between hospital and community services. The 1988 report was believed by some to be the catalyst for the development of independent comprehensive services (Review (News), 1989). Occurring simultaneously were general reforms that involved the DoH developing mental health service guidelines for the AHBs. The turbulence experienced in the mental health service continued, and, if anything, expanded. The quality and type of services available varied up and down the country, partly as a result of how different regions had adopted and accessed funding for new opportunities, but also as a consequence of New Zealand's lack of a "national plan for comprehensive service provision" (Disley, 1990, p.17). Such was the concern about services that the Auditor-General conducted an audit into the "effectiveness and efficiency of the community

services in two areas where psychiatric hospitals closed” (Controller and Auditor-General, 1993, p.6). Significantly for this research, general practice was not mentioned in this report. The 1996 report by Mason found little had really changed; the government’s response to the difficulties reported with the services had been inadequate. The report stressed there was an urgent need to find solutions to the crisis in mental health.

### ***Conclusion***

There were many factors that paved the way for the innovations involving general practice in people with SOMI. The developments that occurred at NUHS and Hawke’s Bay link back to the same mental hospital, Porirua, and both services were in the jurisdiction of the CRHA. On the surface the reasons for the expanded involvement of general practice in mental health appear relatively simple; they concerned location, demand and failures of the current system. The failures included the limited ability for low-income people to access primary care, the mental health system to manage its workload and to work with other agencies and the inability of the secondary health system to contain costs. It was not just failures that resulted in the expanded role of general practice emerging to work with people with SOMI. Other factors such as New Zealand’s social, economic and health reforms, changes to the overall care and treatment regimes, the changing role of the specialist services also impacted. In combination these resulted in a realignment of services to the community, a refocusing of services in the community, and a subsequent introduction of new services. These changes were not limited to people with a mental illness or to the mental health services, they applied to many groups receiving health and welfare services. Factors that shaped welfare service provision covered in this chapter, such as society becoming very risk averse, will be shown to have shaped the details of how the NUHS programme and the HB pilot operated. The changes in the national context resulted in some new problems emerging for the practitioners involved in delivering mental health services. These practitioner problems and what was understood about how to provide the “best” clinical services are covered in the next chapter, the clinical context in which these innovations were located.



## **Chapter 5 – The clinical context in which the innovations were located**

The chapter presents an overview of the health needs of people with SOMI within the context of contemporary mental health and general practice services. The current literature about providing services to people with SOMI in a general practice setting is also summarised. Interestingly, the same literature was used by managers and clinicians to inform their analysis of service delivery. It describes what is known about the provider and service user interface. Sections two and three describe mental health services and general practice separately, using the framework of service delivery. This analysis covers service provision as well as the more explicit concerns about the effectiveness of mental health and general practice services for people with SOMI. The final section considers the specific models of service delivery that have been used in general practice to deliver mental health care.

This clinical context highlights an international move towards an increased role by general practice in mental health. Similar developments are evident in Australia (Carr, 1997a; Carr, Lewin et al., 1996; Carr & Donovan, 1992), Canada (Craven & Bland, 2002) and the UK (Kendrick et al., 1991; Royal College of Psychiatrists & Royal College of General Practitioners, (Royal Colleges) 1993). The discussion of this new health policy provides a point of reference from which to analyse the role of new knowledge and service delivery systems in shaping both the NUHS programme and the HB pilot. It provides the background as well as the rationale for some of the decisions made in respect of the data gathered for this research.

### ***The health needs of people with SOMI***

Typically, people with SOMI have other illness related needs, sometimes referred to as treatment or bio-medical needs; and care or social needs, sometimes referred to as lifestyle or rehabilitation needs (Schmidt-Posner & Jerrell, 1998; Strathdee & Jenkins, 1996). Care and treatment are general terms that encompass the range of services and therapeutic interventions that people with SOMI may require. Care most commonly involves support, housing, employment and social needs, whereas treatment generally relates to medication and specialist counselling or psychotherapy. At times there can be conflict between meeting a person's illness and social needs (Pearson, 1995).

Also people with SOMI have a higher number of physical health problems (particularly cardiovascular, respiratory disease, cancer and auto-immune deficiency syndrome) than the

general population (Armstrong, 1995; Carr, 1997b; Gallucci & Lima, 1996; Gournay, 1996; Strathdee, 1993). An increase in GP involvement has been argued as necessary to better meet these physical health needs (WHO, 1990). It has also been suggested that “mentally ill people are often excluded from health promotion activities in general practice” (Armstrong, 1995, p.75) thereby making them more vulnerable to ill health. Health promotion activities include for example smear tests, immunisation and smoking cessation programmes.

Over time there has been a change in understanding concerning what are the needs of people with SOMI (Pilgrim & Rogers, 1993; Strathdee & Jenkins, 1996). Increasingly, it has been appreciated that the impact of a serious and ongoing mental illness is often “long-term, multifaceted” and disabling (Hogan, 1996, p.19). Appreciating this has meant housing, employment, recreation and support programmes are also required in addition to medical and nursing care. As discussed in Chapter 4, prior to the closing of the mental hospitals these needs had been met through long-term hospitalisation. However, by 1998 they were mainly met through a combination of individual, family and community-based services. Although the expanded role of individuals and families in meeting these needs is important<sup>19</sup>, the focus of this research specifically covered how services are organised to accommodate policy and procedural change.

Needs can be complex and often change. Assessment involves identifying met and unmet needs, identifying what appropriate resources are available for the level of need, and arranging access to these. The model of service delivery and activities carried out by a service influences this assessment process. Mental health service delivery models variously include those that are clinically-focused, consumer-focused, purchaser-focused, rehabilitation and recovery-focused and service-focused (Abbott et al., 1995; Anthony et al., 1993; Cornwell, 1992; Corrigan & Kayton-Weinberg, 1993; Curtis, 1997; Kuno et al., 1999; MHC, 1998a; Rapp, 1996; Roach, 1993; Robinson & Toff-Bergmen, 1989; Schmidt-Posner & Jerrell, 1998). The models place different emphasis on how needs are defined, on the role of the person in establishing their unmet needs, and also on what services are available and how they are delivered. As people’s needs change, reassessment for met and unmet needs requires alterations in service arrangements in order to meet changed needs.

---

<sup>19</sup> For a view of this in the New Zealand setting see e.g. Collings and De Groot (1999).

A key aspect of meeting the needs of some people with SOMI is early intervention and diagnosis of the illness. The longer “symptoms go untreated, the worse the outcome” (Carr, 1997a, p.91). This involves the identification of the symptoms or behaviours that indicate when a person is experiencing an episode, exacerbation or relapse of their illness. Each person has a unique sequence to a relapse, and if they and their health practitioners become aware of these they can minimise and, in some situations, avoid a relapse happening (Carr, 1997b). Sometimes people with SOMI do not have insight into the presence or significance of their symptoms or they avoid seeking assistance as they dread “returning to the patient role, where they felt devalued” (Hall, 1996, p.22). For these reasons, assertive follow-up is an integral part of the service arrangements of many people with SOMIs.

People with SOMI are often involved with more than one organisation or practitioner. Service use is not necessarily related to a person’s mental health state and “what balance of physical, social and psychological care is appropriate for specific patients and who should give appropriate care” is generally not known (Wilkinson & Wright, 1994, p.367). There is also insufficient evidence concerning which are the most efficient combinations of care and treatment. Few services are technically efficient and many are not targeted properly (Huxley et al., 1990). A study by Lang et al. (1997) of 193 people with schizophrenia found that they had used an average of 3.4 (range 0-8) different services within six months.

Since the move to community care there has been an ongoing debate in mental health and general health policy on whether mental health care should be managed and delivered by specialist mental health organisations or as part of general health. This specialist-generalist debate is not restricted to mental health; it also concerns other “chronic” disorders such as diabetes, asthma and hypertension (Wagner et al., 1996). Essentially, the debate revolves around the following question: should primary health services that are mainly organised to respond to acute illness be now seen as a suitable place to locate the care and treatment of disorders that are ongoing? The remainder of this chapter highlights the main aspects of this debate.

### ***Mental health services***

Although there are primary, secondary and tertiary mental health services (CRHA, 1996a; WHO, 1990), most descriptions of mental health services focus on secondary and tertiary services. This is not surprising given that until relatively recently mental illness was not

considered preventable, and mental health care was largely delivered in secondary-type services (Raphael & Hugh, 1997). Primary mental health services have tended to focus on prevention and promotion, that is, reducing the incidence of illness and minimising the impact of illness (DoH, 1993). Agencies that carry out this role include consumer organisations, the Mental Health Foundation, Youthline and Lifeline and in some regions (e.g. Wellington) contracts for prevention and promotion have been awarded to Hospital and Health Services public health units.

Secondary services consist of a specialised group of providers that manage health needs related to their particular speciality. The level of expertise provided by a specialist is seen as higher than the generalist for that particular speciality. The specialist is expected to refer back to the primary or generalist provider when their level of expertise is no longer required. Secondary services are expected to target the 3% of the adult population who at anyone time has a serious mental illness. Given the enduring nature of many mental illnesses, much of the work of the specialist services involves those with an established problem. The work can focus on the social aspects of people's lives, such as social networks, employment and family relationships, the development of coping strategies and on the medical condition such as symptom management (Carr, 1997a).

The major role of inpatient units is to manage acute illness and to stabilise symptoms (Mechanic, 1997; Walkup, 1997). Although community services also have a role in managing acute illness, their principle role is to maintain, support and rehabilitate. The main groups of such community services in New Zealand are CMHTs, supported accommodation, home support services, crisis services, day programmes, recreational programmes, and consumer and carer support programmes. In 1997 there were around 200 such providers (Bridgman, 1997). The CMHT has a central role, and was the mainstay of the community mental health system during the 1980s and early 1990s (Peck, 1995). Community services are staffed by a mix of practitioners including those involved in managing clinical needs (e.g. psychiatrists, psychotherapists), psychosocial needs (e.g. social workers, occupational therapists), social personal needs (e.g. support workers) and those who manage the range of needs such as nurses.

The distinction between secondary and tertiary is less apparent in mental health than it is for the general health services. Tertiary services consist of services that manage the health needs

of people when they are critically unwell or have highly specialised needs. In the main, tertiary mental health services in New Zealand are hospital-based. There are however, some models where these services are provided in the community (Coverdale & Falloon, 1993).

### **Accessible and acceptable mental health services**

Although, except in emergencies, the GP is the gatekeeper for access to most secondary health services (Foster, 1983; Frost, 1997; Glasgow, 1996; Taskforce on Strategic Planning, 1994) this was not a requirement in mental health services at the time of this research. Mental health services could also be accessed directly by contacting the CMHT or by approaching a local crisis assessment (CAT) team. Once these services were accessed, further assessments could be conducted by practitioners in the CAT team, hospital emergency department, mental health outpatients, CMHT or specialist service (e.g. maternal mental health, early intervention service). Following this assessment decisions on care and treatment were made. Access to services such as supported accommodation was usually only available through a referral from the secondary mental health services.

In the 1990s, access to some CHE-based mental health services had become problematic as these services experienced staff shortages and had limited inpatient beds (MacDonald et al., 1999). The ability to provide services was also limited because of the ongoing health reforms, and "workforce skill deficits" (Wilson, 1997, p.9). In addition, accessibility was compounded by an increase in the demand for mental health services. This was attributed to greater public acceptance of mental illness as well as an increase in the incidence of mental illness (Wilson, 1997). It was widely believed by those in the health services that the demand for ongoing mental health services was compounded because access was free whereas there was the co-payment cost of consulting with the GP. In addition, access to some medications (e.g. resperidone) was only available through specialist services. Once a person was assessed as needing these specialist only medicines, the specialist could give a GP authority to prescribe this on the specialist's behalf. Finding a way to increase the involvement of the GP was seen as one way of reducing the pressure on the mental health system.

Minimising the "unwanted" impact of services is an important aspect of making services acceptable. Two unwanted side-effects in mental health are the level of discrimination experienced by people with mental illness and the side-effects of the treatments (Cooper & Klewe, 1996; Tugrul & Cizinsky, 1996). Discrimination works against people with SOMI in

many ways. It can limit access to employment, insurance and housing; impact on family and custody issues and restrict access to financial resources such as loans and hire purchases (Thompson & Thompson, 1997). Some people with mental illness have their first discriminatory experience in the mental health service (Deegan, 1996). For example, O'Hagan a Mental Health Commissioner reported a person telling her that "Nothing compared with the horror of the psychiatric unit. It was the most traumatic experience I've ever had in my life" (1999, p.5). One of the first priorities of the MHC was to ensure "discrimination and prejudice against those with mental illness is reduced" (Thompson & Thompson, 1997, p.7). During the mid to late 1990s strategies to reduce discrimination were targeted at all health services and at the community generally.

The majority of people with SOMI require varied treatments to address their illness related needs, however, for most people with SOMI medication was the treatment of first choice. Medications often have side-effects and the early recognition of these is considered important for improving long-term outcomes (Gournay, 1994). Lack of appreciation by health professionals of the impact of side-effects is thought to contribute to why some people discontinue taking their medication resulting in a deterioration in their mental health (Tugrul & Cizinsky, 1996). There are differing perspectives about what discontinuation of medication means. Health professionals usually refer to this as non-compliance (Carr, 1997b), whereas some in the consumer movement believe that discontinuing medication is not a compliance issue, but part of a journey by people with mental illness (Deegan, 1996). This journey can involve people trialing a period with no medication. Ruscher et al. (1997) found that some people who discontinued taking medication for psychiatric illness believed that the medication did not work or they did not like the physical side-effects. Monitoring of side-effects (which vary depending on the medication) involves screening tests for tardive dyskinesia, blood tests to measure drug toxicity, reviewing how a medication impacts on a person's life (Carr, 1997b). This monitoring and the subsequent management of adverse effects can involve mental health service staff working with general practice staff.

### **Comprehensive and co-ordinated mental health services**

Ensuring there were comprehensive services available was initially the responsibility of the RHAs, and the HFA<sup>20</sup> during the period these innovations were studied. Usually the RHA/HFA purchased clusters of services such as medical surgical, disability, primary health,

---

<sup>20</sup> There was also an intervening period where the responsibility was with the Transitional Health Authority.

mental health, elderly and public health. The division of health into these clusterings was problematic for groups with enduring disorders such as people with SOMI, as these groups required services from several of the clusters. The difficulty of obtaining continuity of care was also reported in the UK where it had been observed that the “purchaser/provider split, the health/social care divide, the hospital/community distinction and incipient competition between providers for service contracts all make the vision of a seamless service spanning agencies and locations seem improbable” (Holloway, 1994, p.84). The health social division was particularly problematic in the UK due to boundary issues around the changing divide between community nursing and home care, continuing care responsibilities and how hospital discharge was managed (Henwood et al., 1996). The need to have a co-ordinated service that provides continuity of care is seen as critical for quality mental health care. It is considered that this coordination should provide greater accessibility for the patient and increased accountability (Muijen, 1993).

One of the key aims of the 1991 health reforms was to increase coordination (Upton, 1991). The mental health services often operated very separately from the general and primary health services. A consequence of this separation was that sometimes service users were only engaged with the mental health system, the focus being on mental health needs; physical health needs being unmet or partially met (Gallucci & Lima, 1996). Coordination in mental health was also particularly problematic, partly because services were purchased based on throughput or patient contact with no funding provided for the liaison required for coordination. The purchasing arrangement was further complicated because the unbundling and subsequent separate purchasing of the components of care and treatment resulted in new mental health providers. The number of new providers expanded further as a result of the additional funding provided with the release of the mental health strategy in 1994 and following the Mason report in 1996. The increased numbers of providers and the competition between them was thought to have increased the danger of people falling between services (St John, 1996). At the individual level it had become more apparent that treatment could “be started, stopped and changed by the patient, psychiatrist, [other provider] or GP without letting the others know” (Wilkinson & Wright, 1994, p.366). This occurred because although there was an expectation that providers needed to work together there was no standard way to do this.

Solutions ranging from service reconfiguration to how an individual's care and treatment is managed have been tried to overcome coordination problems. One managed care organisation in the USA overcame these by introducing a full range of mental health services into their organisation. They considered the organisation needed to do this because of the organisation's

loss of control when patients were referred to community providers, the group's success in making the treatment process more efficient, and a growing awareness of the need for a system in which patients could be accurately diagnosed and appropriately treated either by primary care physicians or by specialists in the mental health field. (Slay & Glazer, 1995, p.1119)

Others considered that such solutions were not ideal as they created monolithic systems that were not necessarily able to meet the comprehensive needs of all service users (Saltman et al., 1993). Case management, a "multidisciplinary activity which draws from the biological, psychological and social fields" (Gournay, 1994, p.141), emerged as a solution for coordinating people's care (Marshall et al., 1998). Case management aims to match services with identified need, rather than demand (Kydd et al., 1991). In a study investigating continuity, the solution to improving linkages between inpatient services and community services required the inpatient unit changing its approach to focus more on compliance with medication and to increase family involvement during the inpatient stay (Boyer, 1997).

Coordination is more than providers communicating with each other. It also concerns meeting people's changing needs and viewing incidents of mental illness not in isolation but in relation to previous incidents and patterns of overall care and treatment. To obtain this level of coordination Holloway considers that people who are mentally ill require "long-term individual support from an experienced professional" (1994, p.85). Bass and Windle (1978) developed a methodology for measuring continuity of care as it related to the needs of the individual. In their study continuity was not maintained because clients/families rejected treatment, missed appointments or sought help elsewhere. In a review of community mental health services Dowell and Ciarlo (1983, cited in Huxley) concluded there had not been much success at increasing co-ordination for some individuals, largely because of what they call "resistant drop outs" (1990, p.20). They found that up to 40% of service users thwarted coordination efforts. Their research was not able to establish why people left services.



Capitation payment arrangements are considered by Dangerfield and Betit (1993) to give mental health providers the flexibility to provide a continuum of services that best meets their clients' needs. In addition Mechanic considered that capitation provides "a way to bring fragmented funding streams together [by] providing resources to develop new services" (1991, p.798). Other factors that influence coordination is how groups value and relate to each other and how they negotiate boundaries (Stevenson & Barker, 1996).

### **Rights and responsibilities of mental health services and service users**

The people of New Zealand have the right to expect that mental health services will be available in the publicly funded health system, and when accessed the services will provide care and treatment to acceptable standards (MoH, 1997b). Mental health services are responsible to the state and community generally to provide services efficiently and to care and treat the individuals who used them effectively (Chiplin et al., 1998). Being efficient requires well-organised structures that enables the best use of the funding and resources available. Throughout the 1990s the health services were expected to make efficiency gains and increase patient throughput. Whilst these gains were being made policymakers, funders, purchasers and users of services also expected the mental health services to utilise care and treatment approaches that were clinically effective. Not only do services users have rights to services, they also have a responsibility under most circumstances<sup>21</sup> to work towards achieving wellness.

Delivering effective services also concerns how people with SOMI are assisted to maximise their wellness while having an ongoing illness. It is generally understood that many people with SOMI are well much of the time, but what sometimes happens is they experience an episode or exacerbation of illness, resulting in deterioration in their mental health. Since 1997 the philosophy guiding New Zealand mental health services to achieve wellness has been the recovery approach. How services could or should work to achieve wellness is not yet well understood, but is considered to involve services providing care and treatment that can "empower consumers, assure their rights, get the best outcomes, increase their control over their mental health and well-being, and enable them to fully participate in society" (MHC, 1998a, p.vii). Related to this is the best way to prevent and manage the episodes where there is a marked deterioration in a person's mental state. Causes for these episodes of worsening health are not yet well understood.

---

<sup>21</sup> The exception to this could be when people are committed under the MH(CA&T)A.

## **Effectiveness of the therapeutic interventions used in mental health**

As this research was concerned with service delivery and not clinical management, the literature pertaining to the effectiveness of therapies in mental health was not explored, except to note that in the 1990s there were two therapeutic developments that influenced service delivery. The first of these was that all therapies were expected to be evidence-based. An issue for clinicians was the need for them to take cognisance of the fact that even though there was evidence that a treatment worked for a particular illness it did not necessarily work for everyone with that illness, or it did not necessarily work in a particular setting. The second change regarding an assessment of effectiveness was the increased awareness that people can, and do, recover from SOMI (GP Weekly, 1995; Rapp, 1996). There are a range of views about recovery and mental health. Briefly, one view is that the health of people with mental illness can improve and people do recover (Strauss, 1996). An alternative view is that the main contribution that treatment has is to bring about change; that there is an "accumulation of evidence that modern forms of treatment are for the most part palliatory, and generally do not offer a cure" (Chapman et al., 1991, p.8). The model of recovery that guides overall service development in New Zealand's health services combines these approaches. Recovery for "some people with mental illness ... is a road they travel on only once or twice ... For others, recovery is a maze ... a maze that takes a lifetime to navigate" (MHC, 1998a, p.1). Recovery rates were enhanced by the introduction of new anti-psychotic medications such as resperidone.

Outcome measures to look at effectiveness of interventions for people with SOMI include health status, health services and consumer-focused measures (Andrews et al., 1994; Wing et al., 1996; Wing et al., 1998). Services have placed more emphasis on developing health status measures and monitoring patterns of service utilisation than on measuring consumer-focused outcomes. Choice is an important consumer outcome measure (Nocon & Qureshi, 1996). Other consumer measures include satisfaction with the information provided, and with how consumers are treated as a person (Carpenter & Sbarini, 1997). Consumers not only wish to be informed about their treatment options, but they want their perspective included in the decisions taken about various treatments (Godfrey & Wistow, 1997; McCabe & Unzicker, 1995). On referral to mental health services, people in New Zealand rarely had a choice as to which provider they were initially involved with or which practitioners were involved in their care. This was not because New Zealand did not see choice as important, it is one of the mental health standards (MoH, 1997b), but the size and demographics of the country do not

make it very practical to achieve. However, if problems occurred between particular staff and clients, or for an individual with a particular provider, changes were sometimes made. Choice was sometimes considered for people with SOMI where decisions were being made regarding community placement.

Sometimes people with mental illness lose their right to choose because of the threat of self-harm or violence towards others. Although the risk of such harmful behaviour is often overstated by the media, an aspect of mental health delivery involves mental health practitioners assessing and managing these risks. Ultimately management can mean using the MH(CA&T)A to restrict a person's right to live freely in the community.

In summary, mental health services encounter many issues in creating service arrangements that are accessible, acceptable, comprehensive and co-ordinated. While many of these issues are unique to mental health services some are shared by services that cater for other groups with enduring disorders.

### ***General practice services***

General practice provides a generalist service that delivers comprehensive, holistic primary health care (Sedden, 1988). This involves the assessment and management of new and old health problems, and delivering public health interventions. Holistic care includes an ecological dimension (all factors that affect health) and a caring dimension (Issued by the conference participants<sup>22</sup>, 1985; Sedden, 1988). In New Zealand, the focus of general practice is principally, but not exclusively around the work of the doctor, the GP. NUHS differs in this regard as its services were built around all the practitioners present. Other personnel who routinely work fulltime in general practice are practice nurses, midwives and receptionists. Personnel who work sessionally include counsellors, social workers, podiatrists and physiotherapists. Research by Walton et al. (1990) found that there was a positive relationship in the number of doctors with the number of ancillary staff. In New Zealand, with the exception of the nurses and social workers, most practitioners working in general practice charge a fee-for-service. Nursing services are usually provided free of co-payment charge because nurses' salaries are partially offset by a government subsidy (Crampton & Brown, 1998; McLennan, 1981). This subsidy is generally paid to the GP, with the practice

---

<sup>22</sup> These participants attended a New Zealand conference held to consider the implications for medical education of the changing role of the doctor.

nurse being an employee of the GP. Social workers have been present in some general practices via special arrangements with the local hospital-based mental health services.

General practices range in size from sole practices (with or without a nurse) to group practices that involve two or more GPs (Walton et al., 1990). Most general practices are small businesses (Taylor & Meads, 1997) that operate out of two or more rooms in a building that may or may not be self-contained. Gordon and Plamping argue that the small size of general practice "is critical to maintaining the non-institutional, personal care which many patients value" (1996, p.3). As indicated in the previous chapter, general practices were increasingly forming collectives such as IPAs to contract for services. These collectives enabled general practices to overcome some of the inefficiencies generated by being small businesses (Brand, 1996). General practices differ in regards to governance, funding arrangements, alliances with other GPs or health organisations, the staff who work there, the involvement they have with local needs and circumstances, and the standards and accountability measures they adopt. Similarly to mental health services, patients and patient groups were increasingly expected to be involved in general practice at both an individual and an organisational level (Wood, 1984).

Although the organisation of general practice differs considerably between practices, how the clinical work within practices is conducted is not considered to vary much (Marshall & Hounsell, 1994). This work can be influenced by who initiates the consultation. The consultation initiated by the GP or nurse is generally more focused on review, such as monitoring the impact of a specific treatment. If it is the person who initiates the consultation, it usually commences with the person stating the purpose or problem, followed by GP clarifying, assessing and then offering advice or treatment. The activity generated by GPs at consultations is influenced by professional factors (e.g. age of doctor, place of training), organisational factors (e.g. practice characteristics and processes), diagnostic characteristics, doctor preferences and by the socio-economic status of the patient (Scott et al., 1996). Common activities include writing a prescription, undertaking procedures such as suturing and counselling and making referrals (McAvoy et al., 1994). It is a commonly held perception that people like to receive a prescription as part of a consultation (Walton et al., 1990). Jenkins (1997) argues that one of the challenges with the increased role of general practice in mental health is to develop services that fit with the constraints of short appointments and how general practice operates. This challenge arises because most

consultations in general practice last 10-15 minutes, which can allow insufficient time, when the consultation is for mental illness related reasons.

In addition to the co-payment requirements that individual practices charge, general practices in New Zealand receive some state funding. This funding mainly consists of the general medical subsidy (GMS) which is paid to offset costs for targeted groups of patients. The GMS is paid using either a fee-for-service or capitation payment formula (Health Funding Authority, (HFA) 1998; Malcolm, 1998). The health reforms of the 1990s enabled other funding to become available to general practice such as one off contracts, some of which have been ongoing for managing the budget for pharmaceuticals and laboratory tests (HFA, 1998; Kerr et al., 1996). One of these other contracts was used to fund the HB pilot.

Pincus (1990) examined the effects of capitation, salary and fee-for-service methods of physician payment on mental health services in the primary setting. He considered that with capitation systems in general, there is no incentive to identify patients with complex problems, and if they are identified then the incentive is to deliver relatively low intensity treatment. There is little incentive to refer on in the situation where the primary practitioner service pays for referral services. With fee-for-service the balance of incentives varies whether the fee is paid for procedure, time or complexity. Pincus considers it important that payment arrangements be assessed so that policy-driven efforts can be influenced by, if not based upon, empirical data and changes made to affect the process and outcome of patient care. The innovations studied in this research received funding under different formulas (NUHS was funded using capitation, Hawke's Bay was fee-for-service). They also obtained funding from different pools (NUHS from primary care, Hawke's Bay from mental health).

### **Accessible and acceptable general practice services**

Some of the advantages that commentators about general practice assert are that it provides geographically accessible services that are available 24-hours a day, seven days a week. Being located in specific communities, it is argued, implies that it understands the language and culture of the people who use its service. The commentators also consider that general practice is accessible because people can bring any health problem to it.

Research to evaluate the accessibility of general practice has largely been carried out from an economic perspective that takes utilisation as a key measure of a service being accessible

(Carr-Hill et al., 1996). In the New Zealand National Health Survey of 1993 accessibility “problems were cited by less than six percent of people with a disability (an estimated 40,000 people)” (Triggs et al., 1995, p.82). Reasons given for these problems included: cost, lack of transport, inability to get an appointment, not liking seeing the doctor, doctors can't help and no doctor nearby. Access to primary care is known to be influenced by income and ethnicity (Barnett & Coyle, 1998; Stewart et al., 1997). The income barrier is particularly relevant in New Zealand because of the co-payment required to see the GP. Union health services, of which NUHS is one, emerged in the late-1980s to enable people on low incomes more affordable access to primary health services (McGrath, 1989). New Zealand health policy in the 1990s focused on minimising the cost barrier by providing targeted assistance to people on low incomes via the community services card and to high users of the health service via the high user health card. People on low incomes who also had an illness or disability of ongoing duration were entitled to the Disability Allowance to offset GP and pharmaceutical co-payments costs.

People with mental illness have been identified as a group that under-utilise GP services in New Zealand. Two studies on GP utilisation found that people appear to utilise the GP for mental health reasons less often than would be expected based on the accepted prevalence data of 20% of the population having a mental illness at any one time. The Waikato Medical Care survey (WaiMedCa) found that 4.4% of all GP encounters were for “psychological reasons” (McAvoy et al., 1994, p.405). Gribben's (1996) analysis of general practice utilisation of enduring disorders found that only 1.3% of GP visits were for a major psychiatric condition. An evaluation in Christchurch of service use by 69 long stay patients with mental disorders (moving into residential accommodation) found over an 18 month period that the consultation rate averaged four consultations a year (Macmillan et al., 1992, p.349).

Studies in the UK, where there is no co-payment charge, have found that people with mental illness consult their GP more often than other patients (Strathdee, 1993; Wear & Peveler, 1995) and that people with long-term mental illness consult their GPs more than they consult any other health professional (Wright, 1995). Gallucci and Lima (1996) reported that people with mental health conditions use the GP 1.5-2 times more than people without a mental illness. However, a comparison of GP use between other groups of patients with a “chronic physical disorder” and patients with schizophrenia found there was no difference between the

two groups in GP use (Nazareth, King, Haines See Tai et al., 1993). Studies have reported quite different GP consultation rates. For example, Nazareth et al. (1995) found that people with schizophrenia consulted on average seven times a year, whereas Wear and Peveler reported a median consultation rate of 12 consults a year. It was also commonly understood that people with mental illness required longer consultations in general practice than other people (Waltham Medical Centre, 1993; Wenley, 1997).

A number of barriers including general practice staff attitudes (most notably GPs and receptionists), people with SOMI's concerns, the skills and knowledge of practitioners and the organisation of general practice influence the provision and success of providing mental health care in a primary setting (Armstrong, 1995; Klinkman, 1997; Nickels & McIntyre, 1996). Lawrie et al.'s (1998) research, looking at the attitudes of UK GPs, found they were less happy to have people with schizophrenia on their practice list than people with other medical disorders. The researchers concluded that some people with mental illness may find it difficult to register with a GP. Kendrik et al. (1991) found that people with SOMI clustered around particular practices because of their location (the central city being preferred) and because mental health services referred people to selected practices.

One aspect of general practice being accessible and acceptable is that it is often in touch with the community who use the service. Community involvement is considered by the World Health Organisation to be an essential component of primary health care (Farley, 1993). The PHO model currently being introduced requires community participation (MoH, 2001). The extent of community involvement by New Zealand general practice staff is unclear. Rural doctors, in particular, regularly advocate for their communities, but general practices in provincial and urban areas appear to have limited community involvement. The exception to this are the union health services (e.g. NUHS) that arose out of community need.

### **Comprehensive and co-ordinated general practice services**

General practice provides comprehensive primary health service in that it caters for differing health needs irrespective of age, race or gender. Given that almost all health problems can be taken to general practice, it is not surprising that individual GPs' and nurses' knowledge and skill to treat a particular health problem can vary greatly. This range of expertise means there is not a shared view of what general practice should provide or its place in the continuum of care (Gordon & Plamping, 1996).

Delivering co-ordinated services needs to occur within general practice as well as between general practice and mental health services. A UK study conducted within one general practice found that patients who did not receive continuity of care (defined as seeing the GP they were registered with on their visits) differed from other patients<sup>23</sup> on socio-demographic (age, social-class and housing), interpersonal (had more relationship problems) and health (were more likely to have a diagnosis of depression) variables (Sweeney & Gray, 1995). A study by Burns et al. (1998) of practice nurses completing structured assessments on people receiving antipsychotic injections found that although the nurses carried out effective assessments, they appeared not to communicate their findings to the GP.

To contribute to the co-ordinated care of people with SOMI general practice needs to be part of the team (Lawrie et al., 1998). However, this may not occur as psychiatric resources are not always targeted to those areas where people with SOMI are geographically located (Kendrick et al., 1991) and when GPs are paid on a fee-for-service formula effective teamwork between GPs and other health professionals is not promoted (Saltman et al., 1993). Effective team work requires general practice staff to know the availability of community resources and the roles and responsibilities of other team members (Pritchard, 1995).

Apart from the Royal College of General Practitioners (1998) curriculum development guidelines, no tools were located in New Zealand to assist GPs with acquiring this knowledge. However, tools were developed in Australia to assist with this (Harris et al., 1997). General practice, through its gate-keeping function, can determine the access to these other services as its focus is on the individual, the expectation being that staff will advocate and obtain the services necessary for the person. According to Conrad and Shortell, coordination can be hampered because in "current practice ... individual medical disciplines and other health professional groups fail to see the connections outside their own immediate roles in the care process" (1996, p.17). Pratt and Adamson believe that the "first step towards good boundary management is to recognize their permanency; they can be moved but they will not be removed" (1996, p.27). This thesis involved understanding the mental health service/general practice boundary in these innovations.

Surveys of GPs in the UK have regularly explored the role of GPs in providing mental health services and been fairly consistent in their findings that the quality of links between general

---

<sup>23</sup> The study group were all those patients who had seen a GP (partner, trainee or a locum) other than the GP who they were registered with, on four consecutive occasions.



practice organisations and mental health professionals vary considerably (see e.g. Corney, 1996; Kendrick et al., 1991). A survey by Falloon et al. (1996), completed by 140 GPs in Auckland, looked at attitudes of the GPs to mental health service provision and the GPs' perceived role and educational needs for managing patients with mental disorders. Falloon et al. found that GPs considered the liaison between general practice and mental health services to be poor, and that they were interested in changing this. Falloon et al. concluded that GPs should become the case managers of those with ongoing needs from mental illness.

### **Effective interventions in general practice**

There are conflicting findings about general practice involvement in mental health. Kendrick et al. in a summary of GP activities when caring for people with mental illness noted that often GPs "only treat physical problems and issue sickness certificates", rather than treat the mental illness (1995, p.93). This may be because people with some mental illnesses, for example those with schizophrenia, "consult more often with physical complaints than the average patient" (Nazareth, King, Haines See Tai et al., 1993, p.910). It is the patient's presenting complaint that may divert the doctors from reviewing mental health issues. Nevertheless, many GPs believe that they can offer appropriate mental health care. Corney (1996) argues that one advantage of GPs working with people with mental illness is that they are able to offer a co-ordinated approach as they are also often involved with the person's family and they have more opportunity for prevention work. However, GPs have reported problems in their ability to deliver comprehensive mental health care in that often the assistance they require from other health practitioners, in particular the mental health services, is not available when needed (Mental Health News, 1991).

Wagner et al. observed that because much primary care work is "organized to respond to the acute and urgent needs of patients" primary care practitioners might not differentiate their approach to people with a "chronic illness" (1996, p.513). Research about lifestyle advice by GPs has also shown that people do not necessarily like the GPs changing their traditional role (Parry & Pill, 1994). It is also known that some people with SOMI choose to keep their mental health care separate from their general care (Nazareth et al., 1995). However, others have cited an advantage; having mental health care delivered in general practice means that mental illness is normalised as it becomes treated the same as other health problems (Corney, 1996). Another factor, reported to act as a barrier to people with SOMI receiving mental health care in general practice, was the GPs' and practice nurses' level of knowledge and

skills about mental health (Royal Australian College of General Practitioners & Royal Australian and New Zealand College of Psychiatrists, (Royal Australian Colleges) c.1997). Studies have shown considerable variation in GPs' ability to identify and assess for psychiatric morbidity (Strathdee, 1993; Tylee et al., 1993).

This research commenced at a time when there was limited information available concerning the role of general practice in the care of people with SOMI (Royal Colleges, 1993), and there was no authoritative specification against which to evaluate the role of general practice against. There was however, a growing "belief in the merit of evaluated pilot schemes" and solutions being found that were evidence-based and negotiated so they advantaged both practitioners and patients alike (Boyle & Callahan, 1995, para 10). Outcome measures used by general practice include immunisation and other prevention measure completion rates, referral rates to specialist services, follow-up, continuity of care and satisfaction. As reported in Chapter 2, the measures used in this research include utilisation, self-reported impact on health and the ability of the innovative services to provide accessible, acceptable, co-ordinated comprehensive, efficient and effective care that met the needs of people with SOMI.

As general practice has increased its role in mental health concern has been expressed as to whether general practice can provide effective care to people with SOMI (Nazareth et al., 1995). The concerns pertain to the GPs' skills and knowledge, the suitability of the general practice setting for people with SOMI and the GPs' abilities to recognise mental health problems. Nickels and McIntyre (1996) commented that although GPs are considered to be competent and able to manage physical health needs, this might not be so for mental health problems. They argued that GPs tend not to recognise such problems, and that once a problem is identified many GPs believe it is often best to get specialist involvement. Kendrick et al. (1991) found that there was an almost complete lack of specific practice policies for the care of patients with serious mental illness by general practice. Parry and Pill question whether the way GPs work is suitable for people with mental health problems.

Doctors have set routines of interviewing patients which are geared towards examination and diagnosis and these routines are only adequate in relation to purely physical processes. This type of 'doctor centred' behaviour does not suit 'non-organic-disease' or facilitate sensitive understanding of psycho-social factors. (1994, p.6)

Despite these concerns most writers see that it is inevitable that general practice will have an increasing role in the care of people with SOMI and that the focus needs to be on providing

training so primary practitioners can acquire the necessary skills and knowledge to take on this increased role (Carr, 1997a; 1997b; Vercoe, 1995). Approaches for increasing skills and knowledge by primary practitioners include learning through reading, utilising resources, attending short courses, and seeking advice from a specialist (Toews et al., 1996).

An Australian report that made recommendations on the education and training of GPs in “primary care psychiatry” considered that training in the detection and diagnosis of illness, the treatment and management of illness including prescribing and being a therapist was required (Royal Australian Colleges, c.1997). The WHO (1990) recommended that training should not only be about diagnosis and treatment, but also involve the psycho-social aspects of care. Resources to progress both these needs were being developed internationally throughout the 1990s. Kendrick et al.’s (1995) research showed that GPs who had participated in training on how to use a structured assessment process when working with people with on-going mental illness increased their role in mental health care. While this study looked at the results in the short term, a study of the “long-term effects of an educational program for general practitioners ... for the prevention and treatment of depression” found that the effects of the programme were limited (Rutz et al., 1992). The authors concluded that if there were to be a sustained impact, the programme would need to be repeated every two years.

In summary, by 1998 there was no consensus concerning what the role for general practice in working with people with SOMI should be, though there was awareness of the necessity for such a role. Because of this lack of consensus there was considerable divergence of opinion as to how well general practice, and in particular GPs, could take on this role. This final section of this chapter describes what is known about the particular models of care that involve general practice working with people with SOMI.

### ***Models that combine general practice and mental health***

Developments in mental health therapies and changing community attitudes to mental illness, have led to an increased awareness of the health needs of those with mental illness. Some have argued that changes in the provision and organisation of mental health, have resulted in the “burden of care” now being located at the general practice level (Strathdee, 1993; Wilkinson et al., 1985; Wilkinson & Wright, 1994). Drivers for the increased burden on primary care have been the push to shift the balance of care from secondary to primary

services (Coulter, 1995; Pederson & Leese, 1997) and the reorganisation of services for chronic conditions (Bates & Linder-Pelz, 1990). The changes are not limited to mental health (Hickman et al., 1994; Orton, 1994). GPs are also increasing their involvement with other enduring conditions such as diabetes (Tracey et al., 1988), epilepsy (Al-Shammari et al., 1996; Ridsdale et al., 1997) and autoimmune deficiency disorder (Winn, 1997).

Whilst the increased involvement of general practice extended to mental health generally, this discussion is focused on people with SOMI. In the report *Shared Care of Patients With Mental Health Problems* some of the advantages in arranging psychiatric care in the general practice setting were described as reducing stigma for patients, enhancing communication between the GP and the specialist, increasing chances of accepting a psychiatric assessment if it does not involve going to the hospital, and providing a more relaxed environment for the patient (Royal Colleges, 1993). The range of interaction between GPs and the mental health service has shown a wide range of interactions, from limited contact through to extensive involvement and engagement by GPs in mental health care (Meadows et al., 1999). The move to increase the role of general practice with people with SOMI has resulted in the development of new services (Calnan & Gabe, 1991; Carr & Donovan, 1992; Goldberg & Gournay, 1997; King & Nazareth, 1996; Lang et al., 1997; Nickels & McIntyre, 1996; Raymont, 1992; Wilkinson, 1998). These new service arrangements can be variously described as basic care, shifted outpatients, consultant-liaison services, shared care and total care. Some services involve a combination of these models.

### **General practice basic care**

The general practice basic care model referred to as outpatient care by Orton (1994), is probably the most utilised model of general practice for people with SOMI. The focus for providing mental health care is located with the mental health service, and physical health needs are the responsibility of general practice (Bindman et al., 1997). With basic care the mental health service usually informs general practice by writing to them about a person's status and care. General practice can be asked to take over the management of some aspects of care such as maintaining prescriptions and monitoring for side-effects, but this system does not always work. Bindman et al. found that "GPs were unaware of fundamental aspects of care received by their patients, and did not feel that their role in the patients' care was clear" (1997, p.175). Other models build in different ways on the general practice total care and basic care models.

## **Shifted out-patients**

The shifted outpatient model involves mental health professions running specialist clinics in general practice rather than at the mental health services (Jackson et al., 1993). The model is based on the belief that mental health services may be more acceptable and accessible to people if they are delivered in an environment closer to where people live, and in a service that does not carry with it the "stigma" attached to mental services. Shifted outpatients is increasingly used in the UK, particularly since 1990 when regulation changes removed funding restrictions on the range and number of disciplines that GPs could employ (Corney, 1996).

Jackson et al. (1993) described and analysed the first year of development of a CMHT that was based in primary care. They found the presence of the CMHT resulted in a doubling of the prevalence of treated psychiatric disorders. Simultaneously, while there was a reduction in the number of hospital outpatient referrals there was no effect on the use of inpatient resources. It was concluded that the no change in inpatient resource use was partly a consequence of the CMHT not offering an extended service to cover out-of-hours and liaison services. Research on shifted-outpatients suggests that the presence of this model may be effective in reducing overall inpatient admissions for mental health (Ferguson et al., 1992; Williams & Balestrieri, 1989).

Saltman et al. (1993) evaluated a community health and medical practitioners scheme (CHAMPS) that involved integrating the provision of some community mental health services within a general practice setting without any alteration to funding mechanisms. The mental health staff were salaried while the GPs were fee-for-service. The aims of the CHAMPS initiative were to improve access to mental health services, improve liaison between community health staff and GPs and broaden the range of services available at general practice. An evaluation six months after implementation identified problems in the mental health component of the pilot. Mental health staff were concerned about philosophical differences, appointment practices and the ensuing inefficient service provision. The GPs considered that the crisis nature of mental health, which could not be accommodated on a roster arrangement, was a major drawback. Once the pilot was completed the mental health workers did not continue to work out of the general practice setting. It was concluded that the study reflects a consensus among both the CMH practitioners and GPs that such services would require substantial administrative support, additional staffing and that further work was

required to focus on communication, expectations of health professionals, consumer input and resources.

### **Consultation-liaison services**

The consultation-liaison (C-L) model involves a psychiatric expert – psychiatrist, psychiatric registrar, social worker, psychologist or nurse – providing a consultant and liaison service by working alongside the GP, providing advice to the GP on the care and treatment of people not seen by the specialist services, and overseeing the treatment of people through supervision on a regular basis (Carr et al., 1996; Carr & Donovan, 1992). The C-L model is based on a belief that with support and guidance GPs will obtain additional skills and knowledge to enable them to increase their involvement in mental health. This form of service has been part of the UK health system for over 20 years and was trialed by several CHEs in New Zealand during the 1990s including Hawke's Bay and NUHS. Nurses, perhaps because in the UK there is specific training in community psychiatric nursing, appear to be the most common psychiatric expert in Britain who work in this model (Gournay & Brooking, 1994). In the main, studies have focused on the use of psychiatric-liaison services for the general population (i.e. minor psychiatric problems) served by the GP. Studies have generally found it to be cost-effective in that the psychiatric expert can contribute to the care of more patients than they could in a mental health setting and it can fill a previously unmet need (Carr et al., 1996; Carr & Donovan, 1992; Epstein et al., 1996; Gournay & Brooking, 1994; Nickels & McIntyre, 1996; Strathdee, 1993; Tyrer et al., 1990). Concern has been expressed that when psychiatric nurses work in general practice the focus can move from the seriously ill to those with less severe illness (Gournay, 1996). While most C-L services discussed involved a one-on-one arrangement, Midgley et al. (1996) found group liaison meetings between GPs and CMHTs were well attended and were a useful way of sharing information particularly regarding patients in joint care.

### **Shared care**

The shared care model applies when the responsibility for the health care of the patient is shared between individuals who are part of separate organisations (Pritchard & Hughes, 1995). The shared care model is based on a similar belief to that of the consultation-liaison model, that with support and guidance GPs will obtain additional skills and knowledge to enable them to increase their involvement in mental health and that this will reduce the demand for mental health services (Wilheim et al., 1999). In addition, the model is based on

the belief that improved health gain will occur if people with SOMI have their care delivered by both the mental health services and primary health services; each provider complementing, not competing with the work of the other. As such shared care builds on "specialism" rather than "mainstreaming" (Huxley, 1995, p.323). Shared care in the mental health services is not limited to primary and secondary services working together, it also involves partnerships between Trusts and housing associations (Millar, 1996). Abbot et al. (1995) described the establishment of a managed care system involving mental health, probation, social and education services for children with mental health problems. The features of the system were a collaborative arrangement that developed a "single case plan" for children.

Shared care involving general practice ranges from merely sharing records (Essex et al., 1990; Nazareth et al., 1995; Wolfe & Stafford, 1997) to actually planning care together (Keks et al., 1995; O'Connor & Willcock, 1997). Keks et al. described a shared care project in Australia that aimed to improve the working relationship between GPs and a community mental health service. In 1996 when this research started most shared care services were relatively new, with limited research available on how these services worked or how effective shared care was. Kendrick et al.'s (1991) survey of some UK GPs indicated that GPs favoured shared care. The HB pilot was based on shared care.

### **General practice total care**

The general practice total care model involves people with SOMI having their mental health care managed by general practice. This management can be at any stage of the illness process, but is most often during the early phases of onset of a SOMI or once people's mental health is very stable. According to Bailey (1997) the Wellington mental health service referred 70% of people they saw back to GPs. People whose care starts out in the general practice total care model are often referred onto the mental health service. Referral information provided by GPs has been found to be inadequate in many instances (Strathdee & Jenkins, 1996).

### **Combination of models**

Some services have combined the models described above. Most descriptions of these combinations involve some aspect of the shared care, shifted-outpatients and C-L models. An Australian development, CHIFFs, combined the C-L model with shared care (Meadows, 1997, 1998). The early evidence from Meadow's work was that combining these models was

a cost-effective way of delivering mental health services. The combination enabled the service to transfer care of a group of people to the GP who would normally be managed by the mental health service, and it facilitated the GP to manage other people's care without the people entering the mental health service. There was also evidence that consumers and providers were satisfied with this way of delivering services, and that it had the potential to increase the number of people who receive mental health care. The NUHS programme used a combination of the shared care, shifted-outpatients and C-L models.

### ***Conclusion***

Given that there is not a specified role for general practice working with people with SOMI, this chapter has focused on highlighting what is currently understood regarding the needs of people with SOMI and how general practice and mental health services worked to address these needs. The literature review revealed conflicting findings in how this role worked and what the main issues facing developing this role are. It indicated that people with SOMI often have additional physical health needs and may require lengthier consultations than other patients. It highlighted that there may be issues in the content of consultations and there is mixed support for involving general practice in providing mental health care for people with SOMI. Despite the conflicting results there was an expectation that general practice needed to expand and increase its involvement in mental health generally and in working with people with SOMI in particular. One aspect of this expansion was the emergence of new models of service delivery. These models were developed to overcome barriers of accessing general practice and to increase the skills and knowledge of GPs. How the NUHS programme and the HB pilot developed services for people with SOMI is presented in the following two chapters.



## **Chapter 6 – The Newtown Union Health Service mental health programme**

This chapter presents the findings of the NUHS case study. Data gathering for this covers four years, starting in 1997 and completed in 2000. Data was obtained from four sources including documents provided by NUHS, newspaper and academic articles, an audit of a stratified random sample of 57 people's records who were in the mental health programme, and interviews with stakeholders.

The chapter commences with an introduction to the people interviewed and whose records were audited. A description then follows of the local context, including how NUHS originated, how it was governed and the hurdles NUHS had to overcome to get established. This section also introduces the staffing policies and patterns of NUHS and the work of NUHS generally. Interestingly, work with people with mental illness emerged soon after the Newtown Union Health Service was established. From small beginnings this work led to the setting up of the mental health programme (hereinafter referred to as the programme) in 1991. The third section traces the development of the programme and describes the nature of the organisational arrangements to support the programme. The fourth section focuses on the actual service arrangements for people with SOMI. The final section presents the effectiveness of the NUHS programme as a model of service delivery and discusses an analysis of the suggestions made by interviewees for how NUHS could improve its service.

### **Research participants and the records audit**

Interviews were held with the GP and nurse who worked in the programme and with two nurses who worked at NUHS during the early years of the programme's development. The focus of the staff interviews was on their work and their understanding of the development of the programme. Four consumer representatives were interviewed; two at the time the research was set up and two later in the research process. These interviews covered the programme and working of the Policy Board as well as ascertaining what the representatives considered important for the case study to capture. Three other providers, including a psychiatrist who had worked at the consultant-liaison service, two Capital and Coast Health (CCH) mental health staff, one of whom had previously worked in an NGO, were also interviewed. These interviews discussed how the NUHS programme co-ordinated services with the mental health service.

Of the 60 letters sent to people on the programme 23 (38%) people responded. A further 12 (20%) letters were returned with address unknown. Of the 23 people who responded 21 were interviewed, one person was not contactable by the phone number provided and the other person did not arrive for two interview appointments. One interview was excluded from the analysis because the requirements of the Ethics Committee to ensure consent from this person (see Appendix 11) were not able to be met. The focus of the interviews concerned people's experience of NUHS, why they joined, what NUHS role was in their health, how NUHS co-ordinated with other providers, and people's likes and dislikes of NUHS (see Appendix 4). People's personal health needs were not discussed at the interviews. Before any analysis was undertaken, the transcripts and notes were altered to replace names of people or providers with terminology such as Doctor 1, Provider 1. The transcripts and a coding sheet were then returned to the interviewees. Three people chose to make changes, including expanding or clarifying what they meant.

In contrast to the interviews, the audit of the 57 records focused on clinical information as recorded in the records (see e.g. Appendix 3). The audit focused on the year 1997 and the interviews took place in 2000. Two records were removed from the audit analysis because one involved a person who had not had a consultation at NUHS since 1993<sup>24</sup> and a second person had advised two years earlier they were moving, but NUHS had not had a request from a medical practitioner for their records. NUHS's policy was that any person who had not been seen at the clinic for two years is no longer considered a current patient. While these records were excluded from the analysis, two other people's records were included even though their record indicated no current mental health problem. Both had a mental illness some years earlier. The decision to include these records was because I assumed that NUHS kept them on the programme because there was a risk of relapse. When the master list<sup>25</sup> of those who had been enrolled in the service in 1997 was obtained it was not appreciated that the computer printout included people who joined the service during 1997. As it is not possible to calculate utilisation rates unless all people's records cover the same time period, the eight people who joined NUHS during 1997 were removed from the utilisation analysis.

The socio-demographics of the 20 people interviewed and the 55 people whose records were audited are provided in Table 7. This shows that these two groups of people were similar in regards to gender, age and catchment area, but that they differed in relation to ethnicity,

---

<sup>24</sup> Their address indicated they were now living some distance from Newtown.

<sup>25</sup> The master list consisted of NUHS file numbers only.

housing and the number of years enrolled at NUHS. The difference in ethnicity may partly be attributed to the number of people whose ethnicity was not recorded in the audit sample, while the difference in housing and the number of years enrolled at NUHS may reflect the timing when separate sets of data were gathered. The people who lived outside of the catchment area, mainly lived in the northern suburbs of Wellington, however some lived outside of Wellington. Those grouped under Other ethnicity included Pacific people, Chinese, Indian and Somalian. Some of those who were interviewed and some whose records were reviewed had joined NUHS within its first year of operation, while others had joined more recently.

**Table 7. Socio-demographic features of NUHS people with SOMI interviewed and whose records were audited**

Variable	Value	Interviewees No (%)	Audit No (%)
<b>Gender</b>	Male	9 (45%)	26 (47%)
	Female	11 (55%)	29 (53%)
<b>Age</b>	Mean	43 years	43 years
	Range	27-72 years	22-73 years
<b>Ethnicity</b>	Māori	5 (25%)	7 (13%)
	European	12 (60%)	30 (54%)
	Other	3 (15%)	7 (13%)
	Unknown		11 (20%)
<b>Living in catchment area</b>	Yes	18 (90%)	51 (93%)
	No	2 (10%)	4 (7%)
<b>Housing</b>	Private	19 (95%)	42 (76%)
	Supported housing	1 (5%)	11 (24%)
<b>No. of years at NUHS</b>	Mean	8 years	5 years
	Range	2-13 years	0-10 years

### *The development and organisation of NUHS 1987-2000*

Newtown Union Health Service was established in May 1987 in order to create a service that was accessible, acceptable, affordable and appropriate to people with low incomes (Matheson, 1992b). It was one of several health services established in New Zealand to provide cheaper access to primary health care for union members and others on low incomes (McGrath, 1989). The push for the service came from the Wellington Trades Council and the Newtown Community Health Association (Submission, c.1987). These groups were supported by the late Professor Ken Newell, an eminent health activist who inspired by a Newtown resident, wanted to see a service develop that was so acceptable to local people that they could go there in their slippers (Bagnall, c.1988). Initial establishment funding came from the DoH, loans from 19 trade union organisations and the Wellington Area Health

Board (Crampton & Brown, 1998; McGrath, 1989). The DoH funding was provided under special contract arrangements which the 1987 Labour Government had put in place to enable new primary health services to be developed. These targeted people on low incomes, as this group had been identified as finding the co-payment cost of accessing GP services a major barrier. A practice nurse subsidy was part of the total funding package. Initial staff employed were a nurse, doctor and a manager.

Apart from establishment funding, operational funds for running NUHS were also required. These came from a combination of capitation funding using a formula devised by the DoH, from the Special Sessional Scheme (DoH funding for non-curative activity carried out by GPs) and from co-payments when people used the doctors at the service. NUHS also received government funding for the services staff provided (e.g. immunisations and maternity care) and funding from ACC when staff attended people with injuries as a result of accidents were also received. Lastly, NUHS received additional funding via one off contracts to provide services to special groups of people such as refugees. The mental health programme was similarly funded with funding coming from the Primary Health Group of the CRHA.

NUHS managed to limit the co-payment to \$10 a doctor's consultation for an adult (Submission, c.1987). Even though the co-payment cost was approximately 50% lower than that usually charged by other GPs, NUHS appreciated that cost would still be a barrier for some people in accessing its service. From the beginning it publicly stated that no person would ever be turned away because they could not afford to pay. There was no co-payment charge to see the nurses. The multiple sources of funding allowed NUHS to establish a service where the community was involved at all levels (Regan, 1991a).

NUHS was an urban-based practice that largely occupied one building in Hall Street Newtown. It also provided outreach services in Strathmore and Newtown Park Flats. Prior to opening these new services were advertised locally using a leaflet drop. Eligibility was restricted to people who lived in the greater Newtown region, to low income earners as defined by earning less than \$20,000 a year, to members of trade unions who were on a low income and to members of unemployed and beneficiary organisations (Submission, c.1987). As NUHS was funded using a capitation-based formula, people had to formally register and NUHS was required, if requested by the purchaser, to supply the names and addresses of people on the register. The eligibility criteria were revisited in 1992 when some union

members on incomes over \$20,000 complained about not being able to access the service (Management Committee, 1992). The reforms of the 1990s had impacted considerably on low to middle income New Zealanders. This issue of income levels took some months to resolve, the major concern being the focus on low-income earners as the target group, but the income level was ultimately lifted (Management Committee, 1993).

The NUHS population drew mainly from the southern suburbs of Wellington (Berhampore, Island Bay, Kingston, Melrose, Newtown and Vogeltown) plus the central city suburb of Mount Cook. The 1996 census data indicate that the total catchment population was 27,768 people. This population was ethnically diverse. For example: Māori (10%), European (65%), Pacific peoples (10%), Asian (10%), other ethnicity (2%) and the ethnicity of 3% was unknown. Nearly a third (31%) were not born in New Zealand. Eighteen percent of the catchment population were under 15 years, 73% between 15-64 years and 9% were 65 years or older.

The geographical boundary was later redefined to be the Miramar and Island Bay electorates. Even though NUHS had geographical borders, data from the people interviewed and the audit indicate some people who used the service lived outside of the geographical borders. Of those who were interviewed the reason for staying was because of the quality of the service. One of the reasons people outside of the boundary were able to stay enrolled was the boundary fence was only a guide (Staff 4). Depending on the distance people had to travel to attend a consultation, NUHS would encourage people to find a more accessible GP. NUHS staff considered people needed to live reasonably close to the service, so that they could provide any after-hours support people needed (Staff 4).

Table 8 shows the changing demographic features of those registered at NUHS from 1987 to 1998. The changes in the ethnicity labels reflect how NUHS saw its population changing, while the changes of age groups and beneficiary status reflect changes in government policy. This constant changing of demographic descriptors makes it difficult to discuss trends over time. However it is evident that the population became increasingly ethnically diverse. In 1998 refugees made up 25% of the practice population. To cope with the needs of this diverse population NUHS specially trained interpreters as 65% of all consultations with refugees required an interpreter (James et al., 1999). To support the care of this group, NUHS

received additional funding, not unlike the mental health contract. Once enrolled at NUHS, people were eligible for any services NUHS provided.

**Table 8. People by socio-demographic features registered at NUHS 1989-1998**

	1989**	1993#	1998##
<b>Ethnicity*</b>	Pakeha 44% Māori 20% Pacific Islanders 23% Vietnam/Kampuchea 3% Other 10%		European 33% Māori 17% Pacific Islander 25% Other 24% Unknown 1%
<b>Age Groups</b>	≥16 years 21% 17-59 years 71% 60 + years 7%	≥17 years 28% 18-59 years 67% 60 + years 5%	≥17 years 31% 18-64 years 65% 65+ years 4%
<b>Benefit status*</b>	On a benefit 49%	Group 1 50% High Users 4% Group 3 28% Unknown 18%	

\*Terms used are as reported in the annual reports. People who have a Community Services Card (determined by annual income) are in Group 1. The High User group includes people who have seen a GP a minimum of 12 times within a 12-month period. People in Group 3 are not targeted for any additional government funding.

\*\*1989 – NUHS Annual Report

#1993 – NUHS Annual Report

##1998 – NUHS Annual Report

Over time, the Hall Street premises became too small for the number of people served, restricting the work NUHS could do. Despite the somewhat cramped conditions, the premises maintained an inviting atmosphere. In addition to toys and magazines, tea and coffee was available in the waiting room. On “the wall of fame” there were photographs of staff and paper clippings of achievements of some of the individuals who worked in or used the service (Kennedy, 1997). Staff were casually dressed and referred to by their first names. Staff attempted to greet patients in a patient’s own language. At the 10-year birthday party, the Policy Board prided itself that NUHS had managed to provide a service where people could come in their slippers (Kennedy, 1997). In 1995 a search for new premises was started which resulted in newly built premises opening behind the existing NUHS rooms in 2000.

### **NUHS community-owned and governed service**

The underlying philosophy for NUHS was that it was essential the service met the needs of, and was acceptable to the people who used it. It aimed to do this by encouraging people to be “involved in their own health” and in how NUHS operated (Staff 1). A Management Committee made up of user, community groups, and staff representatives managed NUHS (NUHS Constitution, 1987). The community owned the service and all staff, including doctors, were employees. In this regard, NUHS right from the beginning, challenged “the

power structure of general practice since historically, doctors have owned general practices and operated them as small business" (Regan, 1991a, p.20). All members on the Management Committee were officially elected onto the committee at Annual General Meetings (AGMs). These were the venues for NUHS formally to report back to the community. Although all members were able to attend the AGMs, only a small group did. Of the 20 people with SOMI interviewed, 15 knew of the meetings, and two had attended one. Some interviewees had also attended other functions such as staff farewells. A few of those interviewed needed an explanation that NUHS was community-owned.

Initially the Management Committee included representatives from the New Mothers Group and the Newtown Park Flats and union officials from the Hotel Workers Union, Nurses Association and Tramways Union. These unions had been instrumental in setting up the service, and some assisted by providing establishment loans. Others, including representatives from the Distribution Workers Union, Hospital Workers Union, Youth at Risk, Te Tai Tamariki and the Wellington City Council were co-opted onto the Committee. In 1990, a decision was made to distinguish between those "attending meetings as a full member of the Committee and those who attended in an advisory capacity" (Management Committee, 1990). This decision was taken as some organisations (e.g. Wellington City Council) wanted to be kept informed and to give advice, but did not believe they should be full members. At that same meeting it was decided that clerical staff should also have a staff representative. Staff representatives, with the exception of the clinic manager, were elected and included a nurse and a doctor. Regan, one of the founding nurses, had this to say of decision-making. "We [nurses] have always been part of the decision making on equal terms with all workers in the service ... All staff work within an equal partnership ... All have direct input to the management structure and all policy decisions have a nursing input" (1991a, p.21).

The Management Committee was renamed the Policy Board in 1995. This was important, reflecting that the Committee was to be more concerned with policy, than day-to-day operations (Staff 1). The make up of the Policy Board remained the same as the Management Committee (see Appendix 12). The Board was chaired by a community person and met monthly. The representatives were advised, that it was not only their interests they were representing, but also those of the group they belonged to, and they needed to think generally about the needs of all the users who attended NUHS. The role and responsibility of the Board

was to oversee the service's direction, set policy, advise and approve all new initiatives, and work through any complaints received about the service.

As targeted programmes began to develop at NUHS, representatives were sought from these groups. Over time, membership of the Board gradually changed and more people who actually used the service were enlisted. Although elected from the floor, initial representation was largely a result of people being "shoulder tapped" by staff or Board members. Staff and Board members also identified new groups needing representation on the Board. Any user of NUHS could nominate representatives. Cost was not a barrier to representation; Board members were given payment for attending all meetings connected with their role as a community representative and training was provided. The 1997 AGM had so many nominations that for the first time voting was required on who was elected to positions on the Board. However, a vote was not held, as a decision was made to have a large committee as this would be helpful for fund-raising for the new building.

Mental health programme representation on the Board was first evident in 1992. This representation came about through networking with people with SOMI (Staff 1). Until 1998 these representatives had been from the Wellington Mental Health Consumers Union and the Schizophrenia Fellowship. However, in 1997 there was some disquiet about who was eligible to be a representative on the Board and in 1998 only people who were registered users of the service were able to take on such positions (Staff 3). This reflected a further change in the membership of the Board; the first was from union to community organisation membership and the second from community organisation to user representatives.

Another way NUHS sought to improve its service was through a formal complaints system that encouraged people to present their concerns verbally or in writing to the service. A notice about this was located in the waiting room alongside a suggestion box. While the complaints system was confidential, the contents of the suggestion box were shared with the Policy Board. Interviewees reported awareness of the complaints process and one person reported they were impressed with the way NUHS staff had handled a complaint they had made (Interviewee7).

Research was another tool used by NUHS to ensure it was delivering the services required and was one of the reasons it was interested in working jointly on this research. The service



was involved in several research projects. The first of these was an evaluation of the first year of the service which the DoH had commissioned McGrath, a public health consultant, to undertake. McGrath (1989) concluded that NUHS had successfully targeted a low-income group; had offered a service acceptable to the people enrolled in it and that it had a major emphasis on prevention. Commenting on doctor-nurse teams, McGrath noted that establishing "the role boundaries has not been an easy process for the staff, but ... what has been achieved ... [is] an innovative and successful style of team-work" (1989, p.59). It was also found that NUHS worked with about 20 community based groups including and representing people at the City Council flats, a trust working with 'at risk' youth, a hostel for ex-psychiatric patients, union members and the unemployment collective, refugees and Kohanga Reo. Several health groups, including one for asthma, diabetes, weight reduction and pregnant women were formed. The mention of the hostel for ex-psychiatric patients in McGrath's 1989 report was an indication of how soon after NUHS opened that working with people with SOMI became a focus. Other research NUHS made itself available for included an examination of nurses' work (Huntington, 1993) and third sector development (Crampton, Dowell, & Bowers, 2000; Crampton, Dowell, Woodward et al., 2000). As already indicated, NUHS staff were interested in a formal evaluation of the mental health programme, but the CRHA declined to fund this.

In addition to external research, NUHS also regularly self-evaluated how it worked and whether it was achieving its goals. For example the staff conducted patient satisfaction surveys in 1988 and 1990 to establish if what they were doing worked for the people who used the service. Evaluations, such as one carried out on the practice nurse role in the maternal and child health team often resulted in considerable change (Practice nurse, c.1988). These surveys confirmed that NUHS was on the right path (Regan, 1991a).

### **Hurdles NUHS overcame in getting established**

Although NUHS was welcomed by many of the residents of Newtown, most health providers, especially other GPs were not so welcoming. Other doctors were "up in arms because ... [NUHS] were going to charge too little" (Other provider 1). There was also a concern that NUHS was obtaining capitation funding for people who were not really registered at NUHS. The other GPs in the area were funded on a fee-for-service basis.

The NUHS nurses had additional hurdles to overcome when it was first set up. Funding of primary care was traditionally tied to doctors, effectively restricting the work of the nurse

(Regan, 1991b). Nurses needed to develop their own role and it was they who mainly led the health promotion side of the service. They did this while balancing a curative role. They also had to find a way to work alongside other community-based nurses such as Plunket and Public health nurses<sup>26</sup> that complemented rather than duplicated nursing work (Regan, 1988). This was important as NUHS was set up with the understanding that the doctors and nurses would spend approximately 30% of their time on health promotion activities outside the “centre” (Submission, c.1987).

In 1989, when the Labour government introduced yet another scheme aimed at increasing the access of low-income people to primary health care, NUHS signed up immediately. By signing the scheme contract, NUHS received additional capitation payments. In return, it had to limit the co-payment charged for people to consult with the GP. However, by late 1990 NUHS's existence was in jeopardy. The newly elected National Government had announced it was discontinuing the special arrangements introduced in 1989 and this threatened the financial viability of NUHS (Matheson, 1991b). Solutions suggested to overcome this included reducing the number of services provided, dropping free services such as cervical screening and supportive counselling, changes were also mooted in the way staff worked such as increasing the nurses' role in clinical management and altering the centre management and reception work. Closing the service was raised and lastly another consideration was to continue the same service, but supplement it by getting additional funding from other sources such as the Wellington AHB for caring for psychiatric patients, or the DoH for refugees (Management Committee, 1991). NUHS decided to recruit more new patients (to increase the register to 10,000 people (Special Options, 1991)), as greater numbers meant more income, increase co-payments to \$15.00 for adults and to find alternative sources of income.

Nonetheless, difficulties continued and in late 1991 NUHS's existence was again threatened. Not only did it have to adjust to the government changes, but the head doctor, Matheson was also challenged about how the service claimed funding. The targeted scheme that NUHS had belonged to required services to lower the fees they charged patients. Matheson was challenged to appear before the Medical Practitioners Disciplinary Committee for not complying with this requirement (Matheson, 1991a). However, the hearing did not take place

---

<sup>26</sup> As a public health nurse based in Newtown when NUHS first opened I was involved in many conversations with other practitioners concerning the arrival of NUHS. While the availability of cheaper GP visits for people was welcome, Public health nurses and other groups often felt threatened by NUHS community development approach to working with the community.

as the New Zealand Medical Association decided not to pursue the action (Management Committee, 1991).

In addition to surviving the funding crisis, NUHS also had to survive the cuts in beneficiary payment rates. These benefit cuts impacted on many NUHS users. In 1989 49% of NUHS users were beneficiaries (Annual General Meeting, (AGM) 1989). The benefit cuts were followed by the 1991 health reforms that paved the way for the introduction of the targeted CSC and HUHC benefits. The funding of NUHS changed; a higher subsidy was payable for people with a CSC or HUHC and the 100% practice nurse subsidy was reduced to 75% (Staff 2). The subsidy for adult CSC holders was approximately \$60 based on four consultations; the rate for HUHC holders was \$210 based on 14 consults a year (Memo, 1993). The rate for elderly CSC holders was \$105 based on seven consultations. In order for NUHS to receive the increased subsidy, staff needed to know how many people had a CSC or HUHC. Developing clinic records that incorporated card status took considerable resources and was problematic because some people did not want to claim their CSC in protest at the reforms, while others wanted to wait to get their card at the end of the financial year (Management Committee, 1992).

The impact of the benefit cuts and changes to funding primary care affected NUHS badly. By the end of 1992 NUHS was "technically insolvent" and had insufficient funds to pay for staff wages and the goods and services tax (Special Meeting, 1992b). The solutions adopted to survive this crisis included:

- most staff giving one half day clinic session a week free,
- approaches being made to the trade unions and the Wellington AHB for loan repayments to be deferred (the outcome of which was that some unions waived receiving interest payments),
- establishing a process to ensure all those who were eligible for HUHC obtained them; pursuing people regarding their CSC card; and
- reducing the level of staffing (Special Meeting, 1992a).

To address the card issue NUHS appointed a reconciliation team. By 1993 NUHS knew the status of 75% of people registered at its service (Management Committee, 1993). The financial crisis raised particular issues for the Management Committee, as NUHS's legal status meant that if NUHS kept trading the Committee could become personally liable. Reducing staff costs involved the loss of nursing resources. By the middle of 1993, NUHS's

financial position was more viable, largely as a result of the DoH changing the funding formula to fund services, rather than people (Management Committee, 1993).

Despite the incredible pressure from the established services, NUHS survived, its membership grew (see Table 9), additional staff were employed and NUHS pursued looking at ways of expanding the service it offered. From 1994 onwards, NUHS's future gradually became more secure. NUHS no longer had to focus on its survival; it could now focus on improving the service it delivered. The success of the annual contract round became less focused on getting base funding, and more focused on obtaining additional funding. One area where considerable additional resources were needed was for refugees. By 1998 NUHS had approximately 500 refugees registered with its service (Kennedy, 1997).

**Table 9. Numbers enrolled at NUHS by year**

Year	Number
1988	4202
1991	6300
1998	7809

Staff numbers at NUHS grew considerably. The expansion was not just more doctors and nurses, it included community health workers, office staff and a social worker. The social worker was on secondment from the Wellington AHB. Apart from the particular "trade skills" that people brought to the job, appointments were influenced by the need to have a culturally diverse staff to reflect the community served and to facilitate communication with the users of the service. Staff had regular meetings called Core Group Meetings.

### **The work of the NUHS generally**

Combining a primary health and a community development approach resulted in NUHS working with the community to establish services at the NUHS rooms and in outreach areas – depending on which location best met the needs of the community. Outreach activities included working with local work places such as factories, the hospital, and unemployment programmes; community based groups such as the City Mission and local Kohanga Reo; and the local community at Newtown Park Flats. In 1992 an outreach clinic opened in Strathmore, an eastern suburb of Wellington (Management Committee, 1992).

Apart from the usual services offered in general practice such as medical and nursing services, family planning, accident services, obstetrics, child health and crisis counselling, NUHS developed some speciality programmes, providing health promotion to groups with enduring disorders and meeting the needs of "at risk groups of people" (Staff 1). These programmes were listed in the 1990 Annual Report as targeting people with asthma, diabetes, psychiatric health, alcohol and weight problems. In addition programmes for well women, elderly, new mothers, workers and refugees and for Club Hapu and the Buller Unemployment Co-op were provided. In 1990 it was also reported that the staff regularly liaised with domiciliary psychiatric nurses. The initial services provided to the hostels that housed people with mental illness had expanded to become a "psychiatric health" programme. This is the mental health programme that is the focus of this case study.

The nurses' work at NUHS differed from that of most other practice nurses in that their work was not usually determined by the doctor. They strove to develop their role to have a health rather than a curative function, and could arrange their own appointments. Regan reported that because of this, it became "necessary to give each nurse extra appointment times to work independently from the curative service". The nurses found that "In some instances the nursing consultation achieved all that the client required and no doctor involvement was needed. In other situations, a short doctor interview was all that was required" (1991a, p.21). This separate, but interdependent role for nurses required the doctors, nurses and the community to change their attitude towards nurses' work.

Huntington's (1993) research found that NUHS nurses had a high level of patient contact that involved health promotion through to curative activities. Huntington reported that NUHS nurses carried out the following nursing activities when they were with patients: Assessment 81%, Treatment/management 27%, Education 27%, Health promotion 25%, Counselling 10%, Information 20% and Communication 60% (1993, p.38). In response to Huntington's work, the subsidies for practice nurses were calculated and shown to meet only 19-27% of costs (Matheson, 1993a). NUHS and the Porirua Union Health Service developed a proposal for the DoH for funding to enable comprehensive practice nursing services to be developed (Matheson, 1993c). Nurses at NUHS also had a triage role (Matheson, 1993b). This involved assessing non-booked people, providing emergency care and answering medical and telephone health enquiries (Health Care Aotearoa Inc, 1998). Phone consultation work could

involve the nurse arranging for a script, assessing people's needs and, as appropriate, advising them to come in for an appointment.

NUHS staff were also involved in advocacy. This involved staff applying for government benefits for individuals through to advocating in general for improved services for low-income groups. The staff regularly consulted with government representatives, funders and purchasers, and other community groups. One area in which NUHS staff sought to challenge the government involved the cost and funding arrangements of primary care. "The funding of primary health care and practice nurses needs to be reviewed so that nurses and clients can become equal partners in health care teams. This would allow nurses to fully use their skills to the greatest benefit of the client and also be part of a multi-disciplinary health care team" (Regan, 1991a, p.21). Advocacy was not just undertaken with locally-based organisations, NUHS joined with other union health services to lobby government for funding for primary care (Management Committee, 1991) and was a founding member of Health Care Aotearoa.

Reflecting the general concern about mental health throughout New Zealand, mental health services were regularly discussed at Board meetings. Discussions included reporting on seminars such as the *Enlightenment of Health Professionals in Their Work with Mental Health Consumers* seminar attended by a Board member in which the Director of Mental Health had presented the government's strategic direction for mental health (Policy Board Minutes, 1995b). At this same Board meeting the role of NUHS in the development of Wellington's community mental health services was discussed. A decision was made that "NUHS staff and the Mental Health Consumers Union should meet to discuss NUHS possible future role in this area". The Board meetings also helped NUHS keep in touch with what was happening in the community. In the April 1995 meeting for example, it was reported that the CRHA had employed a mental health consumer to work at Newtown Park Flats to network and support "people with mental illness" (Policy Board Minutes, 1995a).

### ***The mental health programme 1990-2000***

The seeds for the programme were evident soon after NUHS opened. A common concern raised by the community was the care of the "chronically ill in the community" (Morten et al., 1993). The nurses at NUHS immediately started addressing this concern. The nursing report covering the first four months of NUHS indicated that some outreach work involved "a discussion with psychiatric patients on diet and health screening at the City Mission and Night Shelter" ('Newtown Union', 1987). Diet was initially an important issue as many

residents in supported accommodation were being “taught how to cook” and so needed to know about balanced diets (Staff 1). Two psychiatric domiciliary nurses from the Wellington AHB reported at the first AGM that “they were pleased with [the] range of services currently offered and that many of their patients had been able to benefit from them” (Annual General Meeting (AGM), 1988). Staff 4 considered that one of the reasons the psychiatric nurses got involved was because the nurses “were big union people”. The first mention of the mental health programme was two years later (AGM, 1990). During this year there had been general concern within Wellington about the lack of psychiatric resources in the community. It was reported that the psychiatric nurses’ caseloads were often up to 80–100 people (Staff 2). The Newtown nurses’ group meeting discussed whether the group should lobby for an improvement in mental health services (Nursing Liaison Minutes, 1990). No decision appears to have been made from this discussion. NUHS however, continued to develop its work with people with mental illness.

In 1992, working teams were created to specifically focus on groups of people with special needs (Management Committee Working Party, 1992). These teams were formed to increase efficiency given the financial issues NUHS was having. Other nurses had specialist areas and it was a question of “what are the other biggies in this practice [and mental health was identified] ... I said all right give me three months and I’ll see the kind of inroads that I make” (Staff 2). It was at this time that the mental health programme was formally named. Table 10 summarises the significant events in the history of the programme.

NUHS was able to identify such a need because Porirua Hospital, the region’s psychiatric hospital, was moving long stay residents into the community. Part of this process involved registering people with a GP. A large number moved into newly established supported houses<sup>27</sup> near NUHS. NUHS, from its inception, was actively working with people in the half-way houses and hostels (Management Committee, 1992). It was also willing to register people with SOMI. Not all general practices were willing to do this, and the mental health staff referred people to “sympathetic [GPs]” (Other provider 3). The initial need and focus was on people’s physical health needs. People “had some very real ... physical problems, ... CORD and other smoking related problems ... there was a lot of work done with primary care, but nothing of ... psychiatric management that stage” (Other provider 3).

---

<sup>27</sup> This housing was mainly owned by the Area Health Board. In addition, the Wellington City Council had subsidised housing for people on low incomes.

Formalising the programme required negotiation between the nurse and doctor. They each developed aspects of the programme without an initial plan of action. As Staff 2 said although it “sounds like it was deliberate ... it wasn’t. [We each developed parts] and we pulled it together”. These staff members started writing and talking about the programme and the needs of people with mental illness (Morten et al., 1992). Initial work involved visiting supported accommodation, then “attending the depot clinic” (Staff 2) and a draft programme was developed (see Appendix 13). The doctor and nurse had different ideas on how some aspects of the programme should proceed. The doctor’s vision, highlighted in the draft, was for the programme to have its own psychiatric-domiciliary nurse. The nurse disagreed with this idea, believing that liaison with the mental health services was best, that having their own psychiatric nurse would duplicate existing services, and result in further fragmentation (Management Committee Working Party, 1992). The nurse’s ideas prevailed.

**Table 10. Significant events in the history of the NUHS mental health programme**

<b>Year</b>	<b>Event</b>
1987	First mention of mental health need
1988	Domiciliary-psychiatric nurses regularly liaise with NUHS
1990	First mention of mental health “psychiatric” focus
1992	Mental health and other programmes formalised NUHS takes up Capital Coast Health Ltd (CCH) offer to provide a consultant-liaison service
1993	Follow-up of psychiatric patients no longer possible Programme highlighted in DoH primary mental health discussion paper Programme sets its goals and starts working with Wellington Mental Health Consumers Union
1994	Contract for programme signed with CRHA NUHS invited by CRHA to meeting on primary mental health services
1996	Change in nurse; New nurse has a mental health background Manual developed to describe programme
1997	Research on programme commences
1998	Social worker position removed by CCH Psychiatrist clinic changed from weekly to fortnightly
1999	Criteria for programme redefined Programme received Silver Award at THEMHS Nurse, awarded Club House Award
2000	Training of additional doctor in mental health to accommodate increased workload

The financial crisis experienced by NUHS in late 1992 impacted considerably on the work in mental health. The “follow-up of psychiatric patients outside of the clinic” had to be stopped due to the reduction in nursing staff (Management Committee, 1993) – the nurse working in mental health was not replaced while on maternity leave. In response to this lack of follow-up, a management committee member offered to assist in supporting psychiatric patients in the community on a voluntary basis. This hiatus in community work did not last long. By



May 1993 the nurse had returned from maternity leave and was working alongside the community worker “up to 8 hours a week on co-ordinating the Mental Health patient care in the service” (Management Committee, 1993).

The programme established its own goals in 1993 (Morten et al., 1993). These were sometimes revised, with the latest revision being finalised in 1999. The 1993 goals were more focused on goals for providing care to individuals, whilst the 1999 goals were service orientated (see Figure 6). Also some of the 1993 goals such as “To support the establishment and continued running of community based accommodation” were no longer applicable in 1999 because the services were now well established throughout the community. The goals reflect both the general aims of NUHS and goals specially targeted to those with mental illness.

1. *To provide a high quality, affordable, easily accessible, acceptable and appropriate primary health care service for people with on-going needs from major mental illness;*
2. *To develop a service in which members have a voice, are involved in determining the needs to be addressed, the type of service required to meet these needs and the formulation of policy for the service;*
3. *To develop a service that maintains people in good health, that responds early in crisis, and initiatives [sic] care which may maintain that person in the community;*
4. *To develop and promote a model of Primary Health Care delivery which is based on team work (involving a range of primary health care providers) and team decision making;*
5. *To provide such other health, or health-related services as are required by members, with particular emphasis being on health promotion and health prevention strategies;*
6. *To encourage individual responsibility for health and health care;*
7. *To develop a working relationship with psychiatric secondary care services and other primary health care services including supporting hostels in the psychiatric area, with the aim of providing a shared care service for people with a major mental illness;*
8. *To ensure a healthy working environment for staff of the service and to maximise the opportunity for them to use their skills.*

**Figure 6. Goals of the NUHS mental health programme**

From James et al., 1999

By 1993 the number of people registered at NUHS with severe mental illness had expanded to the point that NUHS realised it needed more resources to manage the need. One of the reasons it was able to realise this need was they had computerised records of diagnoses and so were able to provide evidence to support the request for funding (Staff 1). The increased numbers were paralleled by an increase in the level of need of the people using the service.

To help support this NUHS took up the offer by CCH mental health service to have a consultant-liaison service provided. NUHS was one of only two general practice groups that initially took up this CCH offer (Other provider 1).

In 1993 when the CRHA took over the purchasing responsibilities of the DoH it held planning meetings with providers. At these meetings NUHS was able to argue the success of the programme, noting that it provided “better crisis management, better case management and better liaison with the secondary services” (Opiate Addiction Proposal, 1993). Initial meetings with union health services indicated the CRHA would “roll-over” the existing contracts, and NUHS could suggest amendments (Management Committee, 1993). One such amendment NUHS suggested was the funding of the mental health programme. The proposal to fund the programme was made in co-ordination with the Coromandel Centre (a mental health service) “to improve crisis management and integration with secondary service” (Clinical Staff Meeting, 1993). This approach was successful and NUHS received a special contract from the primary/personal health group. This successful funding typifies how NUHS worked: “We get the programme up and running and then we find a way of funding it” (Staff 3).

This contract provided NUHS with additional funds on a capitation basis to provide primary health care for up to 300 people with serious mental illness. The level of funding provided was calculated using the high user card rate as the benchmark. The CRHA contract stipulated that patients were to receive mental health care provided by the service without having to pay a co-payment. The initial contract, like many given at this time, was only for a year, providing NUHS with little security. In the strategic planning document *Implementation of a Better Life* (CRHA, 1994), the programme was referred to as a pilot, which if successful, would be extended. Definitions of success were never outlined by the CRHA. NUHS was required to deliver 6-monthly reports to the CRHA that contained two weeks of programme activity and a description of NUHS’s relationship with the mental health service generally.

Contract negotiations generally took place in the month of May. The doctor and office manager met in April 1995 to prepare a proposal to extend the programme (Core Group Minutes, 1995). NUHS did not generally apply for funding unsupported; it approached the Consumers Union for their support. This lobbying for resources was usually made by staff in the evenings and weekends, so as not to limit clinic activity.

Contractual conditions for the specific funding related to who was targeted by the service and a requirement to reduce the access barrier for people with serious mental illness. People were defined as having a serious mental illness if they had been seen at least once by the specialist mental health services and had an illness as defined by the diagnostic system, DSM IV, Axis I. In practice, defining people with serious mental illness using these criteria was problematic as people could have a serious illness of limited duration. This was evident when the records were audited. In this review it became obvious that some people who had had a depressive illness several years earlier were now well. After the review was complete, NUHS changed the Code 300 classification, separating out those with serious and ongoing depression (Code 300S) from those with a depression of limited time duration (Code 300). People with an ailment code of 300 were no longer eligible for the programme. It was not expected that this change would have much impact on numbers as CCH was actively discharging people to GP only care (Rodenberg et al., 1998).

Although they were never challenged outright there was a general belief held by other local stakeholders that NUHS exaggerated its work and was trying to be a mental health service rather than a general practice (Other provider 3). In contrast, others appreciated that NUHS had actually “gone and done something about getting funding” to establish a mental health programme (Other provider 1). Formal recognition of the programme came in 1999 when NUHS won the silver award at The Australian and New Zealand Mental Health Services (THEMHS) conference in the category of a specialist service as part of a larger service<sup>28</sup> and the programme nurse received a Club House (a consumer-based group) award for best support to consumers.

### **Entry into the mental health programme**

Although registration at NUHS was usually by self-referral, discussion with NUHS staff, references in some people's case notes, and the interviews with users and providers revealed that often a person's enrolment was a result of a recommendation from family, friends and other providers. Five (25%) of the people interviewed joined on the recommendation of another provider including a counsellor, CMHT nurse (3) and the Māori mental health service. Seven (35%) people joined on the recommendation of friends and family. For Interviewee 2 it was a nurse who “just told [me] that I should enrol in NUHS”, whereas Interviewee 5 “heard through the grapevine” and Interviewee 14 was told by her sister “to go to NUHS”.

---

<sup>28</sup> This research contributed to the application for this award.

Eligibility for the programme was assessed when people joined NUHS; the initial consultation included a well-health check by a nurse. If it was known that a person had a history of mental illness, the nurse from the programme carried out the check. The well-health check involved

identifying past and present health needs both mental and physical, ethnicity and cultural identity, religious and spiritual beliefs, immunisation status, lifestyle patterns, community supports and other agency involvements, current medications, plus health promotion and screening including cervical smears, blood pressure checks, height and weight. All ailments are recorded, coded and put on appropriate computerised recall. (Davison, 1999, p.12)

Generally, if people had previous involvement with the mental health service or disclosed in the initial assessment they had an existing mental illness they were given a mental health ailment code(s) and were entered into the programme on the basis of their diagnosis and history. People did not have to consent to be part of the programme, and although the service aimed to inform people of the programme, one person interviewed was not aware of its existence. NUHS had four mental health codes: depression affective, psychosis, depression reactive and personality disorder. NUHS also has ailment codes for other enduring disorders such as asthma and diabetes. Although alcohol and drugs are often part of mental health, NUHS had a separate programme for people with these disorders. People already registered at NUHS who developed a mental illness could be given a mental health ailment code and join the programme.

The ailment codes of the 55 people whose records were audited are summarised in Table 11. Although people could have more than one ailment code, none of those whose records were reviewed did, despite many of them having a record of having a second mental illness. Many of those with a personality disorder were also reported as having depression. Table 11 also shows the ailment codes for 1993.

There are two probable explanations for why the numbers in the psychosis, depression reactive and personality disorder ailment codes changed between 1993 and 1997. The first is the long stay residents of Porirua Hospital moved to the community, and the CMHTs were discharging more people with psychotic disorders. CCH had traditionally referred 70% of people back to GPs, but in 1997 decided to increase this figure to 80% "as part of a plan to save money" (Bailey, 1997). The second is that to obtain funding people needed a DSM IV,

Axis I diagnosis; Personality disorders are Axis II. In 1993 more emphasis was placed on personality disorder as a diagnosis than it was in 1997. Although NUHS staff were concerned about the high numbers of people in the programme, this was considered manageable as the staff believed that people moved in and out of the programme depending on need. At the early stage of the research there was no evidence that people did move out of the programme.

**Table 11. Mental health ailment codes, 1993-1997**

Ailment Code	Description of code	1993* No (%)	1997# No (%)	Records review No (%)	Records as percentage of 1997
296	Depression bi-polar	59 (21%)	54 (14%)	11 (20%)	20%
298	Psychosis	94 (33%)	153 (39%)	19 (35%)	12%
300	Depression reactive	56 (19%)	169 (43%)	20 (36%)	12%
301	Personality disorder	78 (27%)	16 (4%)	5 (9%)	31%
Total		287 (100%)	392 (100%)	55 (100%)	55 (100%)

\*Obtained from Report to Department of Health 1993

#Obtained from NUHS print out by ailment code

Another problem raised by the review concerned the discrepancies between ailment codes and diagnosis as some people with the same diagnosis had different ailment codes. Of the records audited the principal mental health diagnoses were: Schizophrenia or other psychoses (16), Bipolar disorder (9), Depression (16), Anxiety disorder (3), Personality disorder (3), Drug use (1), Family stress (1) and the mental health diagnosis of six (11%) people were not recorded on the cover sheets. The likely explanation for the non-recording of diagnoses on the cover sheets is that they were recorded in the past history section rather than in the current problem list. Nine people had a second mental health diagnosis, including alcohol and drug dependency, personality disorder and depression.

Sixty-three percent (30) of people had what could be considered an ongoing general health need. Of this 17 people had only one ongoing problem and 13 had two or more ongoing problems. The ongoing health problems included: asthma (6), heart problems (5), alcohol and drug dependency (4), arthritis (4), hypertension (4), thyroid problems (4), diabetes (3), weight problems (3), old head injury (2) and epilepsy (2). There were also individuals who had tuberculosis, diverticulitis, adrenal tumours, chronic pain, liver damage, parkinsonism, renal impairment, and chronic obstructive airways disease. This data indicates that a high level of input for general health needs, people on the programme may have needed.

## **Staffing the programme**

Programme work occupied approximately 40% of the doctor's and nurse's time, the other 60% of their time involved working with other patients (Staff 4). The doctor and nurse initially involved had not volunteered to work in mental health; rather they ended up filling the gap as other staff members took on other speciality programmes. They did not receive formal training for involvement in the programme, rather they learnt on the job. One of the important sources of learning was from people with SOMI and the consumer representatives. Staff 4 reported "she [consumer representative] made me think differently ... She made me think that there were people who had mental health conditions that were going to say yes ... [but others made an] informed choice [in not taking medication]". In addition to this apprentice style training, staff did their own reading, attended courses and study days, and learned from their mental health colleagues. When the programme nurse resigned in October 1995, her replacement was employed on the understanding that she would be working in mental health. This replacement nurse came with skills in mental health nursing; her arrival resulted in some change in how the service worked. She took on more clinical work, a consequence of which was less liaison work (Staff 1). This new nurse believed she was the first mental health experienced nurse employed in a general practice setting in New Zealand.

Although one doctor and one nurse mainly delivered the programme, other staff in NUHS also provided care. Training was provided to all staff, including managers, receptionists, nurses, community workers and doctors on matters pertaining to mental health. Increased demand for the programme meant that NUHS had to up-skill another doctor to be more involved in mental health. NUHS developed an orientation manual that principally targeted information for medical and nursing staff (Davison & James, 1996). The manual was utilised as part of the orientation for all new medical and nursing staff, and was available to share with visitors to the service.

## ***The day-to-day activities of the NUHS mental health programme***

One of the first tasks of the programme staff was to let other providers know that there was "one person in the practice" that they could contact regarding mental health (Staff 2). By 1997/8 the programme was organised around regular clinic sessions and other activities undertaken on an intermittent basis. Both the doctor and the nurse held clinic sessions, seeing people alone or jointly. The doctor was available for eight half-day clinic sessions and the nurse seven (including triage work). All but two of the sessions were at the NUHS rooms; the

other two were nurse clinics were held at Schizophrenia Fellowship rooms and the Club House. The clinic at the Schizophrenia Fellowship commenced soon after the programme was funded, and the Club House clinic commenced in 1998. Clinics in these outreach areas developed following requests by consumers for a service. Other staff activities included follow-up, networking and liaison work, advisory and training functions, and lobbying for improved services.

Once in the programme people were expected to see the GP free of co-payment costs for mental health. Some NUHS GPs allowed free consultations for all health problems, while others only gave them for mental health related problem. Several people interviewed were confused about what being in the programme provided, as sometimes when a GP other than the programme GP had seen them they were charged a co-payment fee. Staff explanations for this were there were different interpretations about what the contract funded; some doctors' interpretation was the contract only funded mental health consultations, while others' considered it covered all health (Staff 4). The latter argued that in a general practice consultation it was not always possible to separate whether a consultation was predominantly for physical or mental health reasons. They also considered that if a person has a SOMI, no matter what the presenting problem, the consultation would involve a review of mental health. The final reason for not charging was to ensure the services remained accessible.

### **Consultations for people in the programme**

People could either make an appointment to see the nurse or doctor or just drop in and wait until these, or other staff, were free. Getting a timely appointment with the programme doctor was not always easy as she was often well booked-up; sometimes people had to wait 2-3 days to get an appointment (Staff 1). There was no set pattern to how often people had consultations with individuals reporting arrangements that varied from "weekly", "fortnightly", "monthly", "6-weekly", "2-monthly", "3-monthly" to "hardly ever". The frequency often depended on people's health. As Interviewee 1 said "at different times its been different ... Like I might see her every three weeks and now [it's] every three months". In talking about this difference, people quite often referred to how, as they improved, the length of time between appointments gradually increased. Those who went hardly ever, talked about being extensively involved with other health services. Of the interviewees three saw the doctor only; one saw the nurse only, while 16 saw the doctor and a nurse. For the occasional person, the nurse they saw was not the nurse in the programme, but the nurse who

specialised in diabetes. Two interviewees talked of seeing the psychiatrist. People did not only see the staff in the NUHS rooms, some also attended the outreach clinic at Newtown Park Flat and at the Club House.

Consultations were for mental health, general health, social or spiritual reasons or combinations of these. "It's the holistic approach ... it's not just about getting into treatment, but getting into sort of working with the client" (Staff 4). People enrolling at NUHS often found it easier to address their physical rather than their mental health needs. Davison noted that initially "people would ... discuss purely physical concerns, however over time and as people ... got to know [her] ... they [would] ... discuss other issues including their mental health needs" (1999, p.11). If the person was a refugee sometimes an interpreter was also present for a consultation. According to Interviewee 14 relying on interpreters was problematic, as sometimes they never turned up.

Over time the consultation activities changed. In the early years some people with SOMI were seen who hadn't had "any kind of primary services for a long long time ... these people [were] coming in with ingrown toenails and hadn't had a smear for 20 years" (Staff 2), they needed "medical attention" (Staff 4). Increasingly the activities were more mental health focused including addressing acute and ongoing general and mental health problems, reviewing medication, providing supportive counselling and undertaking health promotion activities. The nurse and doctor considered their over-arching approach was wellness. They took a pro-active stance to health promotion, and health prevention strategies like immunisation, smears, diabetes and asthma checks and quit smoking programmes were offered. People enrolled at NUHS could also phone the service for advice. It was the triage nurse that provided this advice and they would advise the programme nurse or doctor about the call.

The role of NUHS in people's mental health varied, including teaching people about their medications and how to recognise early warning signs. In talking about the role, people often discussed the work of the nurse and doctor separately. Their work differed in many respects; their roles were separate, yet they overlapped. In addition to providing health promotion and prevention services, the nurse's role included providing supportive and "situational" counselling. This differed from the ongoing support given by the doctor. The former focused on supporting people to make changes in their lives or to address a crisis, the latter focused



more on supporting people in the management of their mental illness. The doctor often being credited for “trying out different medications and things” and the nurse for “being there” (Interviewee 1). “I had a regular ... kind of appointment time with the nurse ... I would go and see her and just sort of have a catch up ... a check in to see how I was doing” (Interviewee 19). Trying out did not just mean NUHS providing the service, it also meant NUHS referring people on to other services such as psychologists, hospital specialists. For others, such as Interviewee 3, NUHS’s role in their mental health was a “backup” to the hospital service.

Once in the programme people moved between the doctor and the nurse depending on their health needs. Although the doctor saw most people, some worked mainly with the nurse. The nurse was less restricted in the length of time she could have with people compared with the doctor. People in the programme often required lengthy consultations (Clinical Staff Meeting, 1993). Working as a team, the doctor and the nurse regularly communicated about the patients they were seeing. This close working relationship enabled continuity of care and helped the doctor and nurse maintain their personal mental health. For example in some of the records reviewed it became apparent that when a person who was seeing the nurse regularly for supportive counselling showed signs of worsening health that the nurse consulted with the doctor who either advised the nurse or arranged to see the person. In some situations a referral was made to the consultant-liaison service. Once a person’s health improved the person returned to seeing the nurse.

Another regular activity, undertaken by the doctor, was the completion of documents required by Income Support for people to be able to access or renew their eligibility for the Invalids and Sickness benefit and Disability Allowance. The records review revealed that NUHS usually advised Work and Income New Zealand that doctors’ visits incurred no charge. The doctor and nurse also advised and assisted people to get financial and practical assistance in order to offset the cost and impact of their disability. This sometimes involved writing in support of a person’s need for housing.

Models of care delivered at NUHS ranged from NUHS only care through to shared care with other mental health services such as supported houses and the CMHTs. Generally speaking it was the nurse who was the “first point of contact in acute situations” (Davison, 1999, p.113); acute meaning needs to be attended to that day. Approximately 20% of all consultations were

of this nature (James et al., 1999). One of the reasons the nurse rather than the doctor was more likely to deal with people with acute problems was her work in triage (Staff 3). Following individual consultations, the doctor or nurse spent time following up issues that arose out of the consultations. Follow-up was required in approximately 25% of all consults (Staff 3). This involved the doctor or nurse liaising with other providers, telling them about medication changes, planning management of difficult behaviours or symptoms or asking advice from them. Initially the programme worked mainly with the psychiatric-domiciliary nurses in providing care to those people discharged from Porirua Hospital. As service providers changed (a result of the health reforms), NUHS increasingly worked with many of the new NGO accommodation providers, such as MASH and Te Ruranganui to hi rere. Shared care worked better with some providers and practitioners than other as "some ... staff are really good at liaising at the moment and letting us know who they're ... following up and ... seeing. Other staff don't and that makes it difficult at times" (Staff 4). Co-ordinating with others took time. However, this time was not recognised in the funding formula (Staff 4). Follow-up was particularly important with the hospital-based staff as many of them were not used to having general practice involved in people's care.

### **Utilisation results for NUHS programme**

Only the cover sheets were used to gather baseline data as NUHS aimed to have these sheets complete. However, the cover sheets were sometimes incomplete and although NUHS also had computer records that possibly contained the missing information, these were not viewed as this would have involved NUHS staff time. Utilisation data was recorded by going through the records to see when people saw NUHS staff. A consultation was either face-to-face or by telephone. Contact with other providers, although recorded was not seen to be a consultation. Of the 748 entries in the notes for the 47 people enrolled at NUHS for the whole of 1997, 635 were consultation notes.

The average number of consultations was 13.5 (SD 12.56, median 11, range 0-59). Most were in the surgery (n=578), with 47 being by phone. Phone consultations were mainly for prescriptions. Eight people had a consultation-liaison review and two consultations were with family. Approximately two thirds of consultations were with doctors and one third with nurses. Of the 47 people enrolled during 1997, 41 (87%) had a consultation with a psychiatric component (range 0-48); 43 (91%) had a consultation with a general health component (range 0-36), and 23 (48%) had a consultation with a social component (range 0-

8). Approximately a third of all consultations (n=196) involved a combination of mental and general health reasons. A further 57 consultations included a social component such as benefit renewal with either mental or general health. Outputs of the consultations include acute or ongoing management of mental health (46%, n=343), management of a physical health problem (46%, n=346), supportive counselling (15%, n=112), health promotion (6%, n=46), liaison and referral (4%, n=26), and change or renewal of medication (13%, n=93).

In an analysis of a month's work by the nurse and doctor during 1997, it was found that 10% of the consultations with people on the programme were for general health issues only (James et al., 1999). Phone contact involved 13% of all consultations (Staff 3). Sometimes as a result of phone contact, home visits were required. In just under half (47%) of all consultations, the patient's mental health was reviewed and found to be stable. The remainder (53%) required active management by the doctor or nurse. This involved decreasing medication as per a plan, or responding to a crisis by increasing or adding new medication. While most decisions to alter medication were made by the doctor alone, others were made following advice from a specialist. Very few people who were not already involved with the mental health services were referred to these services as the consultant liaison service provided the assessment needed.

### **Other activities of the programme**

Staff followed up people they had not recently seen or heard about. Initially the follow-up ensured that people were still in contact with the mental health services (Morten et al., 1993), but in time it was so that NUHS could be assured that people were not unwell (Staff 4). This assurance was necessary, as NUHS had become the only provider in some people's care and it enabled continuity of care. Generally speaking most people increase their contact with health services when they get unwell; however, some decrease their contact and follow-up is important to help prevent people getting too sick. As one person said "[I] got so afraid that I wouldn't go and see the doctors there" (Interviewee 16).

The monthly process for the recall involved the doctor and nurse reviewing together, anyone they had not seen at a clinic visit over the previous three months. This review enabled them to report if they had been in contact with the person in a setting other than the practice rooms, or if they had had a discussion with another provider about someone. If no knowledge was forthcoming, decisions were taken whether to follow-up the person and who would do this. Approximately 10 needed to be recalled each month (Staff 2). Following up involved

contacting the person, their family or the person's care manager or support worker. It involved saying "Haven't seen you for a while, what have you been up to ... how's the medication ... those sorts of things" (Staff 4). The people interviewed appreciated that NUHS would actively look out for them.

The nurse and doctor also liaised and networked (both formally and informally) with consumer groups, non-government providers and the mental health service. Formal liaison involved writing to other providers, attendance at case conferences or following-up on issues identified in consultations (Clinical Staff Meeting, 1993). Informal liaison occurred when the nurse and doctor met with other practitioners such as the nurses in the Māori mental health team. Liaison and networking enabled staff to better support people using its service, and provided for consumer and community input in an ongoing developmental way. Difficulties NUHS encountered in working with other providers, most notably the hospital-based service, were a result of changes to how these services were configured and in the personnel who worked in them. A change made to the CMHT geographical boundary was most problematic as the change effectively meant NUHS staff had to work with two teams (Staff 4). When NUHS patients were admitted to the in-patient unit, the nurse visited the person, with the intention of supporting the person and liaising regarding the person's follow-up arrangements.

NUHS also sought to assist others setting up primary mental health services. It undertook this work by being involved on committees, by attending and hosting meetings with overseas and New Zealand visitors, and enabling its staff to present its work formally<sup>29</sup>. The nurse and doctor in the programme also ran training sessions on a one-on-one and group basis within NUHS (Staff 1).

The final activity involved lobbying for improvements in health and mental health services generally. This lobbying involved staff meeting with Ministry of Health personnel, the Mental Health Commission and with local Members of Parliament. Lobbying for improvement with other mental health services was often a feature of networking and liaison. This lobbying occurred often during restructuring. As Staff 2 said "there was a lot of time when people were in sort of limbo ... not knowing who to turn to ... so we were ... saying who's this person being followed up by".

---

<sup>29</sup> The nurse and I jointly presented to postgraduate nursing students on a number of occasions.

### **The consultant-liaison service**

The consultant-liaison (C-L) service commenced in November 1992 for a trial of four months (Management Committee, 1992). The decision to set up the service was made by the Management Committee as “we had never had anyone coming before” and staff needed to know that this is what [the people using NUHS] wanted (Staff 1). A psychiatrist from Wellington AHB had offered to work fortnightly, seeing patients with acute problems. According to this psychiatrist, NUHS was an ideal venue to come for such work, as an analysis of the Coromandel Centre’s (mental health service) clients revealed that about 100 of the 400 clients had NUHS named as their general practice. NUHS charged Wellington AHB for using NUHS rooms for this service. The service was initially set up on a trial basis as NUHS did not just want the proposed shifted outpatients clinic. NUHS staff negotiated that they could “use the service ... to see out patients ... and to teach us” (Staff 2).

The clinic moved to a weekly schedule in mid-1993 (Opiate Addiction Proposal, 1993), returning to a fortnightly one in 1997. In response to a growing demand for psychiatrist assessments from other NUHS practitioners, a system was put in place for all referrals to the C-L clinic to be made via the nurse in the programme (Other provider 1). This resulted in some referrals being managed by the programme nurse or doctor. Unlike GP appointments, appointment times at the C-L service were similar to those in the mental health service, being 30 or 60 minutes. The 60-minute slots were for new patient assessments. Over time increased numbers of such assessments were held at NUHS rather than a referral being made to the mental health service.

The purpose of the clinic provided an opportunity to review the health of people in the programme and to provide one-off advice and assessment for other NUHS patients. Those requiring ongoing specialist care for an acute problem were usually referred to outpatients, day hospital or to the inpatient units at Wellington or Porirua. The review could be held for routine or acute purposes. Some people had regular appointments with the psychiatrist, the clinic for them working as an outpatient clinic. The reviews mainly concerned those who had been, or were, with the mental health service. Reviews could be held monthly through to 6-monthly. The reviews involved people either seeing the psychiatrist, or the NUHS staff discussing a person’s circumstances/health status with the psychiatrist.

Initially, NUHS staff and the psychiatrist saw people in the clinic jointly, but over time this

changed and the psychiatrist saw some people alone. When the psychiatrist saw people alone, a verbal and written report of the assessment was given to the NUHS staff. Joint sessions not only provided continuity of care, but were also an opportunity for on the job training for NUHS staff (Staff 4). Of those interviewed who had attended the C-L service, most liked it. While Interviewee 3 liked seeing the psychiatrist at NUHS because of its convenience, Interviewee 7 was concerned that what was said to either the psychiatrist or the general practice staff in confidence may be shared by them.

In addition to the reviews, the clinic sessions were also used for liaison. This often involved other practitioners or accommodation providers coming into meet with the team to talk about their work and learn about NUHS work. The psychiatrist also updated NUHS staff on mental health service developments. This was important given the difficulties in obtaining information over the phone. The clinic had a role in NUHS quality and risk management. By having a psychiatrist come regularly the staff were able ask for help, get an opinion (Other provider 1).

### *The effectiveness of the NUHS programme*

Evidence was obtained in the interviews of the people with SOMI and health practitioners and from the records audit concerning the effectiveness of the NUHS programme. The accessibility of NUHS was the reason many people joined and the low cost of GP consultations featured in nine of the 20 people interviewed. As Interviewee 8 put it “the first thing was the cheapness of the consulting fees – it’s as simple as that”. Interviewee 11 joined because of their union status, whereas Interviewee 10 joined following meeting the NUHS nurse. This person knew the nurse when they had been an inpatient at the Psychiatric Unit, and wanted to have the nurse involved in their continuing care. Similarly, Interviewee 21 joined because they wanted to keep in contact with the psychiatrist who worked in the C-L service. The final reason given by seven people for enrolling at NUHS was geographical access. Having joined, people kept going to NUHS because of what they liked about the service.

However, the service was not accessible and acceptable to everyone. A recurring criticism was the time people had to spend waiting for appointments, both in being able to obtain a timely appointment with the programme doctor and the time spent waiting in the waiting room. This problem had also been the subject of several complaints reviewed by the

Management Committee. Appointments ran late because people could call in to see a doctor without an appointment and consultations with people with SOMI or with an interpreter often lasted longer than the time allowed. NUHS appointment schedules made no adjustments to appointment times to accommodate these latter two groups' needs. Waiting time did not seem to be a problem in getting appointments with the nurse. Waiting, for some, was acceptable because they felt when they got there turn they got quality time and they had never felt rushed in an appointment. Several also considered that they had sometimes had extra long appointments, which would have delayed others. One person's solution to the delays was to make an early morning appointment. While another reported that since the new building had opened they had noted that the waiting time was less. The waiting time was particularly problematic for some people in that they became so agitated they were not relaxed for their appointment. Interviewee 19 said "I just sit there and then I get agitated and then I go off and ask ... sometimes if I'm waiting too long there, I usually walk out".

Attitudes of the staff played an important part for why some people liked NUHS. As Interviewee 5 said, the attitude was "So [what] you have a mental illness", while Interviewee 9 conveyed a similar message when they said "[they're] concerned with people as people". The atmosphere of NUHS was "friendly ... non-threatening" (Interviewee 1). Some also liked that they could consult with NUHS staff in the outreach clinics.

The skills of the NUHS staff were another aspect people liked about NUHS. As Interviewee 1 put it "I felt safe knowing that ... [the doctor] knows about that stuff". The skills were not limited to mental health skills, but also how staff addressed people's physical health needs. In addition to people acknowledging the clinical skills of staff, comments were made that staff were "proactive [in] working out whether or not I need ... formal stuff for WINZ ...[or] ... referring to the hospital" (Interviewee 13). In regards to attributes and the relationships with the staff, people used words like "amazing", "friendly", "caring", "comfortable", "nice person", "trust", "good" and "genuine".

Another common theme in the interviews was that people felt part of the NUHS community. For example, it was the social atmosphere of NUHS that was liked by Interviewee 2. "When I first went to NUHS I met up with people who I met in hospital". While many, such as Interviewee 4 noted they liked to "see the different cultures", others found the multi-cultural nature of NUHS difficult. The difficulty arose because of the language barrier, and how

different groups occupied themselves in the waiting room. Aspects that people liked about the atmosphere were that they could get a drink of tea or coffee while they waited. The social atmosphere was not just about meeting people, it was also a sense of belonging “they [the staff] make you feel part of the community ... you do feel part of the place” (Interviewee 1). Not all people liked this; some found meeting people they had met in hospital reminded them of a time they would prefer to forget.

NUHS was not popular with all mental health practitioners or providers and was aware that some providers actually “kept their patients” away (Staff 2). One of the reasons for the lack of popularity was that the doctor in the programme was not hesitant in criticising the mental health services (Other provider 1). NUHS considered that an aspect of advocating involved criticising providers when they were not delivering quality services. Another view why NUHS was not always popular was because it was “innovative” and “people aren’t sure about ... where they fit in” (Staff 4). Although, NUHS was not particularly concerned regarding its popularity with other providers, people who used its service were the voice they listened to, they were concerned that many of the criticisms were ill informed. Few practitioners or management staff from the hospital-based services, the source of most of the criticism, had actually visited NUHS. NUHS was receptive to such visits, but received more from people outside of the region and outside of New Zealand, than it did from local services. While some local providers found it hard to think that a service would have 300 people with mental illness and wondered “who’s a mental health consumer and who’s not” in the NUHS programme (Other provider 3), others considered the service was “plus, plus, plus, gold stars ... We enjoyed it ... it [was] successful, after hours, even if ... [the doctor] wasn’t there ... we could call on the on call GP” (Other provider 2).

While NUHS was the only place where 14 (70%) of the interviewees had seen a GP in the previous year, six had seen other GPs. The circumstances for seeing other GPs varied including changing GPs to come to NUHS, attending a GP to get treatment not offered by NUHS (e.g. dry ice treatment), requiring after-hours services and seeing another GP at the request of WINZ. Three people used NUHS after hours in the year before the interview; two others went to the hospital, one to accident and emergency and the other to the CAT (Crisis Assessment Team) service. One of the interviewees did not appreciate that NUHS ran an after-hours service.



## **Complementarity and co-ordination of the NUHS programme**

While the no cost of accessing NUHS was important for many of those interviewed, another reason several of the people stayed at NUHS was for continuity of care, as Interviewee 17 said, “Even if [I] moved out of the area [I] would want to stay. [I] don’t like to have to go over issues over and over again”. The importance of this continuity is the staff “knows my background” (Interviewee 12).

Of the 55 people whose records were audited, over half (n=30) had other mental health services named as being involved in their care. Three people had four other providers, four people had three other providers, 22 had two and 12 people had one. The other providers included the CMHT (21), supported housing (18), the Māori mental health team (3) and others including therapists, crisis services, recreation services and consumer run services. While it is difficult from notes to pick up how well care was co-ordinated, there was at times a record noting NUHS staff frustration with situations where people were transferred to the service from the CMHT with limited notice. A few people had care plans documented in their notes and 12 (22%) had a record of daily living. Where people’s health appeared to fluctuate there was considerable attention reported in the notes concerning the management of deteriorating health. This attention to managing health was also reflected in what people said in the interviews.

In addition to family and friends, the 20 interviewed reported they were involved with up to seven other providers (range 0-7). Some people also worked with two different practitioners for example a CMHT nurse and a psychiatrist from the same provider. While some people reported their care was extremely well co-ordinated, others reported the opposite. NUHS staff found continuity was dependent on the practitioners, “there was a lot of not sending us notes, not sending us letters” (Staff 4). Staff had hosted some case conferences at the NUHS rooms and attended others in different settings. NUHS staff considered there was a breakdown between them and mental health services in some people’s care. Some of this breakdown was attributed to a lack of understanding of the NUHS service as NUHS provided “something quite different from anywhere else” (Other provider 1). NUHS attempted to overcome this lack of knowledge by arranging monthly meetings (Staff 4), but these meetings didn’t work well. NUHS staff considered the CCH mental health service could do more to understand its work; NUHS wanted to see management and psychiatrists come to NUHS and learn. People did not always appreciate the constraints under which NUHS worked. The

service could not adjust their work to spend long periods of time with people as could the CMHT. Others, gave the CRHA the credit for setting up “this amazing programme” when in fact it had not; it only “came forward with the money” after NUHS had set up the programme (Other provider 1). Co-ordination between NUHS and the patient was reported by most as being very good. To facilitate this some people took a support person to a consultation, or had someone call after the appointment to check things out. However, some interviewees had had experiences of leaving messages and “sometimes ... [NUHS staff] never get back” (Interview support person). Others did not have this experience, but had experienced delays before they had their call returned.

One of the ways NUHS played a role in coordinating care was through its outreach work. As Other provider 2 said regarding working in a supported house “we enjoyed a professional relationship. We identified the issues, either psychiatry or medical and ... [these were] treated appropriately”. In particular what this interviewee liked was the role NUHS played in keeping in touch. NUHS would just “make enquiries about where so and so had been because so and so didn’t attend their appointment. If there was any concerns they would be contacting you”. However, there were experiences where things had not worked. NUHS staff reported such experiences, as did the other providers. People “have gone to NUHS ... had their psychiatric medication altered without our consent” (Other provider 3). At the time of these interviews such problems were reported to occur “once a month, or once every two months”.

### **The success of the NUHS programme in meeting outcomes**

There were three general sets of outcomes – health status, health services and consumer – about which some information was obtained. Of the 20 people interviewed, nine reported improvements in their physical health over the previous year, six reported no change and five reported deterioration. Those who reported improvements considered NUHS helped them by treating health issues when they arose (Interviewees 7 & 15), referring them as necessary to specialists for physical ailments (Interviewees 1 & 20), while others attributed their improved health to actions they themselves had taken (Interviewees 3 & 20). In contrast, those who considered that their physical health was worse felt NUHS had not always provided practical advice. They had not considered the person’s circumstances when giving advice on losing weight or getting exercise (Interviewee 21) or paying much attention to their physical health (Interviewee 10).

For most people interviewed NUHS staff played a role in the assessment and management of physical health needs. This included the diagnosis and management of other enduring disorders such as diabetes, as well as the day-to-day health problems. NUHS also provided health promotion and health prevention services. For example, for Interviewee 2 it was NUHS staff advice that “helped me get my weight down”. People liked the fact that NUHS worked with them to gain their trust before they undertook such procedures as cervical smears. “[I] needed to know [the nurse] for two years first” (Interviewee 5). Table 12 shows that although NUHS achieved high percentages in immunisation and cervical screening, NUHS still have further work to do in terms of achieving its health promotion and preventive goals. The category aware in this table means that people had been approached to come in for a smear or tetanus shot but had not yet had it.

Of the 20 people interviewed, the majority (n=17) reported improvements in their mental health compared with 12 months earlier. Three people reported no change and nobody reported their mental health had deteriorated. Reasons attributed for the improvements varied including changes in people’s life’s circumstances and gaining new insights about managing their mental health. For Interviewee 7 it was “the support of NUHS [that contributed] tremendously to my well-being”, while for Interviewee 2 it was a reduction in medication that made the difference. A couple of people found these questions about physical and mental health difficult; they considered that in life they are not separate, “cutting off mental health as something separate ... I can’t” (Interviewee 9).

**Table 12. Findings from cover sheets on health prevention and monitoring strategies**

	Up-to date*	Not-up-to date#	Aware	Refused	Unknown
Tetanus	40 (73%)	6 (11%)	1 (2%)	1 (2%)	9 (12%)
Cervical smear	18 (67%)	3 (11%)	1 (4%)		5 (18%)
Blood pressure	37 (67%)	4 (7%)			14 (16%)
Weight	30 (55%)	5 (9%)			20 (36%)

\*These figures could be higher as no check inside case notes was made as NUHS considered all baseline data should be on cover sheets.

#Tetanus immunisation due every 10 years; smears every 3 years, blood pressure and weight were expected to be recorded annually

One of the features the staff talked about in regards to the consultations was involving the person in the decision-making. Staff involved the patients in several ways, including negotiating treatment plans, medication changes, follow-up arrangements, and by sharing the writing up process. People with SOMI appreciated this. Many of those interviewed

discussed the support they had from NUHS staff in managing their deteriorating mental health. Some considered this support kept them out of hospital. One of those interviewed and seven whose records were reviewed had been admitted to hospital for mental health reasons during 1997. Four of these people had one readmission. The average length of inpatient stay for the people whose records were audited (combining admissions and readmissions) was 20 days (range 1-78). People were admitted for either very short lengths of stays 1-10 days or long stays (44-78). NUHS staff had their own reports of this, particularly how they would support people who had previously had unpleasant experiences with the mental health services, and wanted to avoid them at all cost. NUHS managed this support with the use of the C-L service. Often one of the goals for NUHS in this management was for people to become involved in the mental health service as NUHS staff considered the CMHT for example had more flexibility and expertise in mental health than they did.

Appointments at NUHS were initiated by some while for others such as Interviewee 2 “the nurse sends me a letter – rings me up or sends me a card to say could I come on a certain day”. The determining factor for frequency of appointments for some people was when their prescriptions were due. Others said although they only need to see the doctor 3-monthly for mental health reasons, their physical health often meant they needed to go more often. Several of the interviewees talked positively about how their appointments alternated between the doctor and the nurse. Significantly most people said the frequency of appointment was “by mutual agreement” (Interviewee 10). Some kept regular appointments because they considered the appointments important in helping them keep well, providing “maintenance” (Interviewee 15).

While all the interviews expressed some likes and dislikes about NUHS, not all had suggestions as to how NUHS could improve. Those who did make suggestions, made very concrete suggestions concerning how facilities and services could be improved. These included the need for an even bigger play area for children or if possible a separate area for “mothers and children” (Interviewee 13) or just a bigger waiting room; a street sign on Hall Street advertising the service saying “doctor is available” (Interviewee 2); a light outside the building in the weekends; bigger toilets; windows that open so as you are less exposed to other people’s “bugs” (Interviewee 3). For interviewee 12, the availability of “a water cooler” would make a difference. This person was not a tea or coffee drinker.

Some people felt NUHS could do more in regards to informing people when it was running late such as calling people and letting them know. While others suggested when people arrive for appointments it would be good if the reception staff informed them the clinic was running late. This happened sometimes, but not consistently. People who had contact with the C-L service would like it to be available more than one afternoon as the limited availability of the clinic meant some people needed to change their work arrangements for a C-L appointment. Receptionists were seen as important by those interviewed. One person felt there needed to be some Māori people on the staff, particularly on reception, while another suggested that the reception staff needed to pay more attention to people's privacy. Another suggestion was that NUHS produce a newsletter containing such details as AGMs, staff names and so forth. The suggestions on improving clinical management included writing down instructions such as medications to enable people to remember the advice given. Interviewee 7 said that when they were unwell they would like the prescription to be "faxed to the chemist" rather than having to go and get it.

There were several features about NUHS, people who used it liked. These included the attitudes, clinical skills and support provided by staff, the relationship people developed with staff, the atmosphere of NUHS and lastly cost. When referring to staff, the comments were not restricted to the clinical staff, some people liked that the "receptionists do their job" (Interviewee 8) and that "they're all very professional" (Interviewee 9). For many people what was important was how NUHS staff respected their autonomy. Numerous people commented NUHS staff took the trouble to listen to what they had to say. "She [the doctor] ... listens – really listens to what I'm saying ... when it comes to medication she asked me what I wanted rather than saying you have to have this medication" (Interviewee 15).

### ***Conclusion***

Since 1987, using a primary care and community development model, NUHS has provided a primary care service for low income people. People with mental illness were amongst the first groups to join the service. In 1990 mental health was identified as an area that needed particular attention, and in 1992 a programme approach involving staff (one GP and one nurse) specifically assigned the responsibility of mental health emerged. Initially, the programme involved considerable liaison with other providers. However, in 1994 when additional resources were obtained from the CRHA in the form of funding, and Capital and Coast Health in the form of C-L staff, the programme took on a life of its own and grew. In 1995 a change

in nurse resulted in the programme having an increased clinical focus. The nurse and the GP saw people alone or jointly. Other features of the programme included outreach and follow-up services. Although the users of NUHS liked and trusted the service, this was not always so of other providers. NUHS provided an accessible and acceptable service that was coordinated internally and with mental health services, contributing towards people receiving comprehensive care. The programme was particularly successful at meeting consumer outcomes.

## **Chapter 7 – The Hawke’s Bay shared care pilot**

This chapter presents the findings of the second case study, the Hawke’s Bay shared care pilot. While many of the section headings are similar to those used in the NUHS mental health programme case study, this case study differs because it was a top-down development. As with the NUHS study the second case study demonstrates how the innovative service developed and changed. For comparative purposes the year 1998 was chosen to undertake the utilisation review and describe the day-to-day activities as there were no major changes in the pilot design during that year. The final section reports on the effectiveness of the pilot’s service delivery arrangements for people with SOMI.

### **Research participants and the utilisation data**

Four sources of data – programme documentation, evaluation reports, utilisation data and stakeholders’ experiences acquired through questionnaires and interviews – were accessed in developing this case study. Some of this data was also used to complete an evaluation of the pilot for the CRHA (Nelson, Duncanson et al., 1997) and HFA (Nelson et al., 1998). As there was more than one set of interviews there were differences in who participated in every stage of the data gathering. References to the timing of interviews are made in relation to the evaluation, namely “a” for entry, “b” for interim and “c” for final. The people with SOMI completed a questionnaire on entry to the pilot, were interviewed at the interim evaluation (9 months after the pilot started), and were either interviewed or completed a questionnaire at the final evaluation (18 months after the pilot started). Providers such as the GPs, the CMHT and managers of four supported houses were also interviewed. This meant that some people participated in three interviews and completed two questionnaires. Because of a high turnover of psychiatrists, individual psychiatrists participated in only one interview. Table 13 summarises the demographic features of people with SOMI from Napier enrolled in the pilot during 1998.

### **The Napier setting**

Napier is one of two cities in Hawke’s Bay and Wairoa is a rural town, 114 kilometres from Napier. Napier’s population in 1996 was 53,463 people of which 16% were Māori, 77% European, 4% other ethnicities and the ethnicity of 3% of the population was not known. Eighty-three percent were New Zealand born. Twenty-two percent of the population were under 15 years, 63% were aged 15-64 years and 15% were over 65 years.

**Table 13. Socio-demographic features of people on the pilot in Napier 1998**

<b>Variable</b>	<b>Value</b>	<b>No (%)</b>
<b>Gender</b>	Male	47 (44%)
	Female	60 (56%)
<b>Age</b>	Mean	40 years
	Range	18-88 years
<b>Ethnicity</b>	Māori	11 (10%)
	European	76 (71%)
	Other	5 (5%)
	Unknown	15 (14%)
<b>Housing</b>	Private	69 (64%)
	Supported housing	37 (35%)
	Unknown	1 (1%)
<b>Source of income</b>	Own income	6 (6%)
	Govt. Beneficiary	79 (74%)
	Other	3 (3%)
	Unknown	19 (17%)
<b>Length of time on pilot</b>	Mean	30 months
	Range	18-36 months

The Napier and Wairoa general practices were owned by the GPs and the nurses were their employees. The majority of the doctors belonged to City Medical, an organisation that the doctors collectively owned. City Medical negotiated some group contracts for the doctors and co-ordinated the running of an after-hours service. In addition, many of the GPs belonged to Paradigm – an IPA for Hawke’s Bay. Paradigm, like the other IPAs in New Zealand, represented and negotiated contracts on behalf of the general practices for its membership (Sibthorpe, 2000).

The government’s funding arrangement for the GPs was via a fee-for-service arrangement for community service cardholders and high user health cardholders. However, people did not have to be registered with the service for the GP to be eligible to claim the fee and GPs were able to claim for each visit. A claim could not be made if people only saw a nurse. Although people were charged a co-payment when they had a consultation with the doctor, the Hawke’s Bay GPs reported that sometimes they did not pursue this.

### ***The origins and development of the pilot***

The pilot had its origins with the CRHA. In September 1994 the CRHA announced in the media that it had consulted with mental health providers and interests groups in Hawke’s Bay to determine how much of a \$3,000,000 government allocation for improving mental health services in the Central Region the district should receive (Maunsell, c.1997). A group of City Medical GPs from Napier responding to this announcement wrote to the CRHA to see why



they had not been consulted about the purchasing of additional services. They wanted to be consulted as they considered that they were receiving an unsatisfactory service from the CHE mental health services. They had ideas about how services could be improved, and were particularly concerned about waiting times for appointments and communication regarding people's care.

Responding to this initiative, the Mental Health Group of the CRHA called a meeting with interested parties to discuss primary mental health services. Those attending included CRHA representatives, managers from the CHE-based services of Palmerston North, Wairarapa and Napier, GPs from Wellington and Napier, a representative from the Schizophrenia Fellowship and researchers from the HSRC (Minutes, 1994). The latter's invitation developed from work about the economic aspects of community mental health services that the HSRC had undertaken for the MoH (Mental Health Services Research Consortium, 1994). Those at the meeting came to be known as the Advisory Group. There were no consumer representatives or psychiatrists in the group though the Schizophrenia Fellowship represented the views of people with mental illness. The lack of involvement of a psychiatrist from the Hawke's Bay was possibly because Napier was in the throes of changing psychiatrists. At the meeting the decision was made to develop a general practice-based project to improve the ability and capacity of primary practitioners to assess and treat mental illness effectively and to improve the support, liaison, referral and linkages between primary and secondary services and other mental health services.

The GP's letter alone did not lead to the development of the pilot. The manager of the Mental Health Group also believed that new ways of delivering mental health care were needed. He considered the current approach, namely care being co-ordinated and principally delivered by CMHTs, was failing because the CMHT was unable to keep up with the demand for their service. He did not believe this failure was a result of increased numbers of people with serious mental illness, rather that people were not being discharged from CHE-based services. The limited involvement of GPs in mental health was also considered to have an adverse affect on the workload of the mental health service. The Advisory Group thought that if this lack of GP involvement was successfully addressed there would be a reduction in non-acute work carried out by the mental health service. Chapters 4 and 5 highlighted that during this time there was also growing support for increasing the role of general practice in mental health.

Several Advisory Group meetings were held with the aim of developing a pilot service to run in three sites - Wairarapa, Manawatu and Hawke's Bay. An early decision was that the project should target people with ongoing rather than short term mental health needs. The CRHA intended all three sites to commence similar pilots simultaneously, but this did not happen. The Wairarapa pilot never commenced, though pilots and new services have since developed in many other parts of New Zealand, including the Manawatu and Wellington. A likely reason why pilots did not commence in Wairarapa and Manawatu was an absence of practitioners from these locations attending the Advisory Group meetings.

The only area that included representatives from both general practice and mental health services was Hawke's Bay. Representation from Manawatu and Wairarapa included only CHE-mental health service personnel. City Medical established an agreement with the CRHA that a GP and a manager would be paid to attend any meeting; no other region negotiated this. It was expected that the CHE-service representatives would communicate with the GPs in their area. So loose were the initial arrangements that it remains unclear if GPs were ever formally invited from these other areas. When it was apparent that pilots were not going to start in Fielding or Wairarapa, the CRHA agreed to a request by Healthcare Hawke's Bay to extend the pilot to Wairoa. Wairoa had some locally based mental health services that were supported by the Napier services. The Wairoa CMHT members were answerable to the Napier manager and the team included a psychiatrist from Napier who visited on a weekly basis. Analysis of the pilot is largely focused on experience in Napier, with only limited mention being made of the Wairoa experience. This is because the Napier stakeholders were involved in making the decisions about the pilot. All but one decision made in Napier applied to Wairoa; the exception concerned the right for the Wairoa GPs to continue to recruit people into the pilot.

Discussion at the meetings was on the broader aims and possible shapes of initiatives, and what would need to happen if these were to be established. A decision was made that a literature review was required to determine models of care involving general practice working with people with serious mental illness and to identify issues to be addressed in the development of such services (Minutes, 1995a)<sup>30</sup>. The Advisory Group decided that no matter what type of service was developed, a training programme would be required. The main rationale for this was to address the perceived lack of psychiatric knowledge and skills

---

<sup>30</sup> The HSRC was awarded the contract for this literature review, and I undertook this work.

of GPs. In addition, it was thought that people joining a new service would feel more confident about going if they knew the GPs had been given some extra training.

The Advisory Group was not a closed group, and as others were identified as having an interest or a “stake” in the possible developments they were invited to join. The membership and attendance was on an *ad hoc* basis. No one person or organisation controlled who was invited, or took responsibility to see that all relevant people were invited. For example, once a decision was made to purchase the pilot discussion between the HSRC and Healthcare Hawke’s Bay resulted in two Napier-based people with SOMI being approached by the CMHT to represent consumers on the Advisory Group. Unlike the other stakeholders on the Group, the consumer representatives did not have a contract specifying their rights and responsibilities. While they were not paid to attend, their travel costs were met.

Members of the Advisory Group were expected to share their ideas and report on progress at the meetings. The City Medical representatives were well organised. They developed and submitted a proposal to the CRHA to develop a new mental health service that would be run and operated in competition with the CHE-service. To support this proposal they had surveyed City Medical GPs regarding their issues with the mental health services. Chapter 4 assessed how there was a general belief at this time that competition between services was the best way to develop health services in New Zealand. The City Medical representatives verbally shared their idea for this new service with the Group; though they did not share the details or their budget in order to develop this. The CRHA manager rejected this proposal because it duplicated existing arrangements, but assured City Medical he was committed to such initiatives and that a pilot service would be purchased (Minutes, 1995c).

At about the same time that City Medical’s proposal was rejected the findings of the literature review were available for discussion with the Group. This review became critical to the development of the goals and overall shape of the pilot. It found that there were three main models – consultant-liaison, shifted outpatients and shared care – involving general practice in the care and treatment of people with serious mental illness (see pp.115-120). A decision was made that shared care was the preferred model (Minutes, 1995b).

In making the decision on the type of pilot to be set up, the existing model of the NUHS programme was considered. However, it was decided not to pursue this option as the Group

considered that the model developed by NUHS (combining features of all three models) could not be replicated in Napier. The conditions in Napier were seen to be too different from those obtaining for NUHS. The Group considering the local features of Napier, most notably that there was usually only one CMHT psychiatrist available and many of the GPs in Napier were located in sole practices decided upon a shared care model. The Napier representatives were advised by the CRHA manager to go and plan their service so that the CRHA could purchase it. The CRHA also made a decision that the pilot service would be evaluated. The purpose of the evaluation was to inform the CRHA and others of the experience of the pilot. The HSRC was offered the contract to undertake this evaluation.

### **Getting the pilot service started**

In my role as head of the evaluation team, I visited Napier in January 1996 to meet with the different stakeholders to plan the evaluation, establish the types of data that were available, and to negotiate how best to access and obtain this data. At this visit it became apparent that limited progress had been made on getting the infrastructure in place to develop and implement a pilot. The mental health service had developed considerable documentation on what they saw as the goals and plans for such a service and who would join, but there had been no meetings of all stakeholders in Napier to get the pilot practically under-way. It was only at the meetings in Wellington that Hawke's Bay representatives from the mental health service and general practice had met together and discussed the pilot. Yet for a pilot to commence there needed to be a system of communication between these two stakeholder groups and between the GPs as a group. The latter being important as GPs in New Zealand are mainly self-employed small businessmen and women.

Following this visit, the Mental Health Group manager was advised that a pilot might not start, as there was no one person responsible for working through the practicalities of getting it established. It was reported, however, that the GPs and the CMHT were both still committed to developing a pilot service. In February 1996, I accepted an offer by the CRHA to undertake the initial project planning and co-ordination functions in conjunction with the evaluation. The CRHA manager had overall responsibility for the pilot. No changes to the pilot design and organisation were to be made without his approval. He also agreed to be available to the HSRC to discuss issues that arose as part of the pilot, and to convene and host the Advisory Group meetings.

The first task in this additional role was to develop an agreed plan of action to get the pilot started. This involved developing and getting agreement from all stakeholders on the objectives and developing baseline documentation. The primary aim of the pilot was to develop shared care services that would “improve the mental health status of a group of long term mentally ill clients currently under the care of the CMHT” (CRHA, 1996b, p.5). The second aim was that, given that mental health status measures were improved or were unchanged, resources were to be used more efficiently. The objectives necessary to meet these aims were as follows:

- to develop shared care services that would improve the mental health status of the targeted clients;
- to develop a workable system of shared care;
- to improve GPs’ ability to identify and treat or refer people with psychiatric illness; change the balance of care from CMHT to include GP care for an average of 20 targeted clients per GP during the pilot;
- to improve communication between GP and CMHT; and
- to decrease CMHT time on routine reviews and treatment for the targeted clients.

The manager of City Medical agreed to be the contact point for the GPs, the CMHT team leader for the mental health service, and the consumer representatives for consumers. The latter group did not however, have details of who was on the pilot.

The plan of action included understanding the existing roles of the services so shared care roles could be developed. Prior to the pilot commencing the role of the Napier GPs, interested in joining the pilot with respect to people with SOMI was generally limited to providing physical health care and, in some situations, writing repeat prescriptions and ordering blood tests required for monitoring medication. Four of the GPs were involved with supported houses. In Napier, for some people, the CMHT was generally the first point of call in an emergency, while for others it was the GP. This contrasted with Wairoa where the GPs were extensively involved in mental health care. They and the practice nurses provided and managed most of the mental health medication and were usually the first point of call in an emergency.

A manual explaining the workings of the pilot (CRHA, 1996b) and a summary information sheet (Appendix 14) were developed in consultation with Napier-based stakeholders. The idea for the manual came from an Australian team who had established a shared-care service

(Keks et al., 1995). The purpose of the manual and information sheet was to provide all stakeholders with a shared understanding of the aims of the pilot. They contained details of how the pilot would work on a day-to-day basis, provided a summary of the evaluation plan and the contact details of the stakeholders involved.

The HSRC became the central liaison point for pilot matters, not pertaining to individual people's care arrangements. The management role principally involved co-ordinating the different strands of the pilot and resolving issues. The co-ordination role was largely achieved through regular letters, telephone calls and visits to Napier. Once issues were raised these were passed on to representatives of the different groups involved in the pilot or the Advisory Group for suggestions on solutions. A system of communication was set up where the HSRC shared information with all parties about developments.

### **Recruiting general practitioners and the community mental health teams**

The first seven GPs joined the pilot because they were either part of the original group that contacted the CRHA or they responded to "shoulder tapping" by the GPs who were on the Advisory Group. The two Wairoa GPs joined in response to a letter from the CRHA to all GPs in Napier and Wairoa regarding the pilot, sent out to give all GPs the opportunity to participate. In addition a number of GPs in Napier and Wairoa who were known to have large caseloads of mental health service patients were personally approached to see if they would also join the pilot. These GPs all declined on the grounds of workload, involvement in other initiatives, or because of plans to be away.

Within four months of the pilot starting, three more GPs joined. These additional GPs joined for different reasons; one had returned from overseas, while another joined because they heard about the pilot. The third additional GP, the 12<sup>th</sup> on the pilot joined because one of his patients wanted to transfer to a GP in the pilot. This GP had previously declined to be involved. Seven of the pilot GPs worked in sole practices and five in group practices with either two or three partners. In two practices both GPs of the practice participated in the pilot.

The CMHTs of Napier and Wairoa did not really have a choice to be involved as their management had agreed to this. They were, however, consulted about how they saw the pilot should work for them. Some consultation was undertaken in-house with their own management, while other aspects included joint meetings between the CMHT and me as

project co-ordinator. The CMHT of Hastings, a sister city of Napier, was also accessed to obtain data required for the evaluation.

### ***The pilot's initial arrangements***

The pilot, while managed by the CRHA in consultation with the HSRC, was administered jointly between the HSRC and the mental health service. The Advisory Group had a role in advising on policy matters. The pilot design ultimately consisted of four components; shared care, consultations for people on the pilot, consultations for other people and a training programme. The inclusion of these components was a result of negotiation between the stakeholders in Napier and consultation with the Advisory Group. The negotiation and consultation focused on how best to deliver mental health services in a primary health setting. The pilot was also shaped by a view promoted by the CMHT team leader and myself that the people with SOMI needed to be actively involved in all levels of their care and all levels of the pilot.

In addition to the clinical roles performed by Napier stakeholders, three people (the manager and a doctor from City Medical, and the team leader from the Napier CMHT) also had roles in the local management and organisation of the pilot. They had these roles because of their position in their organisation or the role they played in the early development of the pilot. The team leader was the overall Hawke's Bay co-ordinator of the pilot. Not only did this person have a key role in co-ordinating the day-to-day work of the pilot, she, along with another CMHT staff member, was the main contact for people with SOMI, the research team and GPs when clinical issues arose. The consumer representatives were expected to have a role in advising the pilot management and the evaluation team.

Generally speaking the City Medical representatives, the CMHT team leader and the consumer representatives met with me, as the project co-ordinator, on my 3-4 monthly trips to Napier. These meetings were to enable the representatives to raise issues they or people with SOMI had about the pilot. Depending on the nature of issues they were dealt with directly or raised with the other representatives for solutions, or taken to the Advisory Group for discussion.

As the pilot involved developing a new way of working, the role of the project management included assisting people in making changes. Throughout the pilot, regular letters from me,

as the project co-ordinator, were sent to the Advisory Group, all GPs in the pilot, CMHT staff and other interested parties. These letters reported on issues raised, matters for consideration, decisions taken as part of the pilot, and provided information obtained through contact with other people working on shared care.

Contractual and ethical matters also needed to be attended to in order that the pilot could commence. Such was the contracting environment at the time that the pilot and evaluation involved four different contracts. These were not signed until the pilot shape was finalised. The details were developed in consultation with the GPs, Healthcare Hawke's Bay and the HSRC staff. The actual payment rates were decided in consultation between the CRHA and the HSRC. There were contracts with: i) the GPs to cover fee-for-service payment for "normal" consultations with people on the pilot, fee-for-service payment for extended consultations, hourly payment rates for liaison and training time and for completing the evaluation requirements; ii) the Wellington School of Medicine (WSM) to provide a regional training programme for GPs; iii) Healthcare Hawke's Bay to provide administrative and clinical support for the pilot; and iv) the HSRC to evaluate the pilot and to present recommendations. Apart from the contract with WSM which was for delivery of a specific training programme, the other contracts were for a period of two years. The HSRC was also responsible for processing the GP returns. This role ensured that the HSRC obtained the GP data required for the evaluation.

An application was presented to the Hawke's Bay Ethics Committee arguing that even though the pilot was new, the evaluation team believed it did not require ethics approval, only the evaluation did. The reason for this was there were already examples of existing practice where people's mental health care was managed jointly or solely by the GP. The Ethics Committee approved that consent was only required for the evaluation.

### **The components of the pilot**

The first component of the pilot was to develop shared care. Shared care was expected to be more than just developing a care plan that each party worked with in isolation. It was to involve practitioners working together with the active involvement of the people with SOMI in the development and implementation of their care plans. It was intended that shared care would be a natural development to the care-planning process already in place in Hawke's Bay. To enable the GPs to participate in care-planning, GPs were able to claim payment for



liaison time. The CRHA managed their exposure to this financial risk by limiting the amount of liaison time (up to 3 hours a month) they would pay each GP.

The second component was that people could see the GP without having to pay a co-payment. In order to receive a free consultation the consultation needed to include a mental health component. GPs were to be paid the co-payment fee by the CRHA and could also still claim for the general medical subsidy benefit for those with a CSC and HUHC. The decisions about the amount paid per consultation were based on the average amount GPs in Napier charged to CSC holders, plus a small additional amount to compensate for the longer consultations. The experience reported by the NUHS doctor who was on the Advisory Group was that their consultations with people with SOMI generally lasted longer than other consultations. The CRHA offered to pay the GPs on a capitation basis. The GPs declined this as they did not wish to carry the financial risk since they considered there was no information available concerning how many visits people might make. They requested payment on a fee-for-service basis, with the CRHA carrying the financial risk. The CRHA agreed to this, but limited the number of claims that each GP could make to an average of 15 per month. The number of claims allowed was based on an assumption that each GP would have between 15-20 people enrolled on the pilot, and people would use the GP monthly.

Consultations with GPs could be by telephone, surgery or at home. The rationale for determining that telephone calls could be claimed as consultations was also on the advice of the NUHS doctor who reported that in her experience some people required lengthy telephone calls. Provision in the payment arrangements was also made for informal carers of people on the pilot to be able to see the GP regarding their friend/family member, and have this payment met by the pilot. This decision was made because there was a belief that sometimes there were issues that arose out of living and supporting someone with mental illness that required discussion with a doctor. The ethics around such consultations were also discussed. It was expected that in using these consultations GPs would work within the Privacy Act 1993 requirements. This Act requires that people have to consent to information being shared about them. Allowing informal carers to consult with no co-payment costs acknowledged the role of friend/family in some people's care.

The third component of the pilot involved the CRHA paying the GP the co-payment costs for anyone seeing the GP for mental health reasons for an extended consultation lasting 20

minutes or more. The GP decided when they would use these consultations. The CRHA limited the number of claims to an average of four per GP per month. This particular component was part of the pilot to meet the needs of the GPs. The original service that the GPs had proposed included this component. GPs wanted this component because they considered that they regularly provided lengthy consultations with people with mental illness whose illness was at an early stage of development or was of limited duration.

The fourth component of the pilot was a training programme. This was initially purchased from the WSM and was expected to be available to all three planned pilot sites. An extension of the training was later purchased and organised by a Hawke's Bay Steering Group. In both these programmes, not only were the training providers paid to deliver the programme, but GPs were also paid to attend. The latter occurred as there was a belief that GPs were not interested in getting involved in mental health work and would require an incentive to attend. Attending the initial training was compulsory for GPs to be on the pilot. This was made easier as the training programme was approved to enable the GPs to get continuing medical education credits for attending. Delays to starting the training occurred because of communication problems in Fielding and Wairarapa. The first training session was an all day session held in Napier in April 1996. Other sessions ranged in time from two hours through to a full day. No representatives from Hawke's Bay were involved in preparing the WSM programme. Training could also be undertaken as self-directed learning or through the liaison and consultation with the psychiatrists and the CMHT.

### **The target population and procedures to join the pilot**

The pathway for people to join the pilot was laid out in the manual. There were four criteria that people had to meet to be eligible for the pilot. The first criterion was that they had to be registered with a GP on the pilot. The basis for this criterion was the Advisory Group considered it was important that people should be encouraged not to change GPs to join the pilot. Pilots by their nature were considered to be temporary. It was appreciated however, that people may request to change GPs, and that they could not be stopped from doing this. If someone wanted to change GPs, it was expected that CMHT staff would encourage them to continue to attend their existing GP. However, allowance was made that if a person who met the pilot criteria was unwilling to continue with their current GP, but wanted to use another GP they could be accepted into the pilot.

The second criterion was that people needed to have an Axis I, DSM IV diagnosis as their primary mental health disorder, excluding alcohol and drugs disorders as the CHE ran a specific service for people with these disorders. People could however have a dual diagnosis. The third criterion was people needed to be involved with the mental health service for six or more months. The rationale for this criterion was to target those with ongoing mental illness that was of a serious nature. If someone had involvement with the mental health service for at least six months it was considered their illness was likely to be of a serious and ongoing nature.

The fourth criterion was people needed to have a CSC or have financial hardship. Initially the CRHA wished to only target those with a CSC. However, at a planning meeting, the CMHT argued for a change in this criterion to include any person with financial hardship. The CMHT's rationale was there were a number of people who were non-working partners of a person earning just enough money to lift them above the CSC eligibility bar. Such people were financially dependent and arguably had financial hardship. One GP tried to have the finance criterion removed altogether. He considered that assessing financial hardship was difficult and that all people with mental illness, irrespective of their financial position, should be eligible for the pilot.

Although the decision on who was eligible to join the pilot was to be made by the CMHT, the GPs were able to suggest people in their practice who might be eligible to join. What ultimately transpired is that some people joined the pilot without the CMHT authorising their eligibility. Having been identified by the CMHT as being eligible, people would be invited by them to join the pilot, and to participate in the evaluation. The CMHT staff were also responsible for obtaining people's consent for the evaluation, and meeting and liaising with the people and GPs in developing and implementing shared care. On joining people were advised on how they could raise any issues or concerns they had regarding the pilot with the consumer representatives, CMHT, GPs or me, as project co-ordinator<sup>31</sup>. The first person joined the pilot in June 1996.

It was later revealed that the procedures to join the pilot were not always followed. An analysis of the relationship between consent signing and first claim from the GP showed that a significant number of people (n=16) had received free GP consultations for two or more

---

<sup>31</sup> People could either write or telephone me collect.

months before formally consenting to participate, and very few care plans had been written at the time of the interim evaluation. These process issues will be revisited later in this chapter.

### *The changing shape of the pilot*

There were many changes made to the pilot. Some changes happened within the first few months, while others happened in response to the interim and final evaluation reports. Table 14 presents a time-line of events in the pilot's history.

**Table 14. Key dates in the history of the pilot**

<b>Year</b>	<b>Event</b>
1994	CRHA article
1995	Initial meeting Decision to purchase pilot and evaluation
1996 - May	Training started
June	First people officially joined the pilot
August	Criteria for eligibility extended
November	Criteria for eligibility reviewed
1997	Changes to entry criteria, pilot objectives, processes After-hours arrangements included
April	Consultant-liaison sessions between GPs and psychiatrist commence
May - June	First care plans written for the majority of consumers Interim evaluation report released
September	Major review of care-planning process
November	GP training run by Wellington School of Medicine completed Consultant-liaison sessions between GPs and psychiatrist ceased
1998 -January	Final evaluation completed Health Services Research Centre (HSRC) tries to pull out of role Audit finds insufficient progress in the development of care plans
February	Mental health service adopts a stance to move shared care patients to increasingly involve the GP; Meeting with all GPs about pilot and confirmation of funding for locally-led training
Feb - April	Further development of care plans
May	Napier-based steering group formed to lead project forward
June	Management of pilot moves from the HSRC to Napier
November	First GP leaves pilot
1999	HFA calls meetings to review pilot

Shortly after the pilot started some GPs expressed concerns about the pilot entry criteria being too restrictive. The evaluation also identified that the criteria were not in line with New Zealand's mental health policy, that the criteria implied service use equals need, and implementing the criteria required some arbitrary decision-making (Nelson, Cumming,

Duncanson et al., 1997). There were also a number of problems that indicated the need for the changes to eligibility criteria.

Firstly, the criterion of having an ongoing need with an Axis I, DSM IV diagnosis was problematic because 'ongoing need' was not defined. People who joined the pilot often came with very different histories of ongoing need. Although the interim evaluation reported most people had an ongoing illness, there were some whose illness had been of limited duration. For example, one person reported their first mental health problem had only occurred "about six months ago I had a breakdown ... but it wasn't that serious I didn't have to go into hospital or anything ... since then I've improved and been all right ... I've never had trouble before" Interview 38a. For others however, their first experience of mental illness occurred up to 40 years earlier. Many people with a long duration of illness reported having spent time in Porirua Hospital.

The definition of seriousness was initially seen to equate with diagnosis. A problem with this criterion was that the GPs did not use DSM IV, and the project never provided a list of disorders covered under Axis I. Some GPs referred people for entry to the pilot who had an alcohol or drug problem, or a personality disorder. As already mentioned the former were specifically excluded because there was an addiction service available, and those with personality disorder were excluded because a personality disorder does not constitute an Axis I diagnosis, rather personality features are covered under Axis II, DSM IV. The decision to exclude people with only a personality disorder was challenged by the GPs because this group of people often required a wide range of support. The evaluation team did not support such a change as they considered there were other issues that needed to be addressed by the pilot at this stage.

The criterion of being involved with the CMHT was also found to be problematic. GPs considered they had people on their books who were not seeing the mental health service, but who had an illness of an ongoing duration who would benefit from being on the pilot. Some of these people disliked or did not want to use the CMHT, while others had been discharged from the psychiatric services in the early 1990s to GPs for ongoing management. However, it was considered that because the pilot was using mental health funds it was important to target the same group that the mental health services targeted. As a result of reducing adherence to this criterion, a number of people joined the pilot on the GPs request. Most of these people

continued to have GP-only care with only a few people's arrangements changing to shared care.

The financial-based criterion of having a CSC or financial hardship was also controversial. If someone did not have a CSC it was not clear how financial hardship was defined. Some GPs reported they thought that some people had been excluded because of the financial clause, yet other people in the pilot clearly did not meet the financial clause. Interviewee 5c even mentioned they had medical insurance and the pilot was saving insurance claims. The interim evaluation reported that on entry to the pilot 17% (n=13) of people did not hold a CSC.

The fourth criterion of the person's named GP being part of the pilot, or the person not having a current GP, was also problematic. The CMHT team leader reported one situation where a GP had suggested to a person who was unwell that they could come to the GP for their care because of the pilot. This person was under the care of a GP not on the pilot. This matter was addressed directly with the GP by the team leader; the GP being informed that this type of behaviour was not acceptable. Enrolment with a GP on the pilot, did not however, ensure a person was eligible for the pilot. Although not understood at the time the pilot was developed, another issue about eligibility concerned geographical boundaries. The geographical boundary was that of the Napier CMHT. However, some of the GPs in the pilot also had patients who lived in the Hastings CMHT area. These people were ineligible for the pilot on the grounds that the pilot involved shared care between GPs and the Napier CMHT.

In light of these problems a series of decisions were taken to review the entry criteria. At the August 1996 Advisory Group meeting it was decided that people could be considered for special entry if criterion 1 and 4, plus one other criterion were met. To overcome the difference in a GP's interpretation about what was a serious mental illness a process was put in place to manage this difference. When a GP identified someone they considered suitable for the pilot, they had to contact the CMHT to discuss the person's eligibility. If the person was considered by the CMHT to meet the modified criteria, a decision was then made as to whether the GP or the CMHT would proceed to obtain the consent and complete the baseline data. Several of the people recommended by the GPs for consideration were not considered by the CMHT to meet the pilot criteria on the grounds of severity and ongoing mental health need, and were not invited to join the pilot.

GPs were expected to have no more than three people who joined the pilot via this route. People who joined other than through the CMHT were considered as receiving entry as an exception. The CMHT was concerned that requests for these exceptions were mainly from a few of the GPs, and that the motive for getting people on the pilot was financial. In November 1996, the project management reviewed with the CMHT how many GP-initiated people had been accepted for the pilot. This informal inquiry revealed that this review came too late, as two GPs had more than three GP-initiated people on the pilot. One GP had seven and another had eight GP-initiated people.

Another decision regarding eligibility was also made at the August 1996 Advisory Group meeting. This decision related to the eligibility of people with ongoing needs from mental illness who moved to Napier during the pilot. It was decided that if a person had been involved for at least six months with a CMHT from another area prior to moving to Napier, they were eligible to join. If someone moved to the area, they were informed of the pilot and given the opportunity to join. They were advised of the names of the pilot GPs and given the chance to go to one.

At the September 1997 Advisory Group meeting a decision was taken to mainly restrict new enrolments to the pilot to people from the supported houses. This decision was made because the pilot's future was uncertain. However, it was thought that people in the same supported house should have equal rights in regard to service use. The CMHT retained the right to invite other people on a case-by-case basis to join the pilot.

### **Changes to what GPs could claim for**

The intention that free consultations were for mental health reasons only was changed shortly after the pilot commenced to allow all GP consultations to be free. This was in response to the GPs, supported by the NUHS doctor, who had argued that general health was interlinked with mental health and it was not always possible in a general practice setting to differentiate these two aspects. GPs were advised of this change in writing. Despite this change several people reported they had to pay for consultations that had not had a mental health component or they had had to pay when a locum was covering. The rule change from only mental health consultations to all consultations had been enacted by all but one of the GPs.

Another change that occurred shortly after the pilot commenced, was removing the limit on

how many consultations GPs could claim for. It was found that GP caseloads varied enormously; one GP on the pilot initially had no people eligible, while another had 35 people. In response to this finding it was decided that the GP with 35 people could have the restriction on the number of consultations they could claim for removed. The rationale for the change was that the 15-consult limit meant the GP would have to encourage people to come and see them early in the month if they wanted a free consultation. The GP with the large caseload was involved with two supported houses. What was reported was that when people left the housing they remained with the general practice they were involved with through the supported house.

A further change concerned those eligible for the extended consultations. In October 1996 the evaluation team started to see a variation in how GPs were using the extended consultations. Some GPs were restricting these to other patients on their books and some others only used them for the target group. When designing these consultations it was envisaged they could be used for both purposes. However, as this practice was only happening with three of the GPs, a decision was made by the project management, in consultation with the GP representatives, to exclude the target group from these consultations. This decision was made as it was considered that a mechanism was in place to pay GPs for seeing the target population. However, this decision was reversed several months later. The rationale for the reversal was people on the pilot sometimes required very lengthy consultations.

When the pilot commenced, no after-hours arrangements were included in the protocol. During a November 1996 visit to Napier as project co-ordinator it became apparent that, in most cases, after-hours care was provided at the City Medical Centre. This Centre ran an open clinic from 9am to 9pm and provided on-call cover through the night. Several people on the pilot had used the clinic, and said because they were on the pilot they did not have to pay. The Advisory Group discussed this issue and decided on new arrangements so that after-hours at the Centre and home-visits could take place. The CRHA agreed to provide a \$30 co-payment rate for these after-hours visits and home visits. A system was devised whereby people could use this clinic after-hours, but they were not expected to use it during day surgery hours. The rationale for not being able to access during the day was aimed at continuity of care. The system required people to sign a further consent to have their names "flagged" at the after-hours service saying they were on the pilot. Not all people agreed to



this. Obtaining this second consent required additional work for the CMHT. A billing system between City Medical and the GPs was put in place as part of the system.

### **Changes in personnel**

Throughout the pilot history there were numerous changes to personnel that impacted upon or raised issues for the pilot. These personnel changes are grouped together according to role (e.g. consumer representation, CMHT staff, GP), and then within the grouping, a chronological order of change is provided. In addition to the details of the changes, the impact these had on the pilot is reported.

In August 1997 a third consumer representative was invited by the mental health service to join the representatives already on the Advisory Group. This additional representative was considered important by the CMHT team leader because of their involvement in a CHE-consumer participation project and in other consumer-led activities. In 1998, a Napier-based consumer owned and operated drop-in centre, The Lighthouse, was opened. The Lighthouse Management Committee agreed to act as the contact point for the consumer representatives for a trial period. A fourth consumer representative came on board shortly after this.

Not long after the pilot started the CMHT team leader who had played a significant role in establishing the pilot was seconded to work in Wairoa. In this seconded role she remained the CMHT co-ordinator for the pilot. However, she no longer had line management responsibility for the work of the CMHT. This change meant she had less authority in seeing the CMHT deliver its contribution to the pilot. Other changes to the CMHT include the replacement of two nurses who had left, and the employment of a new social worker. All new staff were expected to contribute to the pilot. The team leader returned to Napier in 1998 to work as a project worker. In this role she continued to be the overall co-ordinator for the pilot for the CMHT. In July 1999 she resigned from her position in mental health and a mental health manager took over the responsibility of co-ordinating the pilot on behalf of the CMHT.

There were five changes of psychiatrists in Napier over the first three years of the pilot. The first psychiatrist was not involved in any planning of the pilot as he arrived in Napier after the initial planning meetings, but before the pilot commenced. He was thus only able to respond to the pilot after the details had been decided. Following his death, the replacement

psychiatrist (psychiatrist 2) embraced the pilot by working with the CMHT and the GPs. He, along with another newly appointed colleague (psychiatrist 3), established a consultation-liaison service through which the pilot GPs rotated. Psychiatrist 3 was largely responsible for the activities in Wairoa. The liaison service provided an opportunity to review the treatment plans of people in the pilot and for GPs to bring other queries. This service paved the way for trust to develop between the GPs and the specialist services. The reason the psychiatrist commenced the consultation-liaison service was because he had previous experience (in another country) of working in such a clinic. The GPs reported that they found this a very satisfactory way of learning and reviewing their work. However, this practice did not continue as psychiatrist 2, who was only on temporary employment, departed. Following psychiatrist 2's departure, the appointment of psychiatrist 4 was made. Orientation for psychiatrist 4 about the pilot occurred within two months of his appointment. This psychiatrist's approach to the pilot was different again. He was keen to see it work. He worked to decrease the mental health service load by requiring people on the pilot to have repeat medications managed by the GP. He also decided that the pilot provided an opportunity for the mental health service to review its work with supported houses. For one house, this resulted in the mental health service no longer having an active role in the care of residents. This change in the mental health service role was made unilaterally and meant that for some pilot participants, shared care was no longer occurring. Although permanent, psychiatrist 4 did not stay long and in 1999 psychiatrist 5 was appointed. Psychiatrist 5, while accepting that shared care was the way to proceed, considered the Hawke's Bay model was problematic and needed redesign.

During 1998, the pilot had to address yet another unforeseen change in staff involved in the pilot: two of the GPs (GP 4 and GP 5) sold their practices and left the region. GP 5 sold his practice to GP 7 enabling people to remain on the pilot, whereas GP 4's practice-caseload was taken over by a GP who was not on the pilot. GP 4 was the GP with the largest caseload on the pilot. Although CMHT management arranged for this "new" GP to join the pilot, she declined this invitation as she found the work expected of her was beyond her level of skill and competence, and she considered there was insufficient support from the mental health service to assist her in the expanded role. GP 5 managed the change to GP 7 and all people affected had to agree to GP 7 taking over responsibility of their care. The arrangements with the change in GP 4 were more complex. At a meeting between the new GP, myself (as project co-ordinator) and the CMHT co-ordinator it was decided that the CMHT co-ordinator

would write to all GP 4's people who were on the pilot, and advise them that the new GP was not going to be involved in the pilot. In the letter the people were offered the opportunity to stay with the new GP, but become responsible for paying for their own co-payments, or they could change to another GP on the pilot. They were provided with a list of the other GPs to choose from. This lack of involvement of the new GP meant there were no longer any women GPs on the pilot. In response to this letter some people made the choice to leave the pilot as they wished to have a woman GP and because of the quality of service this new GP had given. They considered that they would have to restrict their visits to the GP now that they had to pay the co-payment charge themselves.

### **Changes in shared care plans**

The original care-planning protocol was that the CMHT would provide the GP with some background information using the CMHT documentation, and then once the GP had seen the person on the pilot, the person, their GP and the CMHT member would meet to develop a care-plan. Developing the shared care plans was another responsibility the CMHT had to take on because of the pilot. Staff shortages, and people moving to acting positions, resulted in limited time being available for this. What became apparent approximately four months after the pilot commenced was that neither the CMHT nor the GPs were using a formalised system of care planning that the pilot could build upon and very few care plans had been written. A decision was made by the CMHT team leader and myself as project co-ordinator to review the initial documentation and case review requirements. A form combining the information required was designed and successfully used by the CMHT. For expediency it was decided that where necessary the CMHT and the GP could meet without the person with SOMI and develop the plans. These care plans reflected very much how the services saw themselves working together.

Following the interim evaluation findings, the process and content of the care planning were reviewed. The evaluation found that, with one exception, none of the plans had been developed in consultation with the person joining the pilot and that this was problematic as many people did not know about the care arrangements. The evaluation reported the care plans needed to be more individualised and specific about medication management such as who was monitoring for side-effects.

In light of these findings a further decision by the CMHT team leader, in consultation with me as project co-ordinator, was made. This required people's plans to be reviewed and that people on the pilot were to be involved in this. The content of the care plans was changed to accommodate new knowledge, such as the need to have a shared understanding of early warning signs (Goldberg & Gournay, 1997). The quality of involvement varied considerably. Interviewee 40c considered they had little input in their care plan, "I don't think my doctor really listened to me. I think the computer had more to do with it than me" the doctor was just interested in typing what the doctor wanted written down. Others, however, found the experience of care planning invaluable. As Interviewee 13c said "it was good having an input, I got asked exactly what my needs were". For several people one received the impression that the care-planning process required in the pilot was one of the first times that they had active input into decisions regarding their care arrangements. Some people obtained new insights about their own mental health as a result of the joint care planning meetings. The care-planning process adopted did not automatically involve family or informal support people and other providers. There was never any intention to exclude these groups; rather the aim was that all those involved with a person would be invited, with the person's consent, to participate in the development of the care plan.

While the care plan version worked well for staff, they were criticised by the consumer representatives for being too medically orientated. They work-shopped with people with SOMI to develop a tool that met consumers' needs. Thus the final version of the plan was consumer orientated and had five components:

- information about the person – focusing on who the person was socially, as a family member, what their hobbies and interests were, and how they spent their time;
- information about the person's health history – both mental and physical, including past medication history;
- identification of a person's current goals and needs, and a plan of action including stating who was responsible for medication, the expected frequency of contact that the person would have with their family, the GP, the CMHT and other providers to meet their goals and needs;
- identification of a person's early warning signs of worsening mental health and a plan of action including the steps that the person, family or friends and providers could take in response to recognition of the warning signs; and
- details on who wrote the plan, who had a copy, and the date for review.

As the care plan prototype changed, there was no expectation that the people who already had a care plan would have the changes incorporated into their plan immediately. Rather, the expectation was that the changes would be incorporated at the time of the planned review session of the current plan. The care plans could be written using a set form or with just the headings.

### **Changes in roles and responsibilities**

Throughout the course of the pilot there were numerous changes to stakeholder's roles, responsibilities and administrative arrangements. The consumer representatives' role expanded as they and the project management team saw new opportunities. At the interim evaluation the representatives expressed concern they were not hearing from people about issues consumers may have had. As Napier, at the time, did not have a consumer organisation, the representatives thought the best way to facilitate them hearing from people was to make their names and phone numbers readily available. Due to perceived safety issues of making home numbers available to people they did not know, this decision was overturned following advice from the Wellington Mental Health Consumers Union, the CRHA's consumer advisor, and the Aotearoa Network of Psychiatric Survivors.

When the care-planning arrangements changed the representatives offered to be a contact resource for the people with SOMI to contact if they had concerns about their care-plans. While none took up this offer, several people did take up the offer to have a representative as a support person at the interviews for the evaluation. Two of the three consumer representatives were available for this. Although the representatives would have liked to give the individual participants a choice about which representative would attend, this was too difficult to organise. As reported in Chapter 2 using consumer representatives as support people at interviews required pre-interview briefing and post-interview de-briefing procedures to be put in place.

The consumer representatives also played a significant role in finalising the details of the revised care plans and working as part of the Steering Group to have a major role in the development and running of the ongoing training. This expanded role became possible because of the formation of the local consumer organisation. Involvement of the representatives in the pilot was welcomed by the CHRA and the CMHT, however, no mechanism was in place to fund the increased involvement. The CRHA declined a request to

fund the increased consumer input. As the HSRC considered that increased consumer input was important for both the evaluation and for the development of the pilot it funded some of the additional consumer input and those managing the local training budget funded consumer input into the training.

GPs roles, while not changing during the pilot, did change in relation to the mental health service. In November 1996, to cover the psychiatrist shortage experienced by the CHE, nine of the 10 Napier-based pilot GPs accepted an offer to provide on-call cover for the Psychiatric Unit based in Hastings. The GPs reported this experience helped them gain an understanding in how the local mental health services worked, introduced them to local staff, which made it easier for them to talk to, and gave them opportunities to initiate liaison with the staff about their own caseload. In addition, one of the GPs in Wairoa became a "Responsible Clinician" under the MH(CA&T)A enabling people to be committed under the Act without having to travel to Napier or Hastings to be seen by a psychiatrist.

At the September 1997 Advisory Group meeting it was decided that responsibility for the management of the pilot would move from the HFA and the HSRC to Hawke's Bay during 1998. This decision was made as the interim evaluation noted "At this interim stage, it is important to review whether the current management and co-ordination of the pilot is the most appropriate arrangement for the second phase of the pilot" (Nelson, Duncanson et al., 1997, p.24). In preparation for this transfer, a Hawke's Bay Steering Group consisting of consumer, CMHT and GP representatives was formed in late 1997. The CMHT led the group and was to become responsible for co-ordinating the pilot. The CMHT developed a budget to be paid for this role, however no payment was ever forthcoming. The Steering Group met on several occasions mainly around planning training sessions. The transfer to local management was delayed as the HFA wanted to make a decision about whether to continue the pilot. This decision was deferred a second time because the manager of the Mental Health Group changed roles when the HFA was formed. In the meantime the HFA rolled over the GPs contracts, GPs continued to send their claim forms to the HSRC, and the CMHT continued to approve people to join the pilot.

By mid June 1998 the HFA had still not consulted with Hawke's Bay stakeholders regarding the pilot. This matter was raised in the final evaluation report. The lack of progress occurred because of the high number of personnel changes in Hawke's Bay. An assurance was once more given from the HFA that all administrative responsibility would transfer from the HSRC

and HFA to Hawke's Bay. Restructuring at the HFA in August 1998 resulted in a further change in who, from the HFA, was responsible for the pilot. The new personnel required time to be informed before a decision could be made. Healthcare Hawke's Bay representatives and the HSRC continued to push for change. Some progress was made at meetings and tele-conferences in early 1999 between the HFA, HSRC and Healthcare Hawke's Bay. At the second of these meetings the HSRC requested once more that all administrative arrangements regarding the pilot no longer be based with it. It also advised the HFA that it would no longer be involved in matters regarding the future direction of the pilot. However, by September 1999 still no word was received on progress and people continued to approach the HSRC for advice. In December 1999 the HFA once more committed itself to follow-up with Healthcare Hawke's Bay and began reviewing the GPs contracts. Finally, in June 2000, the HFA advised the HSRC they had re-contracted with the GPs using a capitation based formula and that a person had been appointed to make determine the pilot's ongoing development. Despite this the HSRC continued to receive claims from some GPs until September 2000. The pilot was ultimately transferred to the Hawke's Bay DHB to manage. The DHB discontinued it on the grounds that it was expensive to operate and was inequitable (Nelson et al., 2003).

### *The pilot operations day-to day*

The first person joined the pilot in June 1996. By 1999 180 people had officially joined the pilot in Napier. As reported earlier, the consent process for joining (to enable the evaluation to be undertaken) did not always occur as planned and some GPs claimed for people who had not consented to being involved. For those who had consented, the usual process following completion of entry documentation was that people were free to make appointments to see their GP when they wished to. The GP would then note their unique identifier number on a claim form and submit this to me as project co-ordinator on a monthly basis (see Appendix 3). Ultimately, to control for the lack of consents, all claim forms were checked and only consultations for eligible people were paid for. Few GPs gained new patients as part of the pilot.

The diagnoses of the 107 people on the pilot for the whole of 1998 were schizophrenia or other psychosis 49 (46%); depression 19 (18%); bi-polar disorder 16 (15%); adjustment disorders 4 (4%); other diagnosis 18 (17%); and 1 (1%) person's diagnosis was unknown. Where people had more than one diagnosis their diagnosis was coded using the DSM IV

ranking system. Other diagnoses included anxiety disorders, eating disorders, emotional behavioural problems, personality disorders and intellectual disability.

### Utilisation results for the pilot

The monthly returns from participating GPs provided the data for this utilisation analysis. GPs recorded 1345 consultations with 105 of the 107 people on the pilot for all of 1998. Two people did not have consultations with GPs on the pilot. Table 15 provides a summary of the consultation data. The average number of consultations was 12.8 (SD. 10.72, median 10, range 0-74). Most took place with the person only; only 55 (4%) consultations involved family members. Two families consulted with the GP more than the person with SOMI did. By far the majority (91%) of the consultations took place at the GP surgery during regular surgery hours. The length of consultations ranged from 1 - 60 minutes, with most consultations lasting for 15 minutes. Three hundred and fifty nine (27%) consultations lasted 20 minutes or more (and thus could be defined as extended consultations).

**Table 15. GP consultation data for people on pilot 1998**

Variable	Values	No. (%)
Consult type	Routine	1024 (75%)
	Acute	316 (23%)
	Unknown	35 (2%)
Consult by	Surgery	1228 (91%)
	Phone	75 (6%)
	Afterhours	58 (4%)
	Unknown	14 (1%)
Consult reason	Psychiatric	990 (74%)
	General	597 (44%)
	Social	231 (17%)
	Unknown	43 (3%)
Consult output	Support & ongoing management	906 (67%)
	Prescription	552 (41%)
	Liaison	218 (16%)
	For admission	12 (1%)
	Other	71 (5%)
	Unknown*	181 (13%)

\*Of these 181 consultations, 95 involved a mental health component.

Of the 105 people who had a consultation during 1998, 103 (98%) had consultations with a psychiatric component (range 0-64); 93 (86%) had consultations with a general health component (range 0-41), and 55 (52%) had a consultation that included a social component (range 0-21). Approximately 20% (n=279) of consultations were for a combination of mental and general health reasons. Consultations could have more than one output. The main output



of these consultations was support and ongoing management of mental health (67%), followed by change or renewal of medication (41%) and liaison and referral (17%). Liaison was with health practitioners such as the CMHT, pharmacists, supported accommodation providers and other agencies.

The general descriptions of the roles of the different practitioners and providers are summarised in Table 16. However, general roles do not report the whole picture; each person had a set of care arrangements tailored to their needs. A few people reported the GP and psychiatrist as having the same role, while others reported the GP and CMHT nurse as having similar roles. In regards to medication management for mental health, some people's GPs had the total prescribing responsibility, others GPs managed the repeat prescriptions and for a third group the psychiatrist managed all prescribing. Teething issues in getting the responsibility for medication management safe included addressing who was responsible for making incremental versus substantive medication changes. While the GPs with the larger caseloads of people with SOMI appreciated when to consult with the specialist services regarding medication changes those with the smaller caseloads didn't always. For example, one GP (with a smaller caseload) made substantive changes to a person's medication regime on the basis that the training programme had advised that people should not need two anti-psychotic medications. In making the changes the GP did not consult the CMHT and did not appreciate that considerable effort had been required to stabilise this person's health. The consequence of the change was the person's mental health deteriorated and they needed to be admitted to hospital. A case review identified the cause of the problem and more stringent protocols were developed to prevent such an event happening again.

**Table 16. Role description of health practitioners working with people with SOMI**

<b>Practitioner</b>	<b>Role descriptions</b>
CMHT nurse	Support and medication
Psychiatrist	Oversight, long term overview of mental health, main medication authority, person to talk to about mental health options
GP	Person to talk to about day-to-day health and mental health issues, back-up medication authority, physical health provider
Supported housing staff	Assist with day-to-day issues, provide therapeutic programme
Other providers	Therapeutic programme, daily activity.

Many people reported they did not experience any change in the services they received as a result of the pilot, apart from not having to pay for the GP. Those who did experience a

change, almost always reported a positive one. Most of those who reported no change either only saw the GP or the CMHT. Some people who previously saw both the GP and the CMHT reported there was no change, while others reported they now saw the GP more often.

Reported changes in CMHT use were minimal, most considered there was no change in their contact with the nurse, but some reported they now saw the psychiatrist less frequently. The most common change reported was people using the GP when repeat medication was needed. Prior to the pilot, repeat medications were sometimes arranged by ringing the CMHT nurse. The nurse would proceed to write out a prescription, find a psychiatrist to sign this and deliver it to the person. A repeated concern of many people was that the pilot remained a pilot and had not been extended as routine care. Consequently, they were hesitant to reduce contact with the mental health service in case the pilot was discontinued.

For at least two people general practice also took over the responsibility of giving the intramuscular injections. Comments made about the difference between the CMHT and the practice nurse doing the injection concerned the extent of the nurse's communication. They observed that the CMHT nurse talked to them and found out how things were going, whereas the practice nurse just gave the injection. Although general practice was a more convenient place for these people to receive their medication, they did not find the experience as good.

Some people reported that the pilot resulted in changes in the way GPs interacted with them. In such circumstances, GPs had become more interested in them as a person and were more informed about their mental health. One person reported the "Doctor asks questions and looks as though [he] cares about the answers as well. This is a change" (Interview 30b), and another observed "it seems that you can have more discussion with the GP rather than just whipping in for a script" (Interview 45b). For a third person the change was the "GPs been like more asking more questions about my mental health, sort of taking a professional interest in that" (Interview 52b). People commented they liked the change. They liked it when GPs asked them how things were going at home, or in the supported housing, how they were feeling, and how their family was. This contrasted with the previous situation where people felt GPs were more interested in only the specific health problem they had.

In addition to the variability in how people with SOMI used the GP as part of the pilot, the final evaluation reported considerable variation in how GPs utilised the pilot. GPs claims for

1998 (Table 17) indicate that there were notable differences in the number of target and extended consultations claimed per GP. Some GPs had active roles in liaison and worked with the target population while others largely worked with extended consultations. This variability became problematic as some GPs were claiming over their contract entitlements of 48 extended consultations per year.

**Table 17. Pilot claims by Napier GP for 1998**

GP No.	No. target consults	No. A/H - home consults	No. extend consults	Mins. liaison	Mins. training	Mins. evaluation	Dollars paid
1	151	0	58	123	240	720	\$5684.91
2	168	15	51	90	300	780	\$6905.19
3	230	16	53	575	120	720	\$7953.14
4*	492	33	38	1692	540	1500	\$15428.26
5	89	0	4	210	360	720	\$2928.25
6	111	1	48	1089	360	720	\$5757.07
7	71	4	24	385	360	720	\$3476.32
8	42	2	3	90	240	120	\$1199.25
9	177	1	37	591	90	720	\$5944.11
10	25	3	17	175	420	540	\$2103.51
<b>Total</b>	1556	75	333	5020	3030	7260	\$44551.74

\*Includes one month of claims from new doctor preparing to take over caseload

Some GPs reported they had changed how they treated people in the pilot, others said there was no change. Those who reported a change said they were now more involved in mental health, whereas before the pilot, consultations with the target group were mainly for physical illness. This changed involvement included writing prescriptions for repeat medication as well as carrying out a general consultation on mental health issues. Other changes GPs reported having made concerned asking people to make repeat visits to see them. Some GPs said that they found that when a person brought in multiple issues/problems it was easier, knowing that the person was not going to have to pay, to suggest they return a week later to deal with some of the matters. GP 1c reported they changed the length of time they issued the Sickness Benefits for. Prior to the pilot they would give a certificate requesting three months benefit, but to ensure people came and saw them more often, they changed to give it for only a month. Some GPs considered the pilot enabled them to retain patients by providing a better service to them.

GPs unanimously reported that over the course of the pilot they increased their skills and knowledge in mental health/illness. In addition to the formal training programme that they all really appreciated, GPs also attributed their increased knowledge and skills to patients and to

learning from the mental health service staff. GPs considered they gained increased knowledge in clinical and communication aspects of providing care. Some found they were able to use this new knowledge very effectively in assessment, in discussions with relatives and in the general management of people, especially around the time people were unwell. The GPs with very small caseloads considered their opportunities for using and consolidating new knowledge and skills was limited by their caseload. Only the work of one practice nurse changed on the pilot. This nurse commenced giving the monthly injections to one person.

### *The effectiveness of the pilot*

The effectiveness of the pilot was viewed from the perspective of the people with SOMI, GPs, the CMHT and the managers of four supported houses. Evidence was obtained on how accessible and acceptable the service was and whether shared care had led to comprehensive co-ordinated service arrangements. In addition evidence on the success of the pilot at improving health outcomes was obtained.

People who did not have a GP or who regularly changed GPs were invited to enrol with a pilot GP. At least 20 people considered eligible, declined this invitation. A few of these people reviewed their initial decision and joined the pilot at a later date. Where reasons for declining to participate were given these reflected: a wish to avoid involvement of the GP in mental health issues, the non-identification with the category of long-term mental illness, a belief about the pilot being evil or likely to disturb body metabolism and them no longer being eligible as they had recently changed to a GP who was not in the pilot. Discussion with the CMHT team leader suggested that the people who did not have an identified GP were over represented among those who declined. Many of these people preferred to use the “drop-in” style of general practice available at both City Medical and The Doctors<sup>32</sup>.

Many people who expressed an opinion regarding the mental health care and treatment received on the pilot considered their needs were well met. Most spoke of a good relationship with their CMHT worker and psychiatrist. Several people said they would like more opportunity to talk with the mental health service about their mental health and explore options available to them. Although some people found the changes in psychiatrists hard, they generally reported that the psychiatrist, and “those up the hill [the CMHT]” were the best people at listening to what they had to say. Some considered that their GP had very little

---

<sup>32</sup> Another general practice group operating in Napier.

understanding of mental health, while others thought their GP had an excellent understanding. For a few people such as Interviewee 72c having the GP involved in mental health was problematic because the GP assumed “because I was a mental health consumer ... everything was re: mental health”. People such as Interviewee 72 who were dissatisfied often changed GPs. The commonest reason for changing being the GP was “patronising”. However, the majority of people reported they stayed with their GP because of satisfaction with the service they received, such as the GP being a “good listener”, “very understanding”, “thorough”, “down to earth”, and “approachable”. The “proximity”, “availability” and gender of the GP also played a part in why some people remained with a GP. A minority of the people considered there was a tension for them between having free GP care and staying with a GP they did not have a good rapport with, which they considered important for a GP-patient relationship.

The pilot was acceptable to some people because they now had another resource, their GP, to consult for their mental health. Some had found this extra resource very helpful particularly when they were unwell and a few considered the presence of the pilot helped them avoid admission to hospital. Some people commented they liked having their mental and physical health needs being met by the same doctor. A few reported that at times the brevity of the GP consultation limited talking about things, but considered it was better to see the GP for a few moments more often than not at all. Some who joined the pilot through their GP welcomed the pilot because it has introduced them to the CMHT – they became able to access services they were not previously aware of.

Many people were pleased that the pilot removed the financial cost of seeing the GP. Several spoke of it now being easier to visit the GP. As Interviewee 52c said “I basically avoided going to the doctor ... [the pilot] sort of pushed me to use the services more like before I’d be hesitant about going ... to get some pills because it would cost me to go there, but now I can go there and just get a prescription”. Many felt free GP visits did not mean they used the GP more, rather it just meant the decision to use the GP was easier to make, as it did not also have to involve a financial decision. In this regard they felt they were seeing the GP sooner, that is, when they had a problem, rather than waiting until they needed a new prescription. They consider this was beneficial for their health.

For residents of supported houses there was no personal change to the cost of seeing the GP; the supported houses previously met the cost of any necessary GP care. However, some residents reported that previously they were aware that their visits to the GP were a drain on communal resources. The pilot enabled them to feel more comfortable about arranging a consultation with the GP when they felt it was necessary. An unexpected benefit for some people was the removal of the need to keep track of receipts to maintain receiving the Disability Allowance. For others, the pilot was unacceptable because although the cost to see the GP became free, this was offset by increased medication costs. This was especially so if the GP wrote prescriptions for one month when previously the prescriptions from the psychiatrist were for three months. The increased time and transport costs involved in attending the GP, together with monthly prescription charges, were “a big nuisance and a big expense” for Interviewee 45c.

Access was more than just financial access. Carers reported that by having the GP involved in their family members’ mental health, they were now able to get better access to secondary services. As one family member said “we find it far easier to get contact with the mental health people now through the doctor. He contacts ... [mental] health you see, they act straight away. Whereas if we ring up [mental health] you know there’s not the same urgency with it” (Interview support person 39b).

The GPs mainly reported the pilot to be a positive experience because of their changed role in people’s care, their increased skills and knowledge, and the payment they received for this work. Experiences that were not positive concerned the relationship with the mental health service and the lack of decision-making surrounding the permanency of the pilot. For those GPs whose expectations were about increased involvement in mental health care, their expectations were met. This was summed up by GP 1c who said the pilot allowed him to do “what I wanted it to do, that is more involvement in psychiatry, the pilot allowing us to do that with our patients”. For some GPs the benefit of the pilot was the work they could do with people using the extended consultations. For others, extended consultations played a small role, what was important was the work they could do with people in the target population.

GPs considered that payment while on the pilot, while not necessarily the key factor was crucial to their involvement. For some GPs, the payment rates were considered very good,

they were being paid for what they had previously done free. For others, the payment rates were considered inadequate. As the rates were based on people receiving the CSC, GPs who had people on the pilot who were not CSC holders indicated that the GMS cost of these consultations was absorbed by the practice.

The pilot, largely because of the evaluation requirements was unacceptable to many CMHT staff. Although Healthcare Hawke's Bay received a contract for this, additional staff were not employed to compensate for the additional workload required of the CMHT. Putting the evaluation aside most of the CMHT did report some positive experiences with the pilot. In particular CMHT reported improved working relationships with some GPs. Initially CMHT staff considered that although it was easier to contact the GPs, the communication was still largely one way; it was the CMHT who were initiating most contact and some GPs did not appear to be aware of the constraints that the CMHT worked under. However, over time this relationship was reported by the CMHT to have improved. A particular benefit that some CMHT staff reported was how the GP had given their clients "another support person" which was "very effective" for some people (CMHT 3c).

Another benefit reported by the CMHT was that some people now relied less on them, especially in relation to getting their repeat medication. Some staff felt this resulted in a more planned approach to their workloads, as they were less likely to be required to respond to urgent requests for medication. Another role general practice staff took on was that they were sometimes seen as another person to help out when CMHT staff were absent. For example, the practice nurse in one practice gave the intra-muscular medications for residents in one supported house when the CMHT nurse was on leave. This sharing ensured timely administration of medication.

The CMHT were never completely happy with the pilot entry criteria. Some staff considered that the exceptions led to entry into the pilot being like a "lottery". The CMHT considered the criteria needed to be tighter and include consideration of whether people were well or stable enough to be part of shared care. They also believed that unless shared care was already established, it was inappropriate and not good clinical practice to enter into it when someone was acutely unwell. The final evaluation identified that a few people had been kept on the CMHT books because staff thought this was a requirement of the pilot. The CMHT also had issues with the training programme. Not so much the content, but the fact that local

people were not involved in teaching or planning it. The consequence from their point of view was that the local ways of doing things were not taught. In addition, the training given was very medically focused and did not include aspects of community care and recovery.

Generally, the four supported house managers who were interviewed reported positive views about the role of the pilot in enabling freer access for people to see their GP. This access seemed easier, even when there was not a previous cost to see the GP. As the CRHA/HFA contracts with supported houses, included payment arrangements for the houses to provide primary medical cover, one housing manager reported the pilot “saved them money” (Supported Housing 1c), while another considered it saved some resident money as residents were given the DA to spend as they needed it. The benefits to the supported houses were not just financial; the pilot was also thought to have facilitated the GP and supported housing to sort out a different way to manage the medication for residents in the supported house (Supported Housing 4c). This manager considered the new system was good, and that it made all people more accountable than previously.

### **Co-ordination and comprehensive services provided through the pilot**

For care to be continuous and complementary, the roles providers have in working with individual people need to meet to ensure continuity of care, yet be different to ensure complementary rather than duplicated care. While this occurred for some people it did not for others. Just as there was considerable variability in the roles different practitioners had with different people, there was also variability in the patterns of care provided. Although the pilot was based on developing shared care, people reported three other patterns of care that were not shared. Some had GP only care, others saw their GP for physical health needs only, having all their mental health provided by the mental health service and a third group received parallel care. Parallel care was defined as arrangements where both the mental health service and the GP were involved in providing a person’s mental health care without consulting each other, rather each practitioner worked with the person in isolation. People in the shared care model reported their care was well co-ordinated and worked well, whereas those with parallel care arrangements reported a lack of continuity and co-ordination. For some people it was the actual presence of a care plan that resulted in continuity. They tended to use the care plan especially during times of crises when they required hospitalisation. The care plan enabled other practitioners to see the treatment regime and signs of worsening health. The pilot was considered particularly beneficial when people were unwell.



GPs considered the pilot increased co-ordination. According to GP 7c the pilot was valuable because “the nature of their [people with SOMI] illness, the nature of their life style, living in poverty ... it’s good that they have good follow up with GPs”. Staff had different understandings of each other’s roles. Some GPs considered they were the key co-ordinator of people’s health, while the CMHT considered they were the key in mental health. This posed particular problems regarding medication management. Several people reported there was no coordination regarding how their medication was managed. Although the pilot enabled a comprehensive package of care for many people to be delivered, for others the pilot drew attention to services they were missing out on. In particular, some people reported that they did not see the CMHT as often as the care plans indicated they should do.

### **Meeting health outcomes**

The need to address the impact of the pilot on health outcomes occurred soon after the pilot commenced as two people on the pilot had died as a result of suicide. The question was how, if at all, did the pilot contribute to these suicides? A review undertaken by the mental health service revealed that although these people had joined the pilot they were still being seen by the mental health service and at the point of their suicide, shared care plans had not been developed. The pilot was thus able to continue without changes being required as a result of these deaths.

The final evaluation reported that there was no statistically significant change (at the 5% level) over time on the mental health outcome measure Health of Nations Outcome Scale (HoNOS), however there was a statistically significant improvement in general health as measured on three out of eight sub-scales of the SF-36 Health Survey (Nelson et al., 1998). The scales where improvements were found were: physical functioning, social functioning and role-emotional. Importantly there was also no deterioration. Of those interviewed 22% (n=15) reported improvements in physical health and 33% (n=23) reported positive changes in mental health. A further 47% (n=33) reported no change in mental health or physical health and the data on six people was missing.

Most people found the pilot gave them increased control in managing their health. This control came because they were able to make health not financial decisions on when to see the GP. While many still retained a consultation pattern based on renewing medication, they

considered that not having to pay a co-payment when seeing the GP enabled them to go as necessary. Most did not consider they consulted the GP more often, rather they thought they consulted in a more timely manner in relation to health need. For others, the pilot care-planning process provided them with a voice and a role in their own care. This voice and role was most noted in the realisation by people that they had an important role in monitoring and maintaining their own wellness.

### ***Conclusion***

The HB pilot came about because a group of GPs responded to an announcement that increased money was available for mental health services. Their response came at a time when the CRHA was interested in finding other ways of delivering services. When the pilot started, relationships were such that the GPs and the CMHT only met in Wellington. Due to a lack of a Napier-based co-ordinator to develop the pilot, the HSRC took over this role. While the pilot's initial shape did not change, detailed features of the pilot such as the eligibility criteria, claim rates, shared care plans did change over time. The personnel responsible in every area, apart from the HSRC also changed over this time. Consequently, factors affecting change in the detailed features of the pilot were the individual preferences and commitment to the pilot of the staff, and the findings of the interim and final evaluation. In the main most people involved reported positively on the need to continue to develop shared care services.

## **Chapter 8 – Innovation in service delivery**

The findings of the NUHS programme and the HB pilot provide a number of insights into innovation in service delivery. Some of these insights are possible because these two innovations occurred at a similar time and, although initially addressing different problems, they were both related to the development of a service in a general practice setting for people with SOMI. These case studies shed new light on the origin and shaping of innovative mental health care, provide evidence that the trajectory of such experiments in service delivery is not necessarily unidirectional, and show that a key to such innovations in service delivery being adopted as part of the regular service is that they are sustainable in the long-term.

The chapter is in five sections. The first section reviews the argument why the NUHS programme and the HB pilot can be regarded as innovations. Sections two and three discuss the insights that emerge from the origin and shaping. The fourth section focuses on what has been learnt regarding the type, nature and direction of decision-making used in the development of these innovations and the final section discusses the importance of sustainability in relation to innovative services.

### ***The increased role of general practice in mental health as an innovation***

By definition innovation in service delivery involves the introduction of goods or services that are unique and that no one person or organisation has previously used or applied within a particular context or setting. The specific setting for these innovations was the redrafting of general practice in New Zealand in relation to people with SOMI. From Chapters 4 and 5 it is apparent that there was very little new about the targeting, payment arrangements, relationship between the primary and specialist services, location of services, training or the roles of the various stakeholders in general practice working with people with SOMI. Yet, the NUHS programme and the HB pilot were innovations. They were innovations in that they expanded the number of people who were either having, or expected to have, all or part of their mental health care provided in a general practice setting. For NUHS this expansion occurred because a large number of people with ongoing needs from mental illness were enrolled in their practice. However, in Hawke's Bay the expansion occurred because a service was purchased with the intent of increasing the role of general practice in mental health. To accommodate these developments, both services required specific development. Although they were influenced by the international literature, the services were innovative

because little was known about how to expand the role of general practice in providing services to people with SOMI in New Zealand and what precisely might be needed to facilitate, monitor and develop such innovations in general practice service delivery.

### *Why these innovations came about?*

Analysis of these developments supports the work of Mays (1993), Schultz and Greenley (1993) and Stocking and Morrison (1978) who agree that not only are the national, international and clinical contexts important in understanding why such innovations occur, but equally important is the local context. Although the history of these innovations was traced to specific actions, in order for these to occur, the wider context needed to be right. It is, therefore, not surprising that other innovative services involving general practice working with people with SOMI have since emerged in New Zealand (Nelson et al., 2003)<sup>33</sup>.

The contextual factors that resulted in these innovations were outlined in Chapter 4 where the history of institutional arrangements regarding health and welfare services in New Zealand was described, and in Chapter 5 where the clinical context was presented. These factors included the failure of the mental health system to provide co-ordinated services, to be able to move people through the system and also to meet the individual and changing needs of people with mental illness. These service failures resulted in considerable public criticism. This criticism occurred almost simultaneously as beliefs about the nature of mental illness were increasingly evident in the services and in the community. There was both an increased incidence in mental illness and an increased appreciation that people can recover from major mental illness. This was associated with changing roles in hospitals where the focus was no longer on maintenance and rehabilitation but more that of acute management and the abatement of symptoms. All of these factors were allied with greater calls for community accountability. For example, community-based providers were increasingly required to be involved in providing the social and clinical needs of people with SOMI. This new involvement of and respect for community providers affected the boundary between generalist and specialist services in mental health.

The changes to the boundary occurred because general practice was now having more contact with people with SOMI. These people were now living in the community as a result of the

---

<sup>33</sup> Personnel involved with many of these other innovations consulted myself, staff at NUHS and the Hawke's Bay to learn from issues encountered in the development of primary mental health shared care services so as they could address such issues in setting up their services.

policies of deinstitutionalisation. In some instances, general practice was now the only health service that people with SOMI utilised. Although there was now an increased appreciation of the need to meet people's social and clinical needs, the medical management of mental illness had not changed dramatically since the introduction of long acting medications in the 1970s. However, just prior to the emergence of these innovations the first of a series of new anti-psychotic medications were introduced (Young, 1997). In New Zealand these new medications could only be prescribed by psychiatrists and because of their side-effects, people using them needed to be closely monitored. This close monitoring increased the workload of the mental health service. Apart from those whose medications were changed to newer ones, many people with SOMI's medication requirements were stable and thus there was limited risk of GPs having responsibility of managing some people's medication requirements. Also for many people exacerbations of illness were episodic, and most people in between such episodes were relatively well. In addition, given how the work of the CMHT nurse in maintaining people with SOMI's health was not well understood, there was limited perceived risk involved in care arrangements changing from being principally delivered by the CMHT to including primary practitioners. Lastly, crises within the mental health system generally had resulted in new money being made available to extend service provision. Without this new money the HB pilot would probably not have started.

Not only were there relevant contextual factors in mental health services, there were also factors in the health system generally that paved the way for the development of these innovations. The need to find new ways was particularly evident within NUHS. For example, union health services arose in response to the perceived failure of existing primary health services to meet the needs of people on low incomes. There were also new pressures on the health system such as the need for cost containment, which drove changes in how services were funded and purchased. A major consequence of this was the unbundling of service delivery. In particular, the need for cost containment led to debates about appropriate boundaries between generalist and specialist services. For example, specialist services are generally more costly to operate than primary services. All of this ferment about cost containment led to an increased awareness of the need to develop health prevention strategies to reduce the incidence of preventable conditions and to aid the early detection of other conditions.

Lastly, there were changes in the nature of welfare provision including the move from universal provision to targeted provision. There was an expectation about individual responsibility and a strong focus on the family to provide care. All of this was part of a new rhetoric (particularly in government) pertaining to welfare dependency. These changes occurred in an environment where individual rights and responsibilities also came to the fore. This rise of civil rights underpinned the development of the mental health consumers' movement, which criticised the mental health system, arguing that the system did not provide individuals with rights or choice.

All of these health, social and welfare factors paved the way for the emergence of an increased role for general practice in the care of people with SOMI. These innovations came as no surprise, since neither of them occurred in a vacuum. Rather they arose out of the interaction between international, national and clinical factors that were triggered by local events.

### **Local events**

The local events that facilitated these developments occurred because practitioners seized upon an opportunity in the case of the HB pilot while in NUHS a targeted approach was determined as the best way to deliver quality services to people with ongoing health needs. The focus on people with SOMI was a consequence of the number of people with ongoing mental illness needs enrolled at NUHS. The financial crisis NUHS faced meant that efficiencies were needed in how it worked – an organised approach to networking was required. In Hawke's Bay there was dissatisfaction with existing service arrangements. The NUHS involvement in SOMI was driven by the pressure of their patients while the HB pilot represented a concerted effort by GP's to contract for new service funding arrangements. The first was a bottom-up imperative while the second was more of a top-down innovation. However, whatever the structural origin of the innovations, both providers were keen to try alternative approaches.

Despite NUHS's programme history in the contracting process the CRHA defined the "problem" to be about access to the GP. It did this by funding the service based on GP consultation rates for High Users Health Card holders. This occurred because the model that the CRHA used for funding general practice was based on the work of the doctor. However, NUHS's problem was not about improving access (NUHS had already partly addressed the

cost of access) but rather improving the service that was delivered once people got there. In contrast, the HB pilot had a definite starting point, there was new money available for mental health, and a group of Hawke's Bay GPs considered they should have input in how it was spent. The GPs request for input ultimately led to a decision that a new service would be purchased. The underlying problem the new service aimed to address was the lack of involvement of GPs in the care and treatment of people with mental illness. It was only after the findings of a literature review were reported and discussed that a decision was made to have people with SOMI as the focus for the service.

Schultz and Greenley's framework (Figure 5, p.42) that the development of innovations involves a combination of the skills and aspirations of individuals, the willingness by stakeholders to contribute to and work towards the innovations, and organisational development and strategies is reflected in these developments. The ability of individuals to grasp opportunities, and the openness of stakeholders to create new solutions for people with SOMI that involved general practice, were key reasons for these developments. In NUHS the work of the doctor and original nurse in networking and shaping the programme were crucial. Both of these staff were committed to see NUHS survive as a health care provider and provide a quality service for people with SOMI. They had community development skills, and used them to develop the service. In Hawke's Bay in contrast the skills that were demonstrated concerned the ability to negotiate and work with the CRHA to develop the pilot service even though the shape of the innovation did not meet original aspirations.

The presence of managers was another reason these innovative services commenced as an innovation's resource implications of who (clients and staffing), what (services), where (location) and when (priorities) need to be managed. In both services it was the manager who facilitated the completion of the basic research to establish the need. The managers developed business cases including data on utilisation rates, people numbers, profiles and real costs to support the need for additional funding. They discussed operational costs whereas clinicians spoke of benefits for people. This meant that arguments for funding were couched in language that was in tune with the purchasing authority. As Chapter 4 revealed the period in which these innovations developed was dominated by economic rationalism. In addition, managers were generally available for meetings with the purchaser, and other funders and providers to negotiate service arrangements. They brought with them a systems or operational approach that enabled them to argue what could and could not be provided, given

the funding. These managers were present because of the development in primary care that had seen general practices cluster to form larger practices and combine under umbrella organisations such as City Medical. The managers worked on the infrastructure needed for the establishment of the innovative services. In funding negotiations NUHS also sought the support of the community.

Not only does this research indicate that innovations in service delivery need people who can lead the way, gather momentum and make changes, it also indicates that for them to develop, the support of other people or services may be required. Such innovations in service delivery usually involve several people and several organisations. The willingness of all stakeholders to contribute to and work towards getting an innovation established cannot be underestimated. With the NUHS programme, given its already innovative role in other areas, this was less about fellow staff supporting the idea and development of the innovation but more about the CHE-mental health staff supporting it. Similarly, it was the willingness of the CHE staff in Hawke's Bay to work on developing the pilot that facilitated its progress. Initially this willingness was led by management and not the field staff, but some of the latter came on board shortly after the pilot started. However, one reason that the HB pilot was established was that the mental health services were in disarray as a consequence of the constant turnover of psychiatrists<sup>34</sup> as well as the number of people working in acting and ongoing management positions.

### *The shaping of the innovations*

The initial shape of the innovations was largely determined by what each innovation set out to achieve. The structures and components of the service delivery arrangements were shaped by two over-riding goals and seven general factors. The over-riding goals were the desire to improve existing service arrangements and to develop new services that would be sustainable over time. The first of these goals needs no explanation. Those involved were very conscious that any change in service delivery needed to either equate with or improve existing services. The second goal that of sustainability was not knowingly obvious to those involved in developing the innovations. The general factors that shaped the innovations were as follows: knowledge from the literature and from the evaluations, the philosophy and structure of the original organisations, staffing, consumer input, the assessment and management of

---

<sup>34</sup> Unlike the Wairarapa, it was not possible for clinicians in the mental health service to mount a case against the pilot. Wairarapa Mental health staff did not support a pilot service commencing because they considered there was insufficient knowledge of who was clinically accountable in shared care arrangements.



risk, how opportunities were seized upon and the role of individuals. Although all seven factors were involved in shaping each innovation, their influence varied in relation to structural and delivery aspects; each innovation drawing on other models of service delivery including payment arrangements, training and roles.

### **Shaping the structure**

An innovation by its very nature does not initially have all the evidence necessary to support its desired service outcomes and process. However, existing knowledge, experience and evaluation had a role in shaping these innovative services. Even though the literature rarely provided “gold-standard” evidence (Sackett, 2000), its use indicates an evidence-based decision-making process. The search for applicable evidence was most apparent with the HB pilot where it was a literature review that identified new possible models of service delivery. The experience gained from NUHS was also influential, though NUHS’s use of the literature was more to understand and consolidate what it had already developed.

Once operational, evidence in the form of the evaluations played a further role in shaping the innovations. This was most marked in the pilot where the evaluation led to changes in the maximum caseloads some GPs could have, thus firming up of entry criteria, indicating a new way of care planning and suggesting better ways for managing adjustments to medication. The evaluation of NUHS helped staff to better understand and describe their work. Given how the practitioners in both innovations were interested in the evaluation findings, and were keen to talk and learn from others’ experiences, provides evidence to show that when people are directly involved in developing innovative services, they are open to use all forms of evidence to guide the shaping of the service, rather than evidence principally developed from an evidenced or research approach.

Another factor that shaped the respective innovations was the use and application of existing organisational arrangements. The community development philosophy behind NUHS allowed staff to network with user groups and other providers. They did not always have a clear vision about what their service should look like, but they did, however, have a clear view about the importance of networking relationships. It was these relationships that led to opportunities such as establishing outreach clinics. The presence of the consultant-liaison service arose because NUHS responded to an opportunity to trial such a service. NUHS was able to design a system around two practitioners, a nurse and a doctor. The nurse and doctor

did not however, have total control; they had to conform to the service arrangements in place for all staff at NUHS. One arrangement was that 15 minutes was the time allowed for a consultation. NUHS experienced what had been reported elsewhere in the literature (Wear & Peveler, 1995), namely that often people with SOMI need a longer time for a consultation. This NUHS experience was used by Hawke's Bay to set up contractual payments for longer consultations. NUHS staff understood that a key reason why the appointment system could not change was that each practitioner needed to maintain a certain level of patient contacts. In Hawke's Bay decisions about the pilot's shape were influenced by how the GPs worked clinically and how they were organised. As the pilot GPs were largely sole practitioners, shared care was considered the best model. Other models such as consultant-liaison and shifted outpatients would have been more difficult to implement as they would have required the specialists to work out of many different venues.

The number and types of stakeholders involved in the decision-making regarding the innovations influenced their structure and the needs they were to meet. For NUHS the stakeholders were the community and staff. Those involved in NUHS as a primary service were community people and staff consciously sought to ensure that the voices of those who used its service were canvassed. The CRHA became involved when the programme was running and more funding was required. The CRHA at this point required free consultations and accountability requirements, but apart from that did not have an impact on shaping the programme. Similarly, the Wellington CHE had no real impact on NUHS until it provided a psychiatrist and social worker to support the work of NUHS, and even then these practitioners arrived on NUHS terms. It is possible that closer involvement in decision-making would have made a difference in the unilateral decisions made by CHE to discontinue the role of the social worker and reduce the hours the psychiatrist was available.

In contrast, once the pilot was operational all the stakeholders were involved in making decisions about its shape and direction. This allowed them to state their priorities, identify risks and for safeguards to be put in place to meet these risks. Other research concerning general practice and palliative services also found that practitioner groups had different priorities (Barclay et al., 1999). A reason the pilot developed as it did was because of the input of the NUHS doctor. This doctor was able to use her NUHS experience to suggest what was required in order for the pilot to be an effective service. For example, the need for telephone and liaison time. NUHS support also enabled those in Hawke's Bay to be better

remunerated. The GPs in Hawke's Bay had a key role in shaping the pilot. In order to keep them involved, it was necessary to provide a way for them to better meet the needs of people generally with mental illness. These were addressed by the inclusion of extended consultations. The pilot therefore could potentially reach all people, those with SOMI and those with less severe mental illness or illness of limited duration.

People with SOMI and their representatives also played a part in shaping the innovations. Although people with mental illness registered at NUHS were not initially represented on the Policy Board when the need for the programme first emerged, at the earliest opportunity consumer groups were consulted and involved in the programme's development. Similarly in Hawke's Bay people with mental illness were not involved in the initial decisions, rather they were consulted after the pilot was designed, their input was only able to influence change to components of the pilot, but not to the overall shape. Individuals with SOMI in Hawke's Bay did however, play a significant role in whether the pilot operated, as they had to consent to be involved.

It was important that consumer representatives were able to articulate and negotiate what was important for people with SOMI in the service arrangements. Once these representatives were given power-sharing status in the HB pilot their input was significant. In particular, they played a key part in re-designing the shared care-plans and in shaping the content of ongoing training. One of the reasons the consumers were brought on board was because the government's drive to improve service delivery through consumer representation (MoH, 1995). The individual consumer representatives had less of an impact on the programme at NUHS than they did on the service as a whole. Few specific mental health issues were taken directly to the consumer representatives. Perhaps because of its philosophy NUHS was thus regularly responding to and making adjustments to its services.

### **The role of risk management**

Risk management played a much greater role in the design of the HB pilot than that of the NUHS programme. This difference indicates the influence of the philosophies and structures of each of the services. NUHS's approach to risk concerned its ability to deliver a quality service that met the needs of its client group. Using a community development approach, NUHS staff worked proactively, encouraging the community and individuals to present issues and problems (such as unmet needs) with the service to the NUHS staff or Policy Board.

Once issues or problems were identified staff worked to address them. NUHS's approach was not from a practitioner perspective but from the perspective of those who used the service. People enrolled at NUHS were able to complain about the service and have their complaints heard. NUHS programme did not consider that there were no major risks to address, they were constantly open to evolving and changing the service to meet the needs of those who used it.

However, risk management did play a role in shaping aspects of the NUHS programme. In the first instance the request for additional funding was part of managing the risk of maintaining service quality. The CRHA managed its risk by purchasing the programme as a time-limited pilot service. It also managed its costs by limiting the number of people that NUHS could claim for and specifying accountability measures to review NUHS's performance. Pilots, according to Sederer, "may offer opportunities to define better accountability and responsibility, and to revitalize and improve upon the care of the chronic mentally ill who are currently under public care" (1996, p.293).

Likewise in the HB pilot, the CRHA and other stakeholders used a risk management approach. It was the detailing of the risk management strategy that facilitated the pilot's development. The need to risk manage in Hawke's Bay was partly because people knew it was a pilot. As a pilot there were many unknowns, and all stakeholders wanted to protect their position. Stakeholders were not prepared to participate without safeguards. These were also necessary because of the initial level of distrust between the stakeholders. Safeguards included the training programme, limitations on claims, and consent requirements. For some individuals, both people with mental illness and GPs, the risks were considered too great to join the pilot.

Risk management restricted the total cost of the pilot to the CRHA, limited the financial risk to the GP, involved the development of a systematic process for people to join the pilot including training for the GPs, gave people with SOMI a choice to join, and was the basis for establishing the problem-solving system. The concerns of the GPs about taking on increased financial risk led them to reject capitation as a payment option. Similarly, the CRHA's managers concern about financial risk resulted in a limitation being placed on the number of GPs involved and the amount that each GP could claim. The CMHT were concerned about the skills of the GPs to care and treat the people with SOMI. The compulsory training

programme was designed to address this concern. The people with SOMI were concerned that they may have reduced access to the mental health services if the GP became the principal health practitioner involved in providing mental health care. Reassurance was required that entering the pilot would not impact on future access to care and that the GPs had the necessary skills and knowledge to be involved in their care.

A reason NUHS staff may have been less concerned with risk than the Hawke's Bay stakeholders was that they had already overcome considerable difficulty in setting up the main NUHS service and in fighting for it to continue operating. Starting a mental health programme was therefore seen to be not that risky. NUHS was aware of risk. It refused to take on managing some people's care without the involvement of the specialist service and saw shared care as an essential goal for its service. This level of risk management was based on the type of service that NUHS believed some people with SOMI required. Skills that were beyond those it could provide alone as a primary care service.

Although the Hawke's Bay evaluations raised a number of areas where risk management strategies had broken down (e.g. the duplication of funding, the lack of buy in from some in the mental health service, inappropriate claiming by some GPs and poor co-ordination) these were rarely addressed with the personnel involved. Rather the focus was on increasing the monitoring and rules associated with the innovation. However, if the issue involved could potentially harm a person with SOMI (e.g. the GP changing medication without consultation) while clearer processes were put in place, individual practitioners were also spoken to.

In summary, existing service structures, stakeholder groups and risk management shaped the structure of the innovations. The role of these factors differed especially in relation to risk management. In the pilot all stakeholders up and down the layers were responsible for their outputs and while some anticipated problems were managed in advance, others were responded to with increased rules.

### **Shaping the services provided on a day-to-day basis**

Three factors – organisation, staffing both internal and external to general practice and people with SOMI – were important in shaping the services provided on a daily basis. Although the services developed differently, the transformation in both cases was similar. It included:

- how the services were organised – structured care plans were introduced for some

- people and people did not have to pay a co-payment;
- who delivered the service – primary practitioners took on increased roles and responsibilities;
  - where the service was delivered – services previously provided at home or in outpatients were now sometimes provided in general practice rooms or outreach clinics;
  - who received the service – some people who had previously not been receiving care from the mental health service, but who had a SOMI were able to receive care in these innovations; and
  - how the service was delivered – the new service arrangements drew on, but did not replicate other models of service delivery.

The innovations largely built on the prevailing methods of service delivery. There were similarities in the doctors' roles and how care was organised. On the other hand, there were differences in the nurses' roles, outreach work, consultant-liaison service, assertive follow-up, after-hours arrangements and networking. While the general role of the doctor was clear many GPs, working in these innovative services reported an increase in their mental health knowledge and skills. Although the doctors considered this increase important, it was not essential to work in these innovative services. The training merely expanded the quality and level of service they provided. Training was provided to assist with this expansion.

The one exception to this work being seen as typical of that obtaining in general practice was that of the NUHS nurse. Having one nurse with a focus on mental health provided an opportunity for NUHS to expand its service. It also meant that its service was less dependent on the doctor. This expansion involved the development of outreach work and of supportive counselling. The expansion of the nurse role was possible because NUHS funding was by capitation. Although the level of payment was calculated on consultation rates with the doctor, payment was not dependent on people seeing the doctor. The role of funding in shaping mental health services was also reported by Green et al. who concluded "the evolution of community mental health care in New Zealand has been shaped in part by professional pressures and complex funding mechanisms" (1992, p.373). When the opportunity came for a staff change, a nurse with even greater skills in mental health than her predecessor was employed. This replacement nurse utilised her expert mental health skills with community development skills to consolidate the earlier development of the programme. In the HB pilot payment was dependent on people seeing the doctor; there was therefore

limited incentive to develop the nursing role. Given that primary health care throughout New Zealand is moving to capitation payments (King, 2001), expanding the role of the nurse is an area that could develop.

In both services the innovation was shaped by the location of the service in relation to the primary secondary boundary. The presence of the consultation-liaison service meant that there was not always a boundary present at NUHS. NUHS was able to retain services to some people because the psychiatrist was able to see them in NUHS rooms. Although some people mainly saw the psychiatrist the nurse and doctor were updated on everyone seen. This lack of a boundary made for more effective communication and continuity of care. Despite the lack of a boundary, the psychiatrist had little impact on the overall service delivery model at NUHS because when the consultant-liaison service started, the innovation was up and running. The psychiatrist did however, impact on particular individual's care arrangements.

In contrast, the HB pilot had more defined boundaries. The psychiatrist had an enormous impact on the events and shape of the pilot. The impact of the psychiatrist became very apparent because each of the psychiatrists in Hawke's Bay worked with the pilot differently. In making decisions about this work, the psychiatrists used their experience from other countries and services as well as their beliefs about how things could change. Reasons why the psychiatrists were able to have different impacts on the pilot were because they were not introduced to the workings of the pilot as part of their orientation into the service and their contracts did not specify the need to contribute. This lack of orientation arose from a lack of explicit ownership of the service. The pilot was a CRHA pilot, not one led by Hawke's Bay. In contrast, all staff who joined NUHS learnt about the mental health programme as it was part of the NUHS service. The power of the Hawke's Bay psychiatrist also concerns the autonomy of specialist medical practice in New Zealand.

The extent to which these general practices became involved in people's mental health care varied considerably. The objectives and presence of the innovations had some influence on this but of greater significance was how the people with SOMI wanted their care organised. Some were agreeable to have general practice as their only provider, others only wanted the mental health service involved, and a third group preferred the combined service. Even when an innovation involves staff changing roles, change sometimes only happens if those who are to be recipients of the new service or have control over care arrangements, support the

change. The innovations did however result in an increased role for general practice staff in most people's mental health care. Not only were these staff accessed more by the people with SOMI, but because the staff were prepared to expand their role, the very presence of the innovation influenced a change in practitioner behaviour.

NUHS's focus was on delivering primary care, whereas the HB pilot was very much talked and thought about as a mental health service located in a primary setting. These differences reflect the variations in the source of funding and the stakeholder groups involved. NUHS received its funding from primary health and stakeholder groups came with a primary health role, while the pilot received funding from mental health and the stakeholders included mental health groups.

Over time, some of the staff in these innovations became more expert and specialised in mental health. While specialising enabled improved sector relationships it had a down side. When new staff were employed they generally had to work at a level beyond those of most who worked in general practice. The HB pilot did not manage this transition of staff as well as NUHS. How they managed the replacement of the nurse involved with the programme indicated that they appreciated the skill and knowledge in mental health required by the new staff member. This appreciation meant that the successful applicant came with considerable experience in mental health which both facilitated individual clinical management and networking. In contrast the failure to recognise the level of experience and skill of a departing GPs resulted in a "new" GP withdrawing from the pilot.

The length of time staff were in positions also facilitated clinical management and networking. This occurred in each innovative service because it allowed a workable relationship to develop. Developing these required trust and took time. Trust needed to develop among and between practitioners, provider groups and people with SOMI. In the HB pilot trust involved assurances that the pilot would continue, and if it could not, that sufficient notice would be given to it discontinuing.

In summary, the services provided on a day-to-day basis largely built on the prevailing ways each of the services worked. The innovations did result in the primary practitioners taking on an increased role in providing mental health care to people with SOMI.



## ***Decision-making***

Decision-making in developing these innovations provides some important insights into how decisions are made in the development of innovative services. In the pilot there was a decision-making tree specific to the pilot that could be traced, whereas in NUHS the basis of the decision-making had to be extracted from NUHS documentation and the interviews. This difference was because of the number and location of stakeholders involved and the purpose of the documentation. In the pilot, as there were multiple agencies involved, considerable documentation was provided to inform and share what decisions were made. This was necessary as not all those involved lived in the same city or were associated with the same organisation and were present when all decisions were made. In addition, because an aim of the pilot was to inform the CRHA regarding shared care as a service option, the rationale for decisions were usually documented so that others could learn from the experience. In contrast, at NUHS there were few individuals involved, and they were all involved with working and supporting the one organisation. This resulted in less of a need to communicate the decisions in writing as this could be done verbally. Also in NUHS, decisions were rarely made without key stakeholders being present. Table 18 summarises the similarities and differences in the direction, types and nature of decision-making between these innovations. These are important to understand as they provide some evidence regarding why and how the innovations came about and took the shape they did.

**Table 18. Similarities and differences in decision-making in the innovations**

<b>Stage</b>	<b>Decision-making</b>	<b>NUHS</b>	<b>Hawke's Bay</b>
Design phase	Direction	Bottom-up	Top-down
	Type	Simple	Bureaucratic
	Nature	Fast pace Rational problem-solving approach	Slow pace Incremental bounded rationality
Operational phase	Direction	Bottom-up	Top-down with features of bottom-up
	Type	Simple	Bureaucratic
	Nature	Fast pace Rational problem-solving approach	Slow pace Incremental bounded rationality

### **The direction of decision-making in the innovations**

The NUHS programme developed from the bottom-up in that the need for the programme and the shape it took were both largely influenced by NUHS wanting to find a way “to meet clients’ needs” (Baldwin, 1993, p.40). Although people with SOMI were not directly

involved in the design phase, they were directly involved in how the programme developed its outreach services and representatives were involved in the decisions about employing individual staff. Once the programme was up and running every effort was made by the NUHS staff to have people with SOMI representatives on the Policy Board. These representatives were consulted about this research and were interviewed as part of it. People had a voice in the programme; they were insiders to the decision-making (Maloney et al., 1994). This voice was not so much about shaping the programme, rather it concerned shaping NUHS policy as a whole.

In the HB pilot, although the initial inquiry that led to its development came from GPs, the pilot was developed, managed and controlled by the CRHA. The CRHA unilaterally made some key decisions such as the decision to appoint me as project co-ordinator. Although attempts were made to transfer control of the pilot to those in Hawke's Bay, this was only partly successful. However, there was considerable input and shaping of the pilot by the Hawke's Bay stakeholders. In particular, the consumer representatives played a key part in improving some of the operational side of the pilot such as the care-plan and the training of the GPs, the GPs influenced the need for extended consultations and after-hours services, and the CMHT the criteria and process for entry.

Who the key representatives were in the two innovations differed. Insiders (Maloney et al., 1994) in the pilot's decision-making were the CMHT, GPs, CRHA and the Health Services Research Centre. The people with SOMI and their representatives were largely outsiders until the pilot had been purchased, whereas in NUHS the insiders were NUHS staff and the community via the Policy Board. All stakeholder groups in both innovations relied on representation. In the NUHS staff and community representatives were selected by the groups they were representing, whereas in the HB pilot there was no prescription about which groups should be represented and how the representatives should be selected. Although community representation on the NUHS Policy Board initially came from those who were willing to do the job, these people were paid a stipend. The NUHS experience of representation indicates that as the needs of the service changed so too did the representatives. In the first few years representatives had come from community groups and unions, however, in the latter period people who were registered as patients at NUHS were involved. Given that ultimately consumer representatives did come on board in Hawke's Bay, it could be argued that achieving appropriate representation can take time.

In the HB pilot the initial stakeholder group came together at the invitation of the CRHA. It included people from around the Central Region. Over time, the stakeholder group developed into two, those involved regionally and a local Hawke's Bay group. The Hawke's Bay group included some GP and CMHT representatives who were also part of the Advisory Group. While consumer representatives were ultimately involved in the pilot, Māori were not. Given the high presence of Māori in the mental health services compared with the general population and what was known about the under-utilisation by Māori of general practice services the absence of representation has limited the value of understanding the applicability of shared care for Māori.

Apart from one GP, practitioners such as practice nurses and clinicians from the CMHT were initially not represented in the HB pilot planning meetings. Rather, reflecting the top-down nature of the pilot, it was a management group involving the manager from City Medical, an acting manager and the intake worker from the CMHT, a researcher from the HSRC and a manager from the CRHA. This research indicates that it was not possible in the top-down approach for the representatives to take cognisance of the needs of those at the bottom, since they could not effectively represent the views and concerns of those at the bottom.

Effective representation does not actually mean that people need to be present, rather it means that a group's interests are represented. Nobody made an assessment as to whether the representatives involved knew the status quo regarding service delivery. The findings indicate that to be an effective representative a person needs to have decision-making power and authority; have an appreciation that their personal experience is part of a continuum of experience; realise that representation is not so much about looking after one's own interests, but those of the group they are representing; and that they are able to look at services from the perspectives of other stakeholder groups. Stakeholders varied in their ability to meet these requirements. Early findings about differing definitions of what SOMI meant, and the lack of knowledge about clustering, indicated that stakeholders did not know about the current provision of services for people with SOMI. The Hawke's Bay Advisory Group expanded to include a second GP when it was revealed that the first GP did not have a large caseload of people with SOMI and questions were raised as to how well the needs of the GPs generally could be met. Significant progress in the form of putting the pilot on more secure grounds and working together to solve issues was made when the stakeholder group represented all

parties involved and when the requirements for effective representation were met. NUHS generally always had the stakeholders present that were able to make the necessary decisions.

This research indicates there is a need for training in the skills of representation. NUHS provided this training but the HB pilot did not. In the pilot it was very difficult for the consumer and GP representatives to take on this role. For the consumers this was because there was no forum for them to learn of the views of others. For the GPs the issue arose because the extent of variability in GPs' and nurses' skills and knowledge and involvement in mental health was not appreciated.

### **The type of decision-making**

At the commencement of these innovations the stakeholders involved in decision-making differed in several ways. In NUHS there were Policy Board and staff representatives, neither of whom were necessarily involved in mental health. Their role was to advise NUHS how to develop a service that met the needs of the people who used it. In the HB pilot there was an Advisory Group, all of whom had the role to advise on mental health. In giving this advice the Group members were to represent their stakeholder group and organisation's interests. These differences in representation influence the type of decision-making used.

The HB pilot used a very bureaucratic style in that decision-making involved a consultation process, was documented and involved agreement of stakeholders. Progress was mainly made when there was considerable structure in place around the decisions. In making the decisions there was generally an aspect of risk management involved. For example the need to tighten the recruitment process and to strengthen the documentation requirements were made because one of the GPs applied the criteria very loosely compared with others. The issues that people needed to risk manage were different for each stakeholder group. They were about controlling costs, ensuring workloads were manageable and maintaining access to specialist services if the pilot was discontinued. All major decisions in the pilot had to be approved by the CRHA/HFA. Ultimately, even decisions to add people to the pilot required CRHA authorisation. In contrast, decision-making at NUHS was simple. Decisions were taken to develop a service to meet the needs of people who used it, and then finances were found to fund the service arrangements. This difference was probably a result of size and of which stakeholders were involved.

NUHS worked alone in many ways. Even though NUHS aimed for shared care, it was shared care on its terms; it never had to consult with other providers about how it was delivering services. Other providers did not even know which people with SOMI used NUHS, unless the people told them or NUHS needed to liaise around an individual's care. Many of the shared care arrangements were with the psychiatrist who was working at NUHS, and those that were not were run along the more conventional GP specialist lines. In contrast, the involvement of the mental health services, general practice and other stakeholders meant that the needs and expectations of the different stakeholders had to be balanced. This required discussion on what was required, how a service should develop, whom it should serve and how it fitted into the whole. Although consumer representatives were ultimately involved in the Advisory Group, the lack of initial representation meant that the pilot did not fully understand what consumer issues needed to be addressed in shared care.

### **The nature of decision-making**

NUHS's decision-making was rational in that it was always finding solutions to a problem. It was not about "muddling through" (Lindblom, 1959); rather it had a problem solving approach, based on the aim of wanting to improve its service. NUHS was pragmatic; it acted quickly, rarely exploring options and made decisions based on what staff and Policy Board representatives considered would work, what would be "ideal" for the people who used NUHS. Although the shifts in the location for delivering part of the programme could be seen as incremental in that they were changes on the margin, the fact that the decisions were taken to better meet the needs of the people support a notion of rational decision-making – all decisions were made to support the goal of improving services provided.

In contrast, the HB pilot used a considered approach to defining the problem and developing and implementing solutions. There was usually an "analysis of alternatives" on what could or should be done (Gilbert et al., 1993; Gregory, 1989; Lindblom & Cohen, 1979). Often as there was no agreement about what the problem was it was not possible to have agreement about the solution required. This resulted in the pace of decision-making being slow. Adding to the slowness was the involvement of different agencies and practitioners. There were decisions made about whether the services should focus on people with mild or serious mental illness, and what form the service should take. The decisions made were very incremental in nature, at times there was a sense of muddling through. For example the various changes to the entry criteria. On other occasions there was evidence that decision-

making involved considering options, that is a “bounded rationality” approach to decision-making was used (Simons, 1957 cited in Parsons, 1995). For example the decision to include the component of the extended consultation was made to address the GPs needs for the innovation to target anyone with mental illness and what was known about people with mental health requiring consultation times.

The drivers of the bounded rationality were usually risk-management, the risks stemming from boundary issues. As the model of service delivery was shared care, boundary issues were integral. The CMHT had the greatest say, next to the person with SOMI, as to who could join the pilot. The reason the CMHT had this power was not to limit GP involvement, but to ensure that the pilot targeted people with SOMI, rather than those with less serious mental illnesses. Decision-making thus combined incremental aspects with bounded rationality and it did this in a particular way. This simultaneous combining of the incremental and bounded rationalist approach is different to what Hudson (1992) found in looking at changes to community care in the UK where one form of decision-making followed another.

It was also difficult in the HB pilot to reach decisions, as there was so much conflict and mistrust between the groups. Although this mistrust reduced over time, it never completely subsided. This was largely because it took time for the stakeholders to work together, and the ongoing staff changes meant there were always new relationships to form. As the pilot arose out of an opportunity and not a clear need there was not the same commitment for change by all those involved.

Decision-making in the HB pilot also involved an aspect of trial and error learning – the second form of incrementalism identified by Lindblom and Cohen (1979). As issues were identified in the setting-up phase and in the evaluation, changes were made to address them. The very fact that the service was purchased as a pilot meant the innovation was on trial. Pilots are sometimes used when there is not the confidence by the stakeholders that the model being introduced is necessarily the best way forward (Prescott & Soeken, 1989). When an issue was raised, alternatives were explored before a decision was taken. In making a decision, it was generally believed that the decision taken was the ideal solution given the circumstances and the need to balance the interests and needs of the different stakeholders. However, decisions often had to be revisited because the representatives did not have sufficient information to know how decisions taken would work for all stakeholders. In

contrast, the NUHS programme evolved, its evolution being more about meeting the changing needs of people who used its service, rather than trial and error.

The nature of decision-making used in the innovations relates to the issue of ownership. NUHS owned the innovation and was responsible for its development. Few decisions that NUHS made needed the support of outside agencies; NUHS just needed to know it was improving the services for those who used it. Ownership was easy for NUHS, because NUHS had been set up to challenge the “traditional” power base of primary health care provision. In contrast, the HB pilot from the start involved a group. The top-down approach meant that ownership rested with the CRHA. The pilot never reached the point of being the best way of doing things. If those in Hawke's Bay had the control, resources and shared will power to manage the changes earlier, some of the obstacles the pilot encountered may have been managed sooner.

The changes made to the HB pilot concerned trying to make a system work in the short and long term that maintained or improved peoples' mental health. Similarly, the decision by NUHS to begin a programme and to later seek funds also concerned making a system work. For NUHS, a workable system was one that was accessible and contributed to the health of the people who used its service. NUHS needed additional funds to make a difference, to manage its caseload; it needed to make the system sustainable in the long term.

### ***Sustainability as a goal***

What became obvious in analysing the development of these innovative services is that a driver or goal to many of the changes made was that of sustainability. Sustainability concerns developing a model of service delivery that works over time for the stakeholders involved. When an innovation is sustainable it is adopted as part of routine service. This view of adoption is different from that projected in the S-curve (see Figure 4, p.42) and outlined in the work of McKinlay (1981) and Rogers (1995) where adoption concerns the uptake of an innovation by others. Factors that are considered to influence the rate of adoption concern the attributes of the innovation, namely when it is compatible, easily adapted to existing systems and does not require additional cost or is not too complex (Mays, 1993; Rogers, 1995). The NUHS programme was adopted as routine, whereas the Hawke's Bay was not. The lack of adoption into regular use of shared care in Hawke's Bay was partly influenced by cost and complexity. It was never really tested for adaptability to existing systems partly because the

CHRA never passed the responsibility over to the CHE-mental health services, but also because there was such constant change in the structure of the existing systems over this time.

This need for and awareness of sustainability arose differently in the two case studies. In NUHS it was present almost from the start as this organisation needed to increase its patient population to survive. People with SOMI were not actively recruited, but many enrolled at NUHS. To become more efficient NUHS decided to develop a programme approach to organising some services. Given the large numbers of people with SOMI who had joined NUHS, this group was identified as one of several with special needs. Later, when the Wellington-CHE moved to expand GPs involvement in mental health care, NUHS concern changed to whether it could continue to deliver an effective and efficient service to additional people without more funding. NUHS had more people "enrolled" in its programme than they received funding for. To address these concerns NUHS started to train other staff at the service, and restrict the numbers of people being transferred to NUHS for general practice only care who were not registered with them.

The NUHS programme may have been sustainable because it met Gordon's (1996) criteria for success of a primary care development strategy. Gordon argues that a strategy or in this case the innovation, needs to

- support the work of generalists, both doctors and nurses
- manage chronic illness as an emergent condition and not a series of events
- maintain the scale appropriate to a personal care organisation, and
- incorporate the managing of networks and boundaries as part of the core business.

It met these criteria in that both the nurse and doctor not only had a specialist role in the programme, but they were also part of the wider primary care team. The reviews, assertive follow-up and the changing way staff became involved with individuals indicate NUHS managed peoples' illnesses as an emergent condition. The size of the team and having the consultant-liaison psychiatrist feedback to NUHS staff indicates that the scale of the programme was appropriate. Lastly the very emergence of the programme enabled NUHS to more effectively manage networks as part of their core business. Not only did the NUHS programme achieve on primary care criteria it also successfully addressed issues important for mental health service development. According to Greenley these include control, resources, goal setting, monitoring and feedback and a desirable interorganisational culture to "produce desired outcomes" (1992, p.376). Although NUHS finances were dependent on contract



rounds, NUHS had been able to demonstrate its use of the funding to the purchasing body. Even though the CHE had reduced the hours available for the consultation-liaison service, NUHS had stability of staffing. Systems were in place for appointments and outreach work and a process was well developed that allowed the consultant-liaison service to be efficiently used. However, NUHS could face a difficulty surviving if the programme nurse and doctor left simultaneously.

NUHS staff and the Policy Board had a commitment for NUHS to succeed; they constantly worked on improving the services provided. Staff not only believed in what they did, but also viewed that they offered a quality service that made a difference to the lives of people who used it. NUHS did not have issues in relation to the boundary. It never saw that it was developing a mental health service; rather it was developing a health service for people with ongoing needs from mental health illness.

In contrast, the HB pilot never reached the point of being sustainable. It never obtained security of resources, had cumbersome administrative systems (claims needed checking, one GP rarely submitted claims and the CRHA/HFA needed to approve who could join the pilot), the commitment to making shared care work was not shared by all stakeholders, trust between stakeholders was only starting to develop and there was insufficient information that the innovation made a difference to health outcomes. For example, the CMHT had limited information about how people were using the pilot as part of their mental health care. Not only was the pilot not sustainable, but also it did not meet Gordon's (1996) criteria of a successful primary care strategy in that the practice nurse was rarely involved in the pilot, some but not all GPs managed mental health as an emergent condition and networking and boundary management remained problematic. Similarly it did not address issues important for mental health service development in that Hawke's Bay did not have control of the pilot or of resources, while there was monitoring in place this ultimately focused more as a regulatory aspect than aiming for improvement and there was never the culture to produce the desired outcome. Constant turnover of staff in both general practice and the mental health service meant that there was no security of staffing.

A commitment to the HB pilot succeeding was lacking. Naming the innovation a pilot worked against peoples' commitment to it being sustainable. Another factor that worked against the pilot succeeding was that the stakeholders did not appear to appreciate that it was

designed to bridge the primary secondary boundary. The GPs and CMHT only saw the pilot from their side of the fence. The GPs believed that it was the CMHT that were not working towards the pilot and the CMHT considered most of the GPs were not sufficiently skilled for shared care. These beliefs were partly driven by a lack of trust.

## **Trust**

Developing sustainable services requires trust. Trust can be viewed from two levels: interpersonal and social (Mechanic, 1996). It has expectations of agency, competency, control, confidentiality and disclosure. Trust was also identified by Ayling (1999) as being important in commissioning work with GPs in the UK. Trust was evident in the NUHS programme in several ways. First, and of paramount importance, those who used the service trusted the staff who worked there. People trusted the NUHS practitioners to the extent that they would take along their intimate (mental) health needs, adhere to their advice on how best to manage their mental health and they believed that NUHS could hear and understand what they were saying. Even though some people with SOMI had not had ideal experiences at NUHS, the system had been able to address the problems. People felt that not only did NUHS address their health needs, but also their complaints were heard and addressed. The nurses, doctors and psychiatrist working in NUHS also trusted each other. The regular face-to-face contact and shared interests contributed to this mutual respect developing (Blackburn, 1999). In the main there was also trust from other provider organisations. There was an environment where there could be disagreement, as practitioners and people worked through the best course of action for individuals' care and treatment. NUHS was not dependent on the acceptance and trust of other providers. Some worked closely with NUHS, while others didn't. Those who didn't appeared not to do so, by choice.

In contrast, there was limited trust in the HB pilot. Although many people with SOMI trusted the individual practitioners they worked with, they did not all trust shared care. There had been several experiences where the shared relationship had not worked, where people had received conflicting advice and information. This conflict and difference in information partly concerned the lack of trust between the two provider groups. The CMHT only trusted some of the GPs on the pilot, others were considered to be in it "for the money". There was a general lack of trust in the level of skills the GPs had. Although some areas where skills were considered limited were picked up in training, the evaluation identified other areas that needed addressing. The pilot had no mechanism for ongoing training to address these. This

meant that when there were changes in personnel there was no training in place to maintain or upgrade skills.

Trust takes time to develop. The turnover of mental health staff meant that there were few occasions when there was stability of staffing to build a trusting relationship. When there was stability and the commitment by those present to make the pilot work, considerable progress was made. Trust comes from working together, from talking. Shared training programmes and meeting and working together helped this. Trust between providers and between practitioners and a person with SOMI partly comes from knowing that the service is making a difference in improving health outcomes.

### **Creating effective service delivery arrangements**

This research revealed that providing effective service arrangements (i.e. accessibility, acceptability and so forth) also influenced adoption. From the information gleaned NUHS appeared to be fairly effective in all of these areas, with the exception that some providers did not really accept their service. For example by developing outreach clinics it created a more accessible and acceptable service. It took the opportunity to provide a more comprehensive and co-ordinated service by having a CHE-mental health psychiatrist run a consultation-liaison clinic. Through the use of the nurse the service was more efficient and the effective across a number of areas.

NUHS had mainly anecdotal examples of its service being effective in all three areas of health outcomes. The audit of records showed that some people's episodes of ill health were effectively managed, and some experienced an improvement in their health. People interviewed reported how NUHS had made a difference. NUHS staff also had stories where they contributed to making a difference. There was evidence that it was effective in meeting consumer outcomes of choice and input into decision-making around care arrangements. People felt that decisions made about their care were made in consultation with them and their views were included in the decision-making. People generally decided how often they needed to see the staff at NUHS. NUHS was efficient; it managed a large caseload on limited funding. It had evidence through stories, of keeping people out of hospital; it managed not to refer some people to the mental health service because, with the support of the consultant-liaison service, it could manage people at NUHS.

However, in the HB pilot there were few areas where it could be argued that effective service delivery arrangements had been established. There were unresolved issues concerning accessibility, acceptability, accountability, co-ordination, efficiency and effectiveness. There was some sense that having shared care had created a complementary service in regard to general and physical health, but nothing more.

The formal evaluations of the HB pilot provided considerable information to assess its contribution to health outcomes. This information showed that the pilot did not make a difference to health status; it did however, lead to a change in health service utilisation. Those who were in the pilot two or more years were shown to require statistically fewer outpatient services than the control group (Nelson et al., 2000). The interviews with people indicated that for some, the pilot improved their health status, their service utilisation and their consumer outcomes. However, there were also reports of service duplication, of deterioration in health status and of lack of choice regarding appointments. Although the positives in terms of both frequency and severity outnumbered the negatives, the negatives were of a magnitude that they worked against the pilot being sustainable. This may have been because the pilot and the evaluation were purchased with the intention of informing Central Region policy. Because of this Central Region focus the evaluation placed considerable emphasis on what was working well and what was problematic.

### ***Conclusion***

The involvement of general practice through the development of the NUHS programme and the HB pilot were innovations in the expanded role of general practice working with people with SOMI. The innovations came about because of a combination of international, national and clinical factors that were triggered by local features and events. Local features and events were not only important in determining when the innovations started, but were also in shaping the innovations. The innovation at NUHS was bottom-up whereas the pilot was top-down. These directions impacted on who and what was involved in shaping the services. Although individuals played a key role in shaping the innovations, the goals of NUHS to better meet the needs of people using a service and the pilot to develop shared care to inform future purchasing by the CRHA meant the innovations developed differently. Findings from evaluation played a far greater role in shaping the pilot than it did in NUHS.

A key to how the innovations took shape concerned sustainability. An underlying goal of an innovation in service delivery is to develop sustainable services. Developing a sustainable innovation occurs incrementally – individual components of an innovation being modified as problems arise. The nature of service delivery is such that improvements are always being sought. Sustainable services are those that have a sense of permanence about them, that is, the model becomes endorsed as an acceptable model for routine service delivery. The NUHS achieved sustainability because it had security of resources, had a commitment to the service it provided, developed trust and achieved some positive, albeit limited health outcomes. In contrast, the HB pilot because of its lack of control, changing staff, and pilot status does not appear to be sustainable as it failed to provide services that were accessible, acceptable, coordinated, efficient and effective to the satisfaction of the key stakeholders. NUHS achieved this level of satisfaction. The next chapter discusses issues raised by these innovations concerning delivering services in New Zealand.

## **Chapter 9 – Developing primary health services for people with SOMI**

The experience of these innovative services which involved general practice providing services for people with SOMI highlights issues in funding, targeting and practitioner skills in developing effective service delivery arrangements. This chapter discusses these issues as well as the ability of these innovative services to provide acceptable, assessable, co-ordinated, complementary, efficient and effective service arrangements. According to the MoH (1997a) both the HB pilot and the NUHS programme were experimental pilot services. Although, the NUHS model was seen as atypical by the CRHA, and not suitable to replicate, it is likely that as capitation becomes the preferred mode of funding general practice (and Primary Health Organisations become the dominant structure for primary health services) this model of delivery will be reviewed by those involved in developing primary mental health services as an efficient and effective way to deliver such services.

The chapter is divided into five sections. This first provides a summary of the similarities and differences in the service arrangements. Sections two and three discuss the implications of the funding arrangements and address issues of targeting. Section four discusses issues pertaining to the services provided and the final one discusses issues involved in establishing effective primary mental health services.

### ***The features of the innovations***

The two innovative services involved expanding the work of general practice to better meet mental health needs. Although they had design features that would help anyone with mental illness, the focus of each innovation targeted people with SOMI. The features of the NUHS programme and the HB pilot are summarised in Table 19. In respect of funding for example, GPs in the pilot were paid for each item of service they were involved in, whereas in the NUHS programme the capitation arrangement only provided for consultations. In both services people with a mental illness that was less severe or of limited duration were able to consult with the doctors and nurses. In the HB pilot GPs were paid for some of these consultations, while in NUHS no specific cover was provided. Although initially envisaged to be a small part of the pilot (up to 4 consultations a month), given the low number of people with SOMI in some general practices, these extended consultations were a big part of some GPs' claims. In practitioner roles, the nurse in the NUHS programme, unlike the practice nurses in Hawke's Bay had developed a separate, but interdependent role with that of the

doctor. In the care provided there was more regular involvement with the mental health service in the NUHS programme than the pilot. This involvement came via the consultant-liaison service. There was also a difference in how care arrangements were decided. In the pilot, formalised shared care plans were developed for all people, whereas NUHS only developed formalised plans for some people. There were also different interpretations as to what constituted a consultation. In the pilot, some doctors claimed a consultation fee even if it was a three-minute call, while others did not consider short telephone calls were consultations. Not all phone calls counted as a consultation at NUHS.

**Table 19. Similarities and differences in the innovations**

	<i>NUHS programme</i>	<i>HB pilot</i>
<b><i>Governance</i></b>	NUHS Policy Board	CRHA with Advisory Group
<b><i>Funding</i></b>	Off-set co-payment to see the GP; capitation based on consultations	Off-set co-payment to see the GP, fee-for-service, several items of payment
<b><i>Target group</i></b>	Mainly people with SOMI	Mainly people with SOMI
<b><i>Training</i></b>	Informal, available for doctors and nurses	Mainly formal, targeted to doctors
<b><i>General practice staff involvement</i></b>	Mainly one of 5 GPs and one of 5 nurses, but others could be involved. Nurses' role separate, yet interdependent with doctor	12 GPs at 10 practices. Four of the practices utilised nurses. Nurses' role mainly dependent on the doctor
<b><i>Mental health service involvement</i></b>	Regular consultant-liaison clinic; regular liaison with multiple mental health providers	Intermittent consultant-liaison input; variable patterns of liaison with mental health providers
<b><i>Location of service</i></b>	Service involved mix of surgery and outreach work, and some after-hours work	Majority of the service was surgery based, some after-hours work
<b><i>After-hours</i></b>	At NUHS rooms, by NUHS doctors or nurses	At City Medical after-hours rooms, by any City Medical GPs
<b><i>Care decisions</i></b>	Formalised care plans for some people	Formalised care plans for all people
<b><i>GP involvement in mental health</i></b>	GP-total care to shared care	GP-total care to shared care to GP-basic care

### **Time and trust needed in developing innovative services**

Co-ordinated and complementary care needs trusting relationships. The trust required in these innovations was multidimensional and reciprocal. It was required to develop between the person with SOMI and the practitioners, and between the services. According to O'Neill (2002), trust is accompanied by risk, fear, rights and accountability. Developing trust appeared easier at NUHS where the programme was seen as an integral feature of the range of services provided compared with the HB pilot where it was seen as an optional extra that carried risks. The very presence of the pilot resulted in some people being prepared to try

something new. It enabled them not only to rely on the CMHT for mental health services, but to also utilise the GP. This required people with SOMI to trust the skills and knowledge of the GP and practice nurse.

One of the reasons such people came to trust these innovations resulted from changes in the doctor and nurse patient relationship. In NUHS this was most noted in respect of the outreach service, which required the health practitioners to work off site. In these circumstances traditional power and status of health workers is challenged and changed. Some people in the HB pilot reported a similar change in relationship power. As a result of the pilot, they reported that GPs were more interested in them and heard what they had to say. Pilgrim provides an insight into these altered relationships. He considers that in the future "the power of each of these interest groups [clinicians, managers, users] will interact to determine the types of priorities that come to prevail in the organisation, distribution and delivery of services and resources to those with mental health problems in society" (1993, p.175/6). This change in relationship required practitioners to learn how to facilitate people with SOMI to play a key role in their health management (Miles & Goetz, 1999).

Trust between the GP and CMHT was needed at both a service and clinical level. At a service level there appeared to be limited trust generally by managers and practitioners from the mental health service of either the NUHS programme or the HB pilot. In Hawke's Bay the CMHT were wary of some GPs motives for being involved. However, with the exception of a couple of GPs in the pilot, the CMHT members in both Hawke's Bay and Wellington appeared to trust the GPs' clinical work. Similarly, the GPs in both innovations were highly critical of the actions generally of the mental health service. According to Paxton (1995), both the GP and the CMHT nurse consider that they know the person with SOMI best and, as such, should be involved to guide and direct the care for a person. The lack of trust and respect between the CMHT and the GPs is a carryover from the competitive mode of the early 1990s, and a sign of professional rivalry (Flynn et al., 1995). The CMHT nurse, prior to the reforms of the 1990s, was often the only health professional in contact with people with SOMI in the community setting, and was considered to be the backbone of community mental health (White et al., 1997). While this contact role had started to change as a result of community care, these innovations sped up this process. However, this raises an issue of responsibility in relation to the clinical and legal boundaries in proving shared care. These issues have arisen because there is no mandate as to who has over-riding responsibility in the



relationship between specialist and generalist. More research is needed to define these clinical and legal boundary issues regarding patient care.

In spite of this lack of trust and respect at a provider level, reports from the people with SOMI indicate that clinically practitioners from the primary and specialist services were often able to work together. However, this was not always easy since developing trust and respect was hindered by the constant turnover of mental health staff. Some people with SOMI liked these innovations because of the stability of the general practice staff. Although nursing staff did not turn over at the same rate as psychiatrists, the way their work was organised did change. The re-configurations of CMHTs in Wellington and Hawke's Bay, and the staff turnover, meant that general practice staff almost continuously had to focus on forming relationships with new CMHT members and orient these staff to the innovative services. If integrated care is to happen, more needs to be done by mental health services to support such integration. Ideally, this could mean mental health services case allocation being based on general practice or PHO registration of a person, rather than the current system of case allocation where those with the room take on the care of a person (as in Hawke's Bay) or people are allocated by geographical location (as in Wellington). If this change in case allocation were to happen, the development of closer relations between GPs and CMHTs would have a better chance as the same practitioners would meet on several occasions. Improved relationships between practitioners would ultimately contribute to improved co-ordination and a culture change. For example, there are developments in Australia (Sharrock & Happell, 2001) and in New Zealand (Rodenberg et al., 1998) that have given nurses from mental health services specific responsibility to liaise with general practice.

### ***Funding arrangements***

Funding of health, especially of general practice in New Zealand is very complex. Briefly, how this funding works for an individual varies depending on a person's age, their need to access general practice, their personal income and the specific funding arrangements the general practice has with the government. Each of these innovations needed to address the following questions regarding funding.

- i) Did the innovation require additional funding?
- ii) Where should the source of additional funding come from?
- iii) How or what form should the funding take?
- iv) To whom should the funding go?

v) What should the funding purchase?

A summary of the answers to these questions is provided in Table 20. As the purpose of this chapter is to comment on service delivery, a discussion of the Disability Allowance (DA) alongside the decisions made by the innovations is provided. The DA provides an alternative for part funding the co-payment (the largest component of each of these innovations) of the GP consultations. The DA is a discretionary benefit available to people on a low-income who have costs associated with ongoing illness or disability.

**Table 20. Description of funding arrangements**

	<i>NUHS programme</i>	<i>HB pilot</i>	<i>Disability Allowance</i>
<b>Payment source</b>	Primary health funds from Vote Health	Mental health funds from Vote Health	Discretionary benefit from Vote Social Welfare
<b>Benefit type</b>	Kind Discretionary	Kind Discretionary	Cash Discretionary
<b>Payment type</b>	Capitation funding	Fee-for-service	Payment weekly
<b>Payment amount</b>	Limited - As per High User Health Card rate of \$220 per year per person	Open-ended	Maximum payment in 1999 was \$45.65 per week. Individual's rates varied, based on need and record of past utilisation
<b>Payment to</b>	NUHS service	GPs	Person with SOMI
<b>Payment follows</b>	NUHS service	Person with SOMI in limited circumstances	Person with SOMI
<b>Payment funded</b>	Full co-payment cost of GP consultations for mental health	Itemised rates for: GP consultations, liaison and training, extended & after-hours consultations, and completing evaluation	Individualised for each person. Where GP consultations payment designed to only partially offset GP co-payment rate

When the NUHS programme started it did not require additional funding, it provided the service from its general contract. It was only after the programme had grown that in order to sustain it additional funding was required. This approach to funding (after development of the services) reflects the bottom-up nature of how NUHS worked. In comparison, the HB pilot would not have started without funding being available. Mechanic reported that funding "arrangements can be strong stimuli for increasing underdeveloped services such as psychosocial rehabilitation ... or for directing attention to neglected groups of patients" (1991, p.801).

## **Funding and the shape of the innovations**

Although both innovations were purchased by the CRHA, there appeared to be little, if any discussion between the Primary and Mental Health Groups that purchased the initiatives. Historically, the mental and primary health system developed as if separate or isolated systems. This isolation has resulted in both sectors working alone to create solutions, rather than working inter-sectorally. If the Primary Health Group had been involved in an advisory capacity with the pilot some of the problems encountered might have been avoided.

The sources of funding can affect the accountability mechanisms and standards of service delivery required. Those funded through mental health for example, have a series of mental health standards (MoH, 1997b) and more recently an expectation of competencies that practitioners should meet (MHC, 2000). General practice does not have a national framework for standards; individual practitioner groups have their own professional accountability structures. However, Health Care Aotearoa launched the Te Wana Quality Programme in 2001 for community-based organisations<sup>35</sup>. The NUHS organisation has received accreditation under the Te Wana standards. One of the issues to be addressed at a government level is whether general practice-based services in mental health should be required to meet the mental health standards and competencies.

The type of funding each innovation received matched the existing funding arrangement the services had before the introduction of the innovation. Although it was 'new money' it was given in a way that matched the traditional staffing roles, thereby reinforcing the current way the services worked. That is, all the money that went to the general practices in the pilot was directed at funding GP activity, and the capitation arrangements for NUHS were based on a formula derived from GP consultations rates. As a consequence, the HB pilot arrangements focused on the work of the GP, while NUHS was able to develop the doctor and nursing role.

In the NUHS programme it was the provider who received the payments, whereas in the pilot it was the GP. In the pilot the funding followed the person to the GP, whereas in the NUHS programme, the funding went to the programme irrespective of which people with SOMI were enrolled. NUHS was however, expected to provide evidence of funding use. In contrast, the DA is a cash benefit given to the person. This means that people have a choice

---

<sup>35</sup> The values underpinning the Te Wana programme are: Te Tiriti o Waitangi, community governance and participation, collaborative teamwork, continuous quality improvement, health promotion and social justice (Health Care Aotearoa, 2003).

in how their DA money is spent. It also means that people on the DA have no difficulty in changing general practices. If people left NUHS they had to pay the co-payment to see another GP, and unless Hawke's Bay people changed to another GP in the pilot, they too had to pay if they changed GPs.

A component of both innovations was that people who met the criteria for entry could see the GP without having to pay a co-payment. The NUHS programme had this component imposed on them by the CRHA, whereas in the HB pilot it was a feature from the start. There was no systematic analysis by the CRHA of whether cost was the only barrier for people with SOMI accessing general practice; rather, it was assumed barriers were about cost. If a systematic analysis of access issues had been undertaken, it would have been appreciated that the problem was more complex than cost. Countries such as Australia and the UK, where there is not a financial barrier to seeing the GP, were also involved in developing innovative ways of increasing the role of general practice services for people with SOMI (see e.g. Meadows, 1997; Royal Colleges, 1993). An analysis would probably have asked why the DA, already available to offset the cost of accessing general practice, was not working. Even when it became apparent through the pilot evaluation that the funding arrangements impacted on, and duplicated the DA there was no real attempt by the CRHA to look at the DA. NUHS staff were aware of the DA, they managed this knowledge by not including GP consultations on people's DA applications. However, there continues to be a lack of analysis of how the DA works for people with SOMI.

The lack of knowledge about the DA by the Advisory Group may have been because of the amount of restructuring within the health services or it could be that just as mental health and primary health operated separate systems, so too did health and welfare. Awareness of the DA came by chance when the researcher presented the work in progress of the HB pilot with a group of first year social policy students<sup>36</sup>. Apart from the relevance of the DA to accessing general practice, the experience highlights the need to share with a diverse range of stakeholders, details concerning innovations in service delivery at the development phase. An analysis of the DA may also have avoided a duplication of payment in health. Supported accommodation providers receive maximised rates of the DA for their residents, from which they are supposed to cover people's primary health needs and care costs. Not appreciating

---

<sup>36</sup> A student challenged that the pilot was duplicating an existing funding arrangement, and subsequent investigation revealed this to be correct.

this obligation to fund GP visits, meant that the pilot enabled the supported houses to use some of the DA funds for other purposes.

By not using the DA, the HB pilot and the NUHS programme cost-shifted from Vote Social Welfare to Vote Health. This occurred because these innovations duplicated and ultimately replaced what the DA was supposed to do<sup>37</sup>. Other researchers investigating changes in mental health services have reported instances of cost shifting care onto other providers (Cuffel et al., 1996). Paying for all consultations as occurred in the HB pilot also effectively meant that money targeted for mental health services was now being spent in general health. This raises an issue regarding how integrated care is to be funded in New Zealand. At the time of this research specialist services were purchased in speciality areas such as renal health, mental health and so forth. More recently, under the DHB structure, DHBs are expected to provide services that meet the needs of their community<sup>38</sup>. One of the intentions of this revised structure is to facilitate integration. How the DHBs will achieve this integration is not yet clear as many contracts were rolled over from the HFA. General practice does not work with such boundaries, nor does it usually utilise a mind-body dualism. When someone is seen for a consultation, even if it is for physical reasons, a person can be assessed from a psychosocial framework (Pilgrim & Rogers, 1999; Schmidt-Posner & Jerrell, 1998).

Unless primary health care becomes free of co-payments – a very small possibility under the current primary health care reforms (MoH, 2001) – it is time to consider whether the DA could be used in a different way. This is important because over time, New Zealand has incrementally increased the number of groups who receive targeted GP care. While children under six years of age and pregnant women have national coverage for targeted access to GP care, there are isolated schemes, each targeting groups with special needs (e.g. people with diabetes, asthma or a terminal illness) scattered throughout New Zealand. If the current primary health reforms do not provide for free GP care, the government should consider exploring whether to set up one system for all such targeted groups and those on the DA. A national system would go some way to address equity issues. Advantages of building on the

---

<sup>37</sup> As an aside, as a result of the release of earlier findings regarding funding issues (Nelson, Cumming, Duncanson et al., 1997) and discussions with others involved in setting up programmes, some new programmes have decided to work with the DA as the main source of funding general practice shared care initiatives (Linkage, c.2000; Nelson et al., 2003).

<sup>38</sup> In meeting these needs DHBs must aim to have people on waiting lists for outpatient appointments and surgery for no longer than six months. Volume contracts in regards to the expected number of operations, new patients seen are part of DHB's contract with the MoH.

DA are that it is already a benefit in place, a system could be developed which could simplify some of the issues that those on the DA and general practice has. The DA would still be required for other items such as transport or home help. As the DA is paid directly to the person, they are free to make a choice about which practitioner they see, and how they actually spend their allowance. Another advantage of removing the issue of funding GP consultations is that it would enable greater focus to be placed on overcoming the non-structural issues that these innovations encountered such as attitudes, skills and knowledge. The disadvantage of the DA is that those on higher incomes would not be eligible, but in that these innovations target low-income groups, this is perhaps not a major issue. However, any change would need to address access, take-up and reach issues that are problematic for discretionary benefits (Craig, 1991; Huby, 1992; Huby & Whyley, 1996; Moore et al., 1998; Noble et al., 1997).

The payment systems impacted on the infrastructure requirements. For example with the fee-for-service arrangement in the HB pilot, GPs were required to submit monthly invoices, whereas there was only one transaction required in NUHS. Administering the pilot was complex as there were itemisation and payment rates for each pilot component and the contracts also capped the number of claims a GP could make. As there was considerable variability in GPs' claims attention was placed on monitoring, with increased rules being required to limit the levels of payment.

Funding using a fee-for-service model meant there was no incentive to develop the practice nurse's role in the HB pilot. In addition to its philosophy, capitation funding provided NUHS with an incentive to expand its service beyond GP consultations. The NUHS experience suggests that when the nurse in general practice is involved in working with people with SOMI, the nurse is well received. Recent solutions to primary mental health in the UK push for the development of the nursing role (Cohen, 2003) and Jenkins and Sullivan-Marx (1994) argue that nurses are ready to become the backbone of a co-ordinated, community-based health system. An advantage of the increased involvement of the nurse is that services are more likely to meet the changing needs of people. In NUHS the work of the nurse was integral to the success of the programme. Opportunities for the expansion of the nursing role in primary care are now possible given the announcement in 2002 that seven million dollars have been allocated for this (MoH, 2002). There is concern regarding the low number of doctors joining general practice, and solutions involving other practitioners need to be

developed in order to take on some of the increased primary care workload (Pederson & Leese, 1997).

### **Issues arising out of the funding arrangements**

The problems of locating the payment with the GP (Hawke's Bay) and the practice (NUHS) rather than the person came to the fore when GPs went on leave and when people or GPs left the service. In the NUHS programme any doctor could see any person in the programme, whereas in the pilot, with the exception of after-hours, it was principally the pilot doctors that could claim the consultation fees. A case had to be made for locums to lodge claims when working for one of the GPs in the pilot.

When people left NUHS and enrolled with another practice they had to revert to paying the co-payment to see their GP. Depending on the numbers leaving, NUHS could also lose some funding. The HB pilot also had the difficulty that when people left they could not get free access to a GP, unless they went to another GP on the pilot. That is, if people wanted free access, they were restricted in who they could use as their GP. When GPs left the area and "sold" their practice caseload, a different problem emerged. The new GPs did not necessarily have the skills required to work with the people with SOMI. No ongoing training was available, and support from the mental health service for the GPs who took over caseloads was not always forthcoming. While repeated training for GPs has been shown to be important in regards to maintaining a level of assessment with depression (Rutz et al., 1992), these innovations suggest ongoing training is also important because of the turnover of personnel.

These innovations differed in who or what the funding followed. Gordon and Plamping (1996) in referring to the UK where funding is largely by capitation, argue that one of the difficulties bringing about change in general practice is that the incentives and levers for change are all directed through a contract with the individual (the practitioner) rather than the organisation (the practice). One of the reasons NUHS successfully brought about change was that NUHS, as a provider, was contracted to deliver a service to people on low incomes. When the additional funding for mental health came, this was also given at an organisational level. In contrast, it was individual GPs who were funded in the HB pilot, the payment being for GP activity.

### *Targeting people with SOMI*

Targeting people with SOMI in a general practice setting using diagnosis, duration, health status and financial status as criteria raises a number of issues for consideration. Both innovations utilised similar diagnostic criteria as a way of targeting people. The advantage of using such diagnostic schemes is that there are “shared” understandings about the diagnoses. These understandings have largely been developed and refined in psychiatry through the diagnostic classification systems such as DSM IV (American Psychiatric Association, 1994). Resources based on DSM IV are now available for primary practitioner use (Pingitore & Sansone, 1998). There are however, a number of limitations of using diagnosis criteria, not least being that a person’s diagnosis can change over time. Secondly, diagnosis does not indicate the severity of the problem as many illnesses, for example, depression can vary in their severity. Mild forms of illness often have limited duration. These innovations overcame this limitation by also having a serious criterion, defined as contact with the mental health services. Service use however, is not necessarily indicative of severity; rather it reflects “patterns of use ... during a fixed period of time” (Tansella & Ruggeri, 1996, p.161). Use can be influenced by factors such as a person’s socio-demographic characteristics, personal supports, relationships with professionals, resource availability and criteria for service access. Using criteria of serious and ongoing mental illness was problematic in both innovations. In the HB pilot until the entry process was tightened, differences in understanding meant that the level of seriousness required to join was not evenly applied across the pilot. While NUHS also focused on providing a service to people who had a serious and ongoing illness, it was also able to cater for people whose illness was either serious or ongoing.

The basis for determining whether a person had an ongoing illness was the person’s history of mental illness. The disadvantage of the 6-month time frame used in the HB pilot is that it works against people who are newly diagnosed with mental illnesses such as schizophrenia or bipolar disorder; disorders which usually last for the long term. O’Connor and Willcock (1997) argue that the earlier the involvement of the GP in the care of people with complex mental health issues the better. They considered that if GPs are involved when people are newly ill there is a better basis for developing shared care. Because NUHS could include existing clients on its programme they were able to work with people in the early stages of illness.



Using ongoing illness as a criterion may also work against the concept of recovery as a person may wish to retain the benefits of being on a scheme, and to do this they have to accept that their illness is ongoing. The fourth criterion of having people on a low income was also problematic as mental health staff and GPs are not necessarily in a position to assess income status. Even at a governmental level there are difficulties with such assessment as the income criteria applied to different benefits varies (Boston & St John, 1999). Health practitioners do, however, see people experiencing financial hardship. It was on this basis that the CMHT staff in Hawke's Bay requested a change.

In addition to the difficulties developing these criteria, one consequence of targeting in the general setting is that the innovations are counter to the national policy on discrimination (MHC, c.1998). This policy states people should not be discriminated against because of mental illness. Discrimination because of mental illness had been shown to be delay people seeking assistance from mental health services and impede recovery. Nonetheless, it can be argued that the targeting in these innovations was warranted because it was out to improve the overall services available to people.

### **Determining an individual's eligibility and entry into the innovations**

Having established a range of criteria is only one aspect of determining eligibility; another is who decides who is eligible. There were two steps required for people to be able to access the services. First they needed to enrol at one of the GPs in the HB pilot or at NUHS, and second they needed to be identified as eligible for the targeted services. In each of the services people could independently take the first step, however, it was practitioners who had control of who climbed the second step. In the pilot there were no restrictions on who could join a general practice, however, in NUHS people had to meet criteria such as living locally and receiving a low-income. Once enrolled in the NUHS service, it was the general practice staff who decided who was eligible for the programme, whereas in the pilot it was the CMHT. In making the decisions NUHS staff were conscious of the need not to overly represent their case, but at the same time to provide access to all those who needed it. When the GPs in the pilot were able to recommend people from their practice whom they considered met the eligibility criteria it was found there were differences in understanding amongst the GPs and between some GPs and the CMHT as to what was a SOMI. Given that this difference in interpretation was mainly between the GPs with the smaller case loads, the explanation for this different understanding is likely to be a reflection of the extent of the GPs involvement

with people with SOMI. It is, however, possible that what is a SOMI in a general practice setting may differ from that in a mental health setting. De Gruy suggests that in primary care there can be “intractable problems [that] do not fit into the DSM nosology” that may need mental health involvement (1999, p.35).

This setting difference in defining SOMI may explain why some GPs in the HB pilot attempted to enrol people who did not meet the CMHT’s criteria of serious and ongoing mental illness. Another explanation could be that the GPs were out to maximise their returns. By enrolling people in the pilot, the GPs were eligible to receive additional payment. Payment arrangements between fee-for-service and capitation have been argued to impact on service arrangements (Cumming & Mays, 1999) as they can provide incentives for how practitioners work (Barnum et al., 1995).

By having the CMHT make the decision as to which people were eligible for the HB pilot, there was a reversal of the traditional gatekeeping role that happens in health – the secondary service restricting access back to the primary service. This gatekeeping highlights a difference in the GPs’ role in mental health compared with other specialist services. People do not have to access mental health services via the GP; they can go there directly. A disincentive for the CMHT to transfer clients to general practice is that their services are purchased and funded based on the number of client contacts. Transferring clients could mean that the CMHT may lose contact numbers, thereby threatening the viability of their service. Transferring clients to GP care has also been reported to raise the level of acuity of the mental health service caseload (Rodenberg et al., 1998).

People with SOMI were not directly involved in the decision to be in the NUHS programme; this came about as of right through their enrolment at NUHS. However, in Hawke’s Bay people had to formally consent to join. Some people declined to join, as they were not confident that general practice would be able to manage their needs over time. This raises an issue regarding people’s right to choose to stay in specialist services, and the specialist service’s responsibility to discharge where possible people back to general practice. If efficient services (i.e. the best use of resources) are to be developed people with SOMI may not be able to have a choice; rather the decision may need to be based on the health status of the person with SOMI and the skills, expertise and availability of mental health and general practice practitioners.

Another reason some people declined to join the pilot was they did not trust that they would readily be able to re-access the mental health services if they needed to. This raises an important point about the move to general practice-based care. People believed, and were personally aware, that once in the mental health service they had more timely access to mental health practitioners than those who were not in the service. Given the episodic nature of mental illness ongoing access is clearly an issue.

### **Exit criteria may be needed**

NUHS had a process to review an individual's eligibility, but Hawke's Bay did not. The reasons for the NUHS review were to check if anyone needed to be followed up, and purportedly to assess eligibility to the programme. NUHS had a category of people who had mental illness, but who were not eligible for the programme because the illness was not of an ongoing nature. As there was one person who was recorded as not being seen at NUHS for four years it would indicate that the review system needs some refinement. Since there was no review of eligibility in the HB pilot it had the effect that when people joined they could effectively remain in the pilot indefinitely. The long-term consequence of not reviewing eligibility (when funding comes from the mental health sector) is that mental health funding could gradually move from mental health services to general practice. This move could mean that the funding may not continue to be spent on the 3% of the adult population with serious mental illness as people on the pilot recover. Other developments in primary health have seen services gradually move from catering for those with serious illnesses to providing services to those with less severe mental illnesses (Rohland et al., 1999).

Nonetheless to implement review and subsequent exit criteria is problematic. People would still need to access general practice for mental health. The situation would arise where one day the service was free of co-payment requirements and the next day there would be a cost. This could create an incentive for people not to recover but to remain in the sickness role<sup>39</sup>. Unless GP visit become free of co-payment costs, other solutions need to be found to address this issue. One possible solution is to have a step-down phase where people have a specific time in which they are advised that a change is being made. The DA could be reactivated to cover GP consultations during this phase. This step-down phase would however, merely delay the problem.

---

<sup>39</sup> According to Parsons (1978) and others (Shilling, 2002) by adopting the sick role people can be exempt from ordinary daily obligations and responsibilities.

### *Services received as part of the innovations*

Once eligible, there was not always clarity around what enrolment in the innovative services people were entitled to. The rules were not transparent, nor were they consistently applied in either innovation. In both services some people were charged co-payments for some visits; mainly for consultations for physical health needs. These charges were made because of a confusion regarding entitlements, and doctors' beliefs about the role of payment. To avoid confusion when system changes are made it may be necessary to inform all stakeholders (e.g. written material to GPs and people) to outline such changes. That is, there needs to be clear messages regarding eligibility and entitlement that everyone is aware of.

The change as part of these innovations was that there was a requirement, and not just an expectation for general practice and mental health services to work together. The HB pilot GPs were paid to develop this relationship, whereas the cost of liaising had to be met out of the capitation payment in the NUHS programme. In the pilot with one exception this relationship developed at both the managerial and practitioner level – not all psychiatrists got in behind the pilot. However, when the psychiatrist was actively involved increased progress in developing shared care was made. This happened because it was the psychiatrist who had the authority to create change in practice such as setting up liaison visits and changing repeat medication management.

There was no one pattern of the clinical services received by the people with SOMI in either innovation. Although they had different structures, many services provided did not differ significantly in that each was involved as the sole health provider in delivering general and mental health services to some people, while for others this role was shared with other providers. Differences were in who provided the services, how care was arranged, and the level of service individuals received.

The GPs' roles in both case studies were similar, but the nurses' roles differed. GPs' roles included management of physical health problems, managing medication, assisting with social issues and providing day-to-day support. The GPs with larger case loads in the HB pilot were as extensively involved in mental health as the GP in NUHS. These practitioners also worked closely with specialist services and appeared to have a clear understanding of when to consult with and to involve mental health practitioners. People with SOMI felt they could trust these practitioners with sensitive information. Not only did they find some

practitioners more trust-worthy than others, they also found that some practitioners addressed their needs better than others. Several of those who changed GPs during the pilot commented on the attitude of the doctor.

In Hawke's Bay only some practice nurses were involved in providing mental health care, and this involved very few people. However, at NUHS the involvement of the nurse was extensive, and involved most people on the programme. Their role included assessment, physical health maintenance, providing day-to-day support, supportive counselling, health promotion and prevention activities and assertive follow-up. Unlike the usual public health focused assertive follow-up undertaken in primary care (e.g. immunisation, cervical smear screening), the assertive follow-up focused on checking the well being of a person. In this regard the follow-up was more attuned to mental health than general practice.

The NUHS programme demonstrates differences in the roles and skills of GPs and practice nurses. These are worth noting as it emphasises the uniqueness of the NUHS programme. The supportive counselling given by the nurse differed from the kind of support given by the GP because it was generally structured around addressing specific health issues such as reducing stress. It often involved life-skills management whereas the GP was more expert in disease management. While similar in some regards to the counselling provided by the CMHT nurses, it differed in that it also addressed general health issues. Because of the nurse's role there was flexibility at NUHS to manage a person's changing needs. The service using the consultant-liaison clinic was able to facilitate people with SOMI seeing the right practitioner, in the right place, at the right time with considerable more ease than that in the HB pilot.

Staff turnover in the mental health services, especially that of the psychiatrists, influenced why some people preferred to have their mental health care partly or totally managed by general practice staff. Mental health staff attitudes played an important role in why some people's care moved to increasingly involve general practice. It was mental health nurses that encouraged people to enrol at NUHS and to engage and work with the HB pilot. A key to a positive attitude forming was trust.

### **The skills required in innovative primary mental health services**

In determining the training needs required in the HB pilot, there was no assessment of existing care arrangements and no consideration given to what additional skills and knowledge would be required for shared care to develop. There was a lack of appreciation, that in the main, it was the nurse in the CMHT that worked with and supported people with SOMI to keep well. People only saw the psychiatrist intermittently; the psychiatrists generally depended on the CMHT nurse to determine when input was necessary. It was also not appreciated that skills required by GPs and nurses to work with people with SOMI are more than clinical management; process issues are also particularly important (Nelson, Cumming, & MacEwan, 1997). It was apparent from the people with SOMI that those who had a particularly positive experience acknowledged this when the GP's frame of reference went beyond "the clinical model". That is to say when it incorporated other aspects of a person's life such as their family life and work. Establishing working relationships concerns language, communication, roles and responsibilities, meeting the rest of the team and understanding how the team works. It involves for example, teaching doctors to "relinquish their traditional control over the medical encounter in favour of a more egalitarian relationship with patients" (Parry & Pill, 1994, p.17), it is about teaching awareness of ongoing assessment and review. Such practice is very important for developing shared care, which involves GPs moving from working solely to being part of a team. Who delivers the training can contribute to this process.

Using training specialists from out of town, as in the HB pilot, caused some problems. Local practitioners had their own ways of doing things that the outside presenters, even though they tried, were not aware of. The development of primary mental health services needs to incorporate an introduction to the local service. Local involvement would also assist with ensuring that the content of the programme is targeted to the areas of regional concern. This is particularly important given there is no limitation the clinical role of general practice in working with people with SOMI. Involving local practitioners in training contributes to building the trust required between general practice and mental health services.

The practitioners in both these innovations reported improvements in their mental health skills and knowledge. Subsequently their work in mental health increased in volume and their capacity to manage more complex care grew. While some skills and knowledge were obtained via formal training, the GPs and nurses appreciated what they learnt informally from

their CMHT colleagues and the people they cared for. Much of the informal learning related to the sharing of information and discussion of an individual's care. Rohland et al. (1999) consider that general practice can manage increased work in mental health if they receive additional support. One area identified in the HB pilot where additional training is required concerned the practice nurse giving mental health medication. The practice nurses in Hawke's Bay did not appear to undertake a mental health state examination at the time people came for their 'monthly' injection. This problem could quite easily be overcome with training, as Burns et al. (1998) have found that once trained, practice nurses can provide such assessments.

These innovations indicate there is no definable upper limit to the role and responsibility that general practice can take on in mental health. This is where mental health differs from most other areas of health. There is no clear delineation as to who should have their care primarily managed in a primary or secondary setting. For this reason general practice is often critical of mental health services, and mental health of general practice, and it is also why, according to the Sainsbury Centre for Mental Health (2001), that primary and mental health services need to be integrated. Although considering what is known about their total health needs (Pollack, 1999) general practice should be involved for all people with SOMI, it was up to the GP, the person with SOMI or the mental health services to determine the extent of the input. For example, a group of people did not wish their GP to have knowledge of their mental health history or be involved in providing mental health care and this raises particular issues in being able to develop integrated services. Both innovations had arrangements where care for individuals ranged from GP-basic care through to GP-total care. Of the records reviewed, the NUHS programme appeared to be involved in almost all people's mental health care, whereas in the HB pilot the GP-basic model was more prevalent. This difference arose because of the presence of the consultant-liaison service at NUHS and also the high level of mental health skills that the NUHS GP and nurse had. The factors impinging on the variations in practice were the skills and knowledge of the GP and nurse, a person's experience with the mental health service, the CMHT's awareness of the contribution general practice can make and trust.

Staff expertise was an important aspect as to why people joined and stayed at NUHS and why others stayed with some GPs in the HB pilot. While there is no limit to general practice involvement, these innovations indicate that the level of individual primary practitioner

expertise has implications for service development. The inability of the HB pilot to retain a GP to manage the complexity of a departed GPs caseload indicates that strategies are needed in the development of “specialist” primary care programmes that may include the specialist services having an ongoing role in support and training. It will be important for NUHS to learn from the HB pilot, so that its service is sufficiently prepared should either of its primary mental health experienced practitioners decide to leave.

Despite this lack of a limit on the role of general practice, many people with SOMI wanted to remain involved with mental health services so as they could have their mental health reviewed by a specialist. The work of the psychiatrist at the NUHS consultant-liaison clinic involved undertaking such reviews. New Zealand needs to consider whether it should follow the UK and introduce regular reviews for people with SOMI whose care is managed in a general practice setting (Cohen & Singh, 2001).

### ***Establishing effective primary mental health services***

To be sustainable an innovation in service delivery needs to establish effective service delivery arrangements. These arrangements need to be acceptable to practitioners and to those who the innovation is out to serve. From the GPs and practices perspective these innovative services were effective, the GPs developed new skills and they considered that they were able to provide a better service which often kept people out of hospital. However, from the CMHT perspective, and for some people with SOMI, the push to involve general practice resulted in a degrading of the level of services provided in that people were being encouraged to non-specialist services. From the purchaser position, these innovations were about ensuring that there was a range in the skill of practitioners enabling people to see different practitioners depending on their level of need.

Only a self-selected group of GPs were interested in joining the HB pilot. While this was acceptable for a pilot, it highlighted what others have reported, that all GPs may not be interested in working with people with mental illness (Holloway, 1994). While it is apparent that work is required to ensure all GPs are able to offer a ‘minimum’ service to people, the findings that people with SOMI clustered around particular general practices indicates that some are seen as very accessible.



Clustering of people with schizophrenia around particular GPs had been found in the UK (King & Nazareth, 1996), but had not previously been reported in New Zealand (Falloon et al., 1996), although there has been clustering in particular geographical areas (Gleeson et al., 1996). In the UK, clustering was thought to be a direct result of the location of housing for those with schizophrenia. The clustering experienced in the pilot can only partly be accounted for by involvement with supported housing. When residents in supported housing were subtracted from the total numbers on the pilot there were still some doctors with considerably higher numbers of people with SOMI, than other doctors. The two doctors with the highest individual caseloads shared a practice. Some of the clustering for NUHS could also be attributed to the service's involvement with supported accommodation. What was reported to happen was that when people left supported housing they remained with the general practice that they were involved with in the supported house.

Apart from what is known about women's preference for women doctors (Graffy, 1990) little is known about most people's reasons for choice of GP<sup>40</sup>. This research found that people first registered at NUHS because of its low cost, location, or on the advice of mental health practitioners or family and friends. People remained at NUHS and in the pilot because of cost, the service provided and because they trusted the staff.

The finding that people with SOMI clustered around particular Hawke's Bay general practices provides support that the clustering that is characteristic of NUHS is more typical than earlier thought. Clustering may be something that in the future New Zealand could utilise in new policies. It could choose to restrict additional payments for mental health work to those practices with the higher caseloads. However, such an approach could result in the same inequity issues in relation to access that were found with these innovative services. Such a policy would not be new, this already happens in maternity care in that for GPs to become lead maternity care providers they must meet certain criteria.

There are advantages and disadvantages of clustering. An advantage is that the practitioners could become more skilled in mental health, being specialists in primary mental health. Specialism occurs with other general practice work such as maternity care, women's health, sports medicine and the utilisation of alternative health remedies. More recently, specialism has been suggested as one option for developing primary mental health services in the UK

---

<sup>40</sup> For a broader discussion on choice of GP see Balint (1964).

(Sainsbury Centre, 2001). Clustering could make co-ordination and continuity easier to achieve, as mental health staff would need to get to know a smaller number of primary practitioners. Disadvantages are that the emphasis would move from all general practice having to provide a mental health service, which could mean that some people miss out. There is also a risk that in a group practice other people and staff could resent the attention and time required to deliver the primary mental health service. The chance of this happening (unless additional funding is provided to enable increased staffing) is increased given what is known about the lengthier time of consultations required by people with SOMI.

Access and the skills and knowledge of the staff were the two most common reasons why people joined and remained in the NUHS programme and the HB pilot. Access not only related to finance, but included geographical access and the ease of getting prompt appointments. People regularly talked about the NUHS programme and the pilot enabling them to make a health and not a financial decision when to see the GP. Prior to these innovations many people reported that, even if they were unwell, they would wait until they had sufficient funds to see the GP. Cost was more than just general practice co-payments, people also needed to balance the cost of the pharmaceuticals that had to be paid following a consultation. Medication costs raise another set of issues, which primary mental health services need to consider. These issues arise because New Zealand also has medication co-payment costs. The reduction in the length of time a prescription was given by some GPs resulted in people having increased medication costs. This increased cost accrued because pharmacies calculated co-payment rates.

People in the HB pilot particularly liked the accessibility of being able to see practitioners on demand. However, the NUHS programme was not able to do this. The programme had become so large that people found that they were not able to get "timely" appointments. The ability to deliver on accessibility will need to be addressed by NUHS if it wishes to maintain an acceptable service as there was a sense of disquiet among many of those interviewed about the difficulty in getting appointments with the GP on the programme.

The organisation of the services influenced how people could access the service. In NUHS, for example, people could drop in for an appointment. Similarly, when the City Medical after-hours service in Napier extended its hours to run a day clinic, several people in the HB pilot used that service for consultations. In the pilot the impact of this was different to

NUHS. In NUHS, where possible, the programme doctor or nurse was the consulting practitioner. This seeing of "casuals" contributed to why people with an appointment had to wait so long in the consulting room. In the pilot whichever doctor was on duty saw the person. This doctor did not have to be on the pilot. Nonetheless, involving any doctor posed particular problems for continuity and co-ordination of care and is a possible reason why some people on the pilot saw at least six different GPs.

Although these innovations were acceptable for the majority of people with SOMI, they were unacceptable for some. Acceptability was more than just access, but was also determined by the relationships people developed with the service. Once eligible, both innovations had similar evidence as to the take-up of the service. In both innovations there were people who were extremely infrequent users of the service, while others were high users. High use does not necessarily mean unnecessary intervention, nor low use deprivation (Coulter, 1991). Since many people's utilisation patterns changed year-to-year the variability in utilisation was influenced more by health status than free financial access. Few people remained extremely low users of the innovations, and few very high users. Both services had a similar mean annual consultation rate.

Apart from these organisational matters, the findings indicate that positive experiences with these innovations lie principally in the hands of the practitioners; most particularly, how the practitioners balance and handle mental health. Several of those who changed GPs during the pilot reported that the reason was the attitude of the doctor. It was important for the people with SOMI that they could trust practitioners with sensitive information and talk and be heard. People with SOMI found some practitioners to be more trust-worthy and that others addressed their needs better. The few people who regretted joining the HB pilot disliked the fact that mental health became too dominant in their consultations. Some people tolerated some GP's behaviour on the grounds that it was "just the GP". In other words, if there is enough that is positive in the relationship there is a tolerance about other things. If people experienced problems with practitioners at NUHS, rather than leave some used the complaint service to address their issue. However, given that the general consensus of people was that they would reduce the use of seeing the GP if they had to return to paying the co-payment, a certain level of acceptability of the services can be attributed to funding.

### **Achieving complementary and co-ordinated services**

Developing complementary and co-ordinated services involves providing integrated arrangements to meet changing personal health and welfare needs. The findings of this research suggest that NUHS achieved this integration better than the HB pilot. There are a number of reasons that could account for the relative success of NUHS including its philosophy of community development, the staff mix which enabled different practitioners to be involved in care at different times, the staffs skills and knowledge in mental health, and the length of time the programme had been in existence. In addition, NUHS emphasised that the programme was not just about mental health it concerned total health care. This focus on physical health is important given what is known about the high level of co-morbidity that those with mental illness have with physical illness (Cohen & Hove, 2001). Given that many of the people in both innovations reported improvements in their physical health status over the previous 12-months, it is possible that the pilot services also had this emphasis on physical health, and the data collection tools did not capture this.

While the early experience in the HB pilot showed there were issues with developing complementary and co-ordinated services, the shared care plans developed midway through improved the level of co-ordination and clarified stakeholders roles and responsibilities. Shared understanding, people's input, and the care plans being consumer-focused were important catalysts for making the services more complementary and co-ordinated. Achieving an understanding of others' roles and responsibilities has become more difficult in mental health as the workforce has become increasingly diversified. Given the variability in individual people's arrangements, it is important that the boundaries for each person are clear concerning "who is responsible for following up ... generalist or specialist" (Pratt & Adamson, 1996, p.23). In the HB pilot care planning followed a very prescriptive process – a documented care plan negotiated between the person, the CMHT and the GP was considered an essential pre-requisite to getting shared care established. There was no such required care-planning in NUHS. In NUHS some people had their care arranged through formalised care plans, but many did not. Yet, because of the close working relationship between the nurse, doctor and psychiatrist and the involvement of the person with SOMI in the decisions taken, NUHS provided a co-ordinated service. According to Freeman et al. it is the "user involvement [that is likely to be] ... the key to delivering better continuity of care" (2002, p.12).

Despite the care-planning process in the HB pilot people still reported care was not always being delivered in a complementary or co-ordinated way; rather it was delivered as if the providers were working side-by-side, delivering parallel care. Since very few care plans were reviewed or changed in the pilot, it can be argued that the care plans were based around the concept that need is constant, rather than elastic; that it is permanent rather than variable (Kettner et al., 1990). More timely documentation and sharing information between sectors would help overcome some of these problems. The arrangements reported by Midgely et al. (1996) where CMHT and GPs met on a regular basis may be a way forward. Services need to cross barriers to “ensure a more unified care system for users and carers” (Sainsbury Centre, 2001, p.26).

People holding a copy of their records may assist in situations where people are unwell or where more than one provider is involved. Services using consumer held shared records have found them to be effective at improving communication (Essex et al., 1990; Nazareth et al., 1995; Wolfe & Stafford, 1997). To reduce fragmentation, sectors in health care need to work together. This means that one sector has to build on the impact of its decisions with other sectors. This, as Abbot et al. (1995) found requires more than just good will. The emphasis has historically been on the mental health services keeping general practice informed about what is happening. With shared care there is also a need for this communication to be the other way, and not just around a crisis.

Providing care 24-hours a day seven days a week is also part of developing comprehensive and co-ordinated services. NUHS had this provision in place from the start, whereas in the HB pilot arrangements were developed later. Some of the CMHT time could have been saved if the after-hours system was set up prior to the pilot commencing. In that a few people were fairly regular users of the after-hours arrangements in the pilot, consideration also needs to be given to how to ensure co-ordination and complementary care is provided for such users.

### **The clinical effectiveness of the services provided**

Although, measuring the clinical effectiveness of these innovations was not a primary aim of this research, some findings regarding this were obtained from both case studies. In other presentations (Nelson & Cumming, 1999; Nelson et al., 1998; Nelson & MacEwan, 1998; Nelson et al., 2000) it has been argued that insufficient time has been available to demonstrate the effectiveness of the HB pilot in improving outcomes, and that given differences in the

comparison and study group, it is unclear whether changes found in health service utilisation and health status are attributable to the pilot, highlighting the difficulties identified by Gask et al. (1997) in evaluating such interventions. One of the issues was that services received by individuals varied. Nonetheless, people with SOMI in both innovations did report improvements in their mental health. Some people reported that these improvements occurred as a result of the services received, while for others it involved other factors. Fewer people reported improvements in their physical health, as a result of being involved in innovative services. The NUHS case study captured more details concerning general health. Although the cervical screening rate for people with SOMI in NUHS was lower (at least 67%) than that reported nationally (at 87%) (MoH, c.2002), it was considerably higher than the 28% reported in a UK study of women with severe mental illness (Burns & Cohen, 1998).

### ***Conclusion***

The experience of these innovations raises issues for consideration in the development of primary mental health services; such as funding, targeting, relationships, training and trust. These innovations while effective on some aspects of service delivery were not effective on others. One of the reasons the HB pilot was not effective in terms of complementary and efficient service arrangements was that there was no real analysis of whose role was to be replaced. The pilot was administratively cumbersome and staff turnover worked against the development of trusting relationships. In contrast, while NUHS was more successful at providing assessable, acceptable, co-ordinated and complementary services it nonetheless has, because of the size of the programme other issues such as the inability of people to obtain timely appointments to address. As New Zealand pursues the exploration of further general practice-based mental health services, the mental health and primary sectors need to collaborate at both a policy and service level in order to address the issues highlighted in these innovative services.

## **Chapter 10 – Developing and shaping innovations in service delivery**

This final chapter draws together the two aims of this research. The first was to understand why and how the innovative services were developed and shaped. This will be integrated with the second aim to develop a wider understanding of the implications of increasing the role of primary practitioners in working with people with SOMI. The chapter is presented in five sections starting with a reflection on the research. The next three sections highlight the research conclusions regarding the analysis of the origin of these innovations, and the decision-making and shaping of innovative services. The final section addresses the implications of the research for policy, practice and research.

### ***Reflection on the research***

This research commenced with some broad questions about the implementation of new services involving general practice working with people with SOMI. The data gathering and analysis phases opened up other avenues for interpretation and theoretical exploration such as the concepts of innovation and service delivery. Although the selection of cases to study was partially opportunistic, studying the NUHS programme and the HB pilot provided an opportunity to gain an understanding of how working with people with SOMI impacts on the establishment, shaping and acceptance of innovative services in general practice. While the approach used conforms with case study methodology some aspects of the framework that were applied and some research questions were arrived at after the data were collected. Instead of a prior literature review the researcher went back to the literature to identify relevant theory in order to better understand the events that took place. The research was grounded in an analysis of service delivery arrangements as they evolved. Treating these new service arrangements as innovations seemed an ideal choice because there was no prior knowledge of how such services might work in New Zealand nor any assessment of what obstacles might be encountered. If the framework had been fully developed before data gathering commenced more consideration and exploration of decision-making and of effective service delivery arrangements might have been incorporated into the design. However, one benefit of establishing the detailed framework late in the research process was the opportunity to examine the development of these unique services that had the potential to influence the role of national and clinical contexts, local events, existing service arrangements and stakeholders. Combining the life-cycle with the descriptive approach to study worked well with the case study methodology in that it enabled a rich description of the development

of the NUHS programme and the HB pilot – providing detailed insights into the workings of the innovative services and the obstacles they had to overcome.

The research design achieved at least three of Yin's (1994) criteria of exemplary case study research in that each service represented a unique development involving general practice expanding its work with people with SOMI. Alternative explanations were explored for why the services developed and changed, and different stakeholder perspectives and multiple sources of evidence were used. The detail provided in Chapter 2 and the accompanying appendices conforms to Datta's (1997) checklist regarding the transparency of data collection, database information and analysis techniques. Datta's advice on reporting and impartiality was useful given my role and association in each of these studies. In the role as project co-ordinator in the HB pilot I was involved in decision-making and in advising the CRHA about the pilot. This enabled an invaluable insider's view of the issues encountered and decisions taken. As a participant observer I was able to describe in detail the issues raised by the stakeholders related to service development as they worked with these issues in their attempts to develop effective service arrangements. I was also able to maintain a collection of key documents and describe the rationale for why particular decisions were taken.

### ***Innovations and local factors***

These innovations did not occur in a vacuum, rather they resulted from a coming together of international, national and clinical context factors, triggered by local events. These factors concerned changes in welfare such as the move from universalism to targeting and an increase in consumer rights. It also involved reforms in the health sector resulting in the funder/purchaser/provider split; and changes in mental health services as a result of community care, deinstitutionalisation and pharmacological advances. An increased demand for the mental health services saw them increasingly being restricted to those who were acutely unwell. The therapeutic advances were accompanied by a realisation that people with SOMI needed satisfactory living arrangements, rehabilitation, an ability to occupy their day, access to physical health care, and independence and choice in managing their lives. The change in the services, combined with the management of the symptoms of many people's mental illness not varying considerably on a daily or even yearly basis, meant there was a degree of routine care being delivered by the mental health services. Community-based services such as supported accommodation, recreation and employment services and general practice emerged to deliver aspects of the routine care that the CHE mental health services



decided to no longer provide. The innovations required practitioners in general practice and mental health services and people with SOMI to change attitudes and practices about who and where some mental health care should be delivered.

Additional funding was required to initiate and establish the HB pilot and, in the case of the NUHS programme, to maintain the service offered to the large numbers of people with SOMI who were registered. Working with a community development and primary health approach, NUHS developed programmes for groups of people with particular health needs where it considered assertive action in the management and co-ordination of services would lead to better health outcomes. Mental health was seen as one such programme. In contrast, the trigger factor for the HB pilot was the response by some GPs to a public announcement of new funding for mental health services. The GPs were able to respond to this announcement partly because of the structure (City Medical) which they had set up in response to health reforms. The willingness of the Napier CMHT to work with the GPs and the CRHA to develop a primary mental health service was critical to shared care being established as part of the pilot. The purchasing authority, the CRHA, was receptive to the approaches for funding, the new health contracting environment enabling it to be open to explore new ways of delivering primary mental health services.

The innovations commenced from similar, yet different starting points. Those that were similar were that the primary practitioners in both settings considered improvements were needed in the general practice services available for people with mental illness. The differences on the other hand were that NUHS identified the need as pertaining to people with SOMI already enrolled in its service, whereas in Hawke's Bay it concerned creating a new service for all people with mental illness. It was only when restrictions were put in place on what the CRHA was prepared to purchase, that the focus in Hawke's Bay changed to those with SOMI. The different origins determined which stakeholders were involved in shaping the services. NUHS mainly developed on its own, whereas from the outset multiple stakeholders – one of whom was a GP from NUHS – were involved in shaping the HB pilot. NUHS used a bottom-up process to determine the need for the mental health programme, while in Hawke's Bay a top-down approach was used in that the service first had to be developed on a contractual business plan in order to be purchased by the CRHA. An Advisory Group, set up and managed by the CRHA, led this development. Other differences included the location of the services, ownership, funding and practitioner roles.

### *Existing features, evaluations and risk management*

Providing services for the increased number of people with SOMI receiving some or all of their care in general practice led to changes in the expectations, roles and responsibilities of the stakeholders. It also affected the implementation of targeting, and led to changes in how general practice and mental health services worked together. While the precipitating factors and goals of the innovations were important in shaping the specific service arrangements that were developed there was no linear pattern to how the NUHS programme or the HB pilot were shaped.

Local features, the existing funding and ways of working and the need to overcome real or perceived obstacles in providing the service influenced the initial and subsequent changes to the arrangements. Although the CRHA attempted to fund only mental health consultations, both innovations largely funded all consultations because the GPs considered that general practice did not treat physical, mental health and social needs in isolation. The source of funding was also important in shaping the expectations and accountability structures of the innovations. As NUHS received funding from a primary source it was only required to account as a primary service. In contrast the HB pilot had to accommodate both mental health and a primary health service issues as it received funding from mental health.

Evaluation and the management of risk informed many decisions made in the development and service delivery ethos in these innovations. The development of the NUHS programme was revolutionary in nature as NUHS could rapidly respond to opportunities and new knowledge as it arose. This compares with the HB pilot where a structured development took place. Some elements in service delivery were changed simultaneously as increasing knowledge and understanding of the issues involved in developing the pilot service, more were appreciated as a result of the evaluations. This reflects a difference in the pace of decision-making. In the top-down development of the pilot this was slow and incremental, using bound rationality shaped by risk management strategies. Risk management shaped what the CHRA purchased, what the GPs were prepared to agree to deliver, why the CMHT ultimately controlled access to the pilot, why a training programme was purchased, and why some people with SOMI chose not to join the pilot. Risk management aspects were displayed in the pilot manual where each group of stakeholders' roles and responsibilities were spelt out. In contrast, because NUHS only had to consult with itself, it was able to make quick

decisions. Rational decision-making was used in that all decisions were aimed at developing the ideal service for the people NUHS served.

Review or evaluation was critical to the development of both innovations. NUHS used a community development approach to review the service it offered. It was NUHS's very belief in the role of research and the purpose of review that opened its service to this research. NUHS's process of evaluation was a mixture of formal and informal review. Formal review processes were designed to meet the purchaser's contractual requirements and was seen to play a part in feeding back to the community that NUHS served. Informally NUHS reviewed itself – both through staff processes as well as with the community through the Policy Board. It was constantly asking questions to improve what was being delivered. It was an aspect of this internal review that enabled it to identify that there was a sizeable group of people with mental illness enrolled in its service. Many of the changes that occurred at NUHS did so because of this informal process. Changes also occurred because of new information. NUHS reviewed its practice in light of findings of the HB pilot and what was happening within Wellington.

The Hawke's Bay service was purchased as a pilot that included a formal evaluation. This was set up with the expectation that it would inform service development both locally and nationally. Therefore, the pilot from the start was under a microscope and there was an expectation that lessons learnt there would be addressed and shared more widely. The findings of the evaluation played the greatest role in shaping the pilot after it started. For example, the ongoing evaluation found there were issues with consent, cost-shifting and duplication of payment, difficulties with targeting, GP claims, and the person with SOMI being left out of the care-planning process.

Critical to the people with SOMI using general practice for their mental health needs, to the primary practitioners providing mental health care and to the mental health services working with the primary providers was a sense of trust. Gaining trust involved overcoming risks and this took time. There was no difference between the two innovations in what was required for people with SOMI to trust the primary providers. Trust was influenced by people's past experience with GPs, with the mental health service and with the stability of their mental health. It was aided by the support that mental health services provided to the primary providers. While this trust appeared to develop as the NUHS programme emerged and

evolved the top down nature of the HB pilot required barriers to be removed to enable trust to develop. These were different for different people; for some it concerned the skills and knowledge of the providers, for others it was about ongoing access and for a third group it concerned attitudes.

How trust developed differed considerably at a provider level between the two innovations. In NUHS the providers commenced working together soon after NUHS started. The working together concerned arrangements for individual people with SOMI as well as at a provider level. Where and when NUHS provided outreach services was a result of negotiation and invitation between other providers, the community and NUHS. In contrast, there was considerable mistrust in the HB pilot between general practice and mental health services. For trust to develop between the provider groups rivalry needs to be reduced. In particular, the CMHT needs to accept that general practice is not out to take over mental health work, but rather to complement the work the CMHT provides and to contribute to the overall health of the person with SOMI. The mental health service also needs to trust that GPs and practice nurses have or can acquire the necessary skills and knowledge to meet the needs of people with SOMI. GPs needed to appreciate that the CMHT are not necessarily into patch protection. Not wanting to allow general practice to have an increased role in mental health occurred because mental health providers believed they already discharged people who were well enough back to the GPs, and those who remained on their books were there because of mental health needs.

### ***New understandings regarding innovations in service delivery***

These case studies provide some insight into the origin, shaping and adoption of innovative service arrangements. Given that the shapes of each service drew on international models of primary mental health, before evidence was available as to the clinical effectiveness of the models, provides support for Mays' (1994) finding that some innovations involving clinical behaviour are adopted before clinical testing. While some of the literature reviewed was in the form of what McKinlay (1981) referred to as "promising reports", much of it was written from the standpoint of calling for an increased involvement by GPs in mental health. Thus providing support for the establishment of these innovative services. There is a need to take cognisance of such contextual factors in this era of evidence based policy and service delivery, if innovative services arrangements are to continue. The evidence required to initiate innovative services is different from that required to shape such services. Just as these

innovations came as no surprise, the context was ripe for their development, so too is the context ripe for the development of other innovative ways of working, particularly increasing community and practice nurses involvement in providing separate and interdependent primary care.

While the literature about the development of innovations reported that a number of factors, for example the adaptability, trialability and observability of an innovation are considered to influence the adoption of an innovation, the experience of these innovations provides a different insight into their adoption. This research suggests that in the development of innovative service arrangements practitioners adapt and trial arrangements with a goal of making them work, to make them sustainable that is as part of routine service arrangements. In order for these innovations to be sustainable, they needed to be accessible, acceptable, coordinated, complementary, efficient and effective, and this requires time. While the NUHS programme was adopted as a routine feature of the services provided by the Newtown Union Health Service, purchasing authorities did not adopt the model. The acceptability of the innovations appeared to be less about whether the model was adopted as routine, but more about their fit with the capacity of central authorities to control how services are delivered and the extent to which they conformed with the dominant patterns of working. The NUHS programme was viewed as on the periphery or “outside” of mainstream New Zealand service development. The pilot on the other hand was on the “inside”, being used to inform future service development. In this regard, it is not so much an innovation’s compatibility with existing values and beliefs that influences possible acceptance, but its compliance with existing systems and power structures. Existing values and beliefs were that primary practitioners needed to have a greater role in providing a service to people with SOMI. Existing systems favoured the doctor being the practitioner that provided the service, and power structures provided for a bias towards service contracting involvement.

For these innovative services to be sustained several things needed to occur. All stakeholders needed to work towards delivering the new arrangements and system or governmental support was needed. The arrangements, while able to be shaped by individuals, cannot be controlled by individuals. Risks to all stakeholders needed to be managed. The nature of such innovations means that all risks are not known at the time these new service arrangements commence. The innovation therefore used a trial and error approach to modify the arrangements in order to address issues in a particular setting at a particular time. Innovative

service arrangements are rarely constant in form and shape, the process of change being constant. The point at which an innovative service is surpassed by a new one is problematic. It is perhaps only with a retrospective review that significant shifts in service arrangements, reflecting new innovative arrangements, can be seen.

Apart from managing risks new incentives to engage stakeholders in these innovative services were needed. In the bottom-up approach of the NUHS programme these came from the satisfaction of providing a service that met the needs of individuals enrolled in the service. In comparison, in the top-down approach of the HB pilot it was additional funding that attracted the involvement of GPs. With this funding came the expectation that the practice staff would get involved with providing a service to the people with SOMI. The level of service provided developed over time as a result of the increased knowledge and skills that were acquired through the training and by clinical experience.

Although innovative services manuals can prescribe roles and responsibilities for practitioners, how particular practitioners actually work with individuals involved the practitioner's skills, knowledge and belief systems as well as the expectations and requests made of them from people with SOMI and from themselves. While there was no difference in the range of services provided in both these innovations the actual extent of GP involvement in managing individual's mental health care was influenced by any one or a combination of factors including people's wishes, the GPs skills and willingness to get involved, and the policies of the mental health services. Differences in the roles of the practice nurse arose from the financial arrangements, management of the services and skills of the particular nurses.

### ***Implications for policy, practice and research***

The findings of these case studies are particularly applicable to the current development of primary health organisations. PHOs are new innovative organisations with a mandate to develop services to address the health needs of their populations. As with these innovations PHOs are expected to identify and target services (to address their population's needs) that are accessible, acceptable, co-ordinated, complementary, efficient and effective (MoH, 2001). The experience of these innovative services indicates that achieving these attributes of service delivery is complex. The complexity arises from funding constraints, boundary issues and the need to develop a targeting approach that addresses access, reach and take-up.

While additional funding was required to establish the HB pilot and in the case of the NUHS programme to maintain and extend the service offered to the people with SOMI registered there, how these innovations were funded and the form the funding took raised unexpected issues. A consequence of the funding coming from health resulted in some cost shifting from welfare to health, and within health sometimes funding duplicated that already provided to those in supported accommodation. Many people involved in these innovations should have been eligible for the Disability Allowance to offset their co-payment costs. A possible explanation for why the DA was overlooked as the main source of funding these innovations is that it may not work as intended for people with SOMI.

If the future development of primary health initiatives to target populations with special needs such as people with SOMI draws on funding from specialist services (as occurred in the HB pilot), particular issues may arise. For example, using mental health funding poses problems as it may result in non-compliance with mental health policy of targeting the 3% of the population who have serious mental illness at any one time. This is because having no exit criteria, as people recover, funding could shift away from those with a serious and ongoing illness to those with less serious illness or no mental illness. However, a difficulty with discontinuing the payment arrangements when people are considered to no longer have a SOMI is that they would still need to access primary care. These difficulties demonstrate an underlying problem with how New Zealand health services are funded in that having to pay a co-payment for primary care while having free access to secondary services puts incentives on people to remain with specialist services, and for practitioners to retain people in such services. New Zealand in this regard differs from many other countries developing similar innovations.

While some of the GPs repeated the stand historically taken by New Zealand GPs that people do not value what they do not pay for (Hay, 1989), the experience of these innovations suggest otherwise. While there were some high users of the innovative services, some people rarely used them, but wanted to retain the right in case they needed to. The people with SOMI reported that not having to pay the co-payment did not necessarily result in them attending more often, rather it meant they could make a health not a financial decision to consult with the GP. People with SOMI considered that the ability to access the GP in a timely manner gave them more control and contributed to their wellness and independence. Many people found that their involvement in these innovative services resulted in an

improvement in their overall health. Physical health problems were addressed that had otherwise been neglected or undetected. However, for others the experience was not as positive as sometimes too much emphasis was given to their mental illness at the expense of their physical health problems. Evidence was obtained from both innovative services that indicated that most people with SOMI had self-reported improvements in health status, and the findings in the HB pilot reported some improvements using outcome measurement.

The impact of removing the co-payment cost for people with SOMI to see the GP also impacted on general practice. It enabled practitioners to expand their role and facilitated a changed relationship between GPs, practice nurses and the people with SOMI. For mental health providers it allowed them to encourage and recommend the use of primary providers, freeing up some demand on their own service. It also changed the working relationship of the providers – allowing the development of a more seamless integrated service. Paying additionally for liaison time as occurred in the HB pilot and having the psychiatrist attend as at NUHS contributed to this.

An issue that the change in service arrangements created was a difficulty with the normal scheduling arrangements of general practice. The longer consultation required on many visits by people with SOMI raises particular issues for how general practice organises itself on a daily basis. This is not necessarily an issue for those practices with few people with SOMI on their books, but is a problem for practices such as NUHS where a large number of people with SOMI are involved. The longer consultations mean that the GP and practice nurse do not necessarily have the same patient throughput on a daily basis compared with their colleagues, which if payment arrangements are determined by standard consultation times will result in the GP or practice receiving less income. Longer consultation times also impact on patients unless appointment times are structured differently – people in the second part of the day will always have to wait for appointments. This waiting was definitely a problem identified by both practitioners and people with SOMI at NUHS. Waiting to see the doctor impacted on the quality of the consultation and in some cases actually resulted in people with SOMI walking out in frustration. Longer consultations were not only because of the time required by some people, but were also a result of liaison that was sometimes necessary.

Assuming that specialised payment arrangements are to continue, consideration needs to be given to what form these should take. The fee-for-service arrangements of the HB pilot were



time consuming compared with the capitation arrangements in the NUHS programme. The underlying system of payment in NUHS and the pilot was based on a concept of discretionary benefit. The people who were to receive the innovative services purchased with this funding needed to be defined or "identified". The experience with these innovations demonstrates the difficulties in developing criteria for targeting people with SOMI. The criterion of diagnosis, seriousness, duration, service utilisation and income all posed problems as there was a level of discretion that could be applied to each of them. In addition, the restrictions concerning eligibility for these innovative services being linked to particular GPs (in Hawke's Bay) and to NUHS practice raises issues of relevance for PHOs. Depending on which PHO people attend they can be eligible for cheaper access to GP care. However, as with these innovative services if people move from some PHOs they could lose this cheaper access. Ultimately within PHOs, groups with special needs are also to be targeted. If this targeting follows a similar pattern to these innovative services it will include some reduction in co-payment. PHO management could benefit from the experience of these services concerning the different ways to develop systems that target individuals. In the bottom-up approach of the NUHS programme, targeting came as a response to identifying a population with specific needs; it was the NUHS staff and Policy Board who devised a way of working to improve the needs of such populations. Although, the need to define what the service provided and who was specifically eligible arose out of contracting, NUHS criteria allowed anyone within their service who had or who developed a mental illness to be part of the programme. In contrast, the top down approach of the HB pilot involved the establishment of strict criteria as to who was eligible. An individual's eligibility did not just have to satisfy the primary service, but had to satisfy the multiple positions of the Advisory Group. To achieve this satisfaction a number of checks and balances needed to be in place.

Until a universal system is available where there are no co-payments required, New Zealand will continue to see different targeting systems emerge. The issue is more complex than just free access to primary care. The finding that people with SOMI clustered around particular GPs indicates that even if people had free care, additional resources may be needed for some practices to ensure that once they are enrolled in a service, all people can have access to a service of similar quality. Otherwise practices with the larger numbers of people with special needs may not be able to deliver the same level of service as those without such needs. While New Zealand policy accommodates this in that additional funding is available for PHOs that

have populations with higher percentages of Māori and Pacific Nations people and children<sup>41</sup>, no additional funding in the PHO formula is available for groups of people within specific health or illness categories.

Clustering also raises the question of whether specialism in providing general practice mental health services is warranted. The GPs with large caseloads in the HB pilot worked similarly to the NUHS GP. Specialisation is not just about training and funding, it is also linked to patients' belief and understanding of the skills and knowledge of a practitioner. The reason many people enrolled with particular GPs was because their friends or mental health practitioners had recommended them. When people and health practitioners believe in the knowledge and skills of a practitioner they encourage people to utilise the particular practitioner thereby reinforcing the practitioner's expertise. However, given the incidence and prevalence of mental illness there is a need for all primary practitioners to have skills and competence in providing mental health care.

While the content of Hawke's Bay training was initially focused on clinical knowledge and skills, it became apparent that there was also a need for training on process matters. This is because co-ordinated care requires practitioners to have an understanding of the roles and responsibilities of others in the team. For services to become complementary they need to work with this understanding. This requirement to focus on process issues will also be important for PHOs as they develop closer working relationships with the community, and with other health and social service providers. Consideration also needs to be given by funding and purchasing authorities to fund nursing and other primary care practitioners' work so that they develop separate yet inter-dependent roles. Other training related issues that these innovative services point to are the variation in the level of skills and competence of primary practitioners and the need for ongoing training.

Even though all GPs reported that they increased their knowledge and skills in providing mental health care, concerns were nonetheless raised by the people with SOMI about the ability of the practitioners to remain up-to-date with medications and to review their mental illness and treatment options over time. They were concerned that the lack of expertise could impact on whether they obtained their maximum health status. Although the innovations involved up-skilling GPs and some practice nurses, some people with SOMI were concerned

---

<sup>41</sup> These groups are known to have barriers to access primary care.

that increasing the involvement of general practice could down grade the level of skill of the practitioners involved in providing their mental health care. Consideration needs to be given to whether New Zealand follows other countries' policies of providing regular reviews of the mental health of people with SOMI whose care is transferred to general practice.

As a result of the increased role of general practice there were changes to people's care co-ordination. This resulted in improved co-ordination for some and fragmentation for others. The innovations had the potential to reduce access to people with SOMI to mental health services. This reduced access was both to the specialist services, as once in the system it was easier to get assistance, and to community services. The latter is a result of how information about community mental health services has largely been shared in the past, namely through the specialist. Primary providers will have to find a way of being made aware of community services. The PHO structure may foster this awareness.

These innovations raise issues regarding clinical and legal responsibilities. This is particularly so in the shared care model where there are dual providers. Mental health services have constantly had to balance control/custodial care with individual freedom; being regularly criticised over the past few decades for their inability to manage this for particular individuals. If primary health services are specifically funded to deliver mental health care will they too have to learn to balance individual rights against social responsibility? If anything untoward happens to someone who has been or is involved in the mental health service it is the actions of mental health services and not general practice that face public scrutiny. More work is needed to understand the clinical and legal accountabilities in shared care arrangements.

### **Implications for further research**

A number of questions for further research about mental health and general practice services arise out of this thesis. From the literature reviewed it was shown that considerable research has been undertaken on GPs' attitudes concerning their role in providing services to people with SOMI and on the numbers of people within general practice who have mental illness. The findings in this thesis point to the need for similar research to be undertaken to capture mental health practitioners' attitudes of general practice involvement in providing mental health care and to establish the degree to which general practice is involved in the care of people who are known to use the mental health system. Such research should provide

increased understanding of why mental health practitioners do not appear to actively involve general practice in all people with SOMIs' care and come up with possible solutions to change this practice. Research is also needed to investigate the effectiveness of the Disability Allowance for people with SOMI to offset the cost of accessing GPs and obtaining pharmaceuticals.

Research is also required on the physical health needs and the level of health promotion and health prevention provided to people with SOMI. Research is needed to better understand the role of the CMHT in keeping people well, as when this is understood it may be possible to teach other practitioners these skills. In addition, research is required to establish the mental health skills and knowledge of the practice nurse in New Zealand so that there is a basis for expanding and supporting the development of this role. Such research is important given the perceived failures of the undergraduate nursing education system to provide a sufficiently skilled workforce in mental health.

Other innovative services also need to be studied to find out whether the range of decision-making involved in these innovative services is used and whether the underlying goal of this concerns sustainability. Research is also needed to see if monitoring the implementation of innovative services (using the principles of accessibility and acceptability, co-ordination and complementarity, efficiency and effectiveness that meet the needs of the targeted user group and incorporate a country's unique policy) is an effective way of identifying issues to be addressed and to determining the success and thus adoption of an innovation.

The value of understanding how the NUHS programme and the Hawke's Bay pilot developed innovative services to meet the needs of people with SOMI provides an invaluable insight into the complexity of developing targeted services in the primary care setting. While the detailed application of this research will be most useful for those involved in developing primary mental health services the research should also be extremely useful to others involved in developing innovative service arrangements.

## Appendices

### Appendix 1 – Contract with NUHS service

#### Contract for Research Proposal between Newtown Union Health Service and Katherine Nelson (The Researcher from Health Services Research Centre)

This agreement is made this 29 of April 1997

Between NUHS

And Katherine Nelson

#### 1. Research

1.1 The researcher will carry out a case study evaluation of the Newtown Union Health Service Primary Mental Health Service

1.2 The researcher will provide a detailed research proposal to NUHS prior to commencement of the research.

1.3 The case study will involve staff interviews, records review and members input.

1.4 The case study will describe, analyse and evaluate the development and workings of the mental health service.

1.5 The case study will provide feedback to NUHS and contribute to knowledge on the role of general practice in the care and treatment of people with major mental illness.

#### 2. Indicative Time frame

2.1 The Researcher will provide a Provisional Research frame work by end February 1997

2.2. NUHS will respond to this framework by end of April 1997

2.3 Research involving staff will commence in May 1997

2.4 Records review will commence July 1997 and be completed by end September 1997

2.5 Member interviews will commence in October 1997 and be completed by December 1997

2.6 Provisional findings will be available by the end of March 1998

2.7 The major project of which this case study is a part will be completed by end of February 1999

#### 3. Consultation

3.1 The researcher and NUHS will work honestly and openly raising any issues and matters of concern with the other party in a timely manner.

3.2 The researcher and NUHS will work to resolve any areas of conflict.

3.3 The researcher and NUHS will confer on matters not specified in research proposal.

3.4 The researcher and NUHS will meet at least once every two months during the data gathering phase.

These meetings will be at a time and place convenient to both parties.

#### **4. Participation**

4.1 The researcher and NUHS agree to work in partnership with respect to finalising the details of the research.

4.2 The researcher will have access to NUHS staff, records and a sample of members at a time and place convenient to NUHS.

#### **5. Ownership**

5.1 All the data and findings of the case study evaluation shall be and will remain the property of NUHS.

5.2 The researcher has the right to utilise the data and findings of the case study for her PHD

5.3 All decisions ,(eg authorship, audience, content )regarding the dissemination of all findings shall be subject to the agreement of both parties.

#### **6. Confidentiality**

6.1 The researcher agrees to treat all service and member data confidentially as stated in Wellington Ethics Committee Agreement.

#### **7. Reimbursement of Costs.**

7.1 NUHS shall invoice the researcher for staff time accessed in the data gathering phase and practitioner staff time in the consultation phase at the rate of \$40.00 Plus gst per hour. This amount will be subject to review if the sum of \$2,240 (50 hours research) is exceeded.

7.2 NUHS agrees to cover the non practitioner cost of the consultation and dissemination processes

7.3 The researcher agrees to compensate members interviewed for any reasonable out of pocket expenses incurred as a result of participating in the research

#### **8. Termination**

8.1 Where for any reason, other than outlined in 8.3 , this contract is terminated both parties agree to consult and give reasonable notice ( 1 month) regarding termination.

8.2 Where for any reason this contract is terminated prior to the completion of the evaluation, agreement shall be reached as to the use of the findings to date.

8.3 The NUHS shall have the right to terminate this contract without notice if the researcher acts illegally or in any way that might bring NUHS into disrepute.

This contract is between the **Newtown Union Health Service** and **Katherine Nelson** and both parties agree to participation in the case study under the terms and conditions mentioned above.

Signed for the **Newtown Union Health Service**  
by Petra vanden Munckhof

Petra vanden Munckhof On 29 April 1997

in the presence of

Witness J. DANSON

Occupation Nurse Practitioner

Address 7 Hall St, Newtown.

Signed by

J. Danson On 29/4/97

**Katherine Nelson**

Katherine Nelson Katherine Mary Nelson  
As the researcher in the presence of

Witness Christine Mary Parnell Christine Mary Parnell

Occupation Office manager

Address HSRC, PO Box 600, Wahn.





27. CX smear date .....  
 Up to date 1. Yes 2. No 3. Aware 4. Refused 8. N/A 9. Missing
28. B/P date .....  
 Up to date 1. Yes 2. No 4. Refused 9. Missing
29. Weight date .....  
 Up to date 1. Yes 2. No 4. Refused 9. Missing

---

**Mental health history and care**

---

30. Legal status .....
31. Year of first mental health episode ..... Missing 9999
32. Number of admissions before 1987 .....
33. Longest length of inpatient stay .....
34. 1987 Admissions ....., ..... Length of stay ....., .....
35. 1988 Admissions ....., ..... Length of stay ....., .....
36. 1989 Admissions ....., ..... Length of stay ....., .....
37. 1990 Admissions ....., ..... Length of stay ....., .....
38. 1991 Admissions ....., ..... Length of stay ....., .....
39. 1992 Admissions ....., ..... Length of stay ....., .....
40. 1993 Admissions ....., ..... Length of stay ....., .....
41. 1994 Admissions ....., ..... Length of stay ....., .....
42. 1995 Admissions ....., ..... Length of stay ....., .....
43. 1996 Admissions ....., ..... Length of stay ....., .....
44. Mental health inpatient admission1 1997 1. Yes 2. No
45. Length of stay in days .....
46. Mental health inpatient admission2 1997 1. Yes 2. No
47. Length of stay in days .....
48. Mental health inpatient admission3 1997 1. Yes 2. No
49. Length of stay in days .....
50. Other agencies named as being involved 1. Yes 2. No
- | <i>Agency</i> | <i>Notes (worker name etc)</i> |
|---------------|--------------------------------|
| i. ....       | .....                          |
| ii. ....      | .....                          |
| iii. ....     | .....                          |
| iv. ....      | .....                          |
51. Record of daily living plan 1. Yes 2. No
52. Details of Daily living plan  
 .....  
 .....
53. Details of last two mental health scripts written by NUHS
- | <i>Date:</i> | <i>Script</i> |
|--------------|---------------|
| i. ....      | .....         |
| ii. ....     | .....         |
54. Researchers Comments.....  
 .....

Appendix 3 – Example of NUHS and Hawke’s Bay utilisation review tools

GP Utilisation Data Sheet 1      GP Name .....      GP Research Number .....      Month

Date	NHI no	Regular Consultations with Target Group (ave 15 month)										TIME (in minutes)												
		CONSULT WITH (Tick Any)		CONSULT BY (Tick One)		CONSULT TYPE (Tick One)		REASONS FOR CONSULT			OUTCOME (Tick as many as necessary)			REFER FOR										
		Patient	Family	Surgery	Telephone	Home Visit or After Hours	Routine	Acute	Psychiatric	General Medical	Social	Support and ongoing treatment	Prescription renewal	Prescription change	CMHT case worker	CMHT Psychiatrist	Other agency	Case Review	Admission	Other	Use notes next page	Use notes next page	Please indicate if extended consultation	
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
9																								
10																								
11																								
12																								
13																								
14																								
15																								
16																								
17																								
18																								

Extended Consultations (ave 4 month)

Date	Surname	Sex M/F	Age in years	Ethnicity E, M, PI, O	Provisional Diagnoses (use codes)	REASON FOR EXTENSION			Time in mins	Notes
						Assess- ment	Ongoing Manage- ment	Other Coun- selling (explain in notes)		
1										
2										
3										
4										
5										
6										

Ethnicity: E - European; M - Maori; PI - Pacific Islander; O - Other

Provisional Diagnoses

- 01 Schizophrenia
- 02 Bipolar Disorder
- 03 Other Psychoses
- 04 Personality Disorder
- 05 Anxiety Disorder
- 06 Situational Crisis/Adjustment Reaction
- 07 Self-Harm
- 08 Depression
- 09 Sexual/Physical Abuse
- 10 Anger Problems
- 11 Post-Trauma Stress Disorder
- 12 Grief
- 13 Somatisation Disorder
- 14 Eating Disorder
- 15 Sexual Dysfunction
- 16 Self-Acceptance problem
- 17 Mute Maori
- 18 Family disruption
- 19 Relationship Problem
- 20 Emotional/Behavioural problem
- 21 Intellectual Disability
- 22 Addiction
- 23 Autism
- 24 Other ( Explain in notes)

Liaison Time

Date	Name or NHI number	Liaison with: (name, & organisation)	PURPOSE			Time in mins	Notes
			Approve drug	Please see Advice (tick as many as necessary)	Manage- ment Review (explain in notes)		
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

*Appendix 4 – Example of interview schedule used with people with SOMI<sup>43</sup>*

---

**Newtown Union members interview schedule**

---

*This interview will ask about your use of the NUHS, about your other than mental health care and about who you are. Some questions require very short answers while others will require longer answers. There is no correct answer to any question.*

---

**Part 1: Questions about Newtown Union Health Service and primary health**

---

1. How long have you been enrolled at NUHS?
2. Why did you choose to enrol at NUHS?
3. What is it about NUHS that has kept you going there?
4. Which staff do you usually see at NUHS?
5. What or who determines how often you go to NUHS?
6. How often do you usually go to NUHS?
7. Could you tell me generally the role NUHS has in your health care
8. What do you like about the NUHS?
9. What do you dislike about the NUHS?
10. How do you think the NUHS could be improved?
11. Have you used other GPs or practice nurses apart from NUHS in the past 12 months? If yes, what were the circumstances you used other GPs or practice nurses?
12. Have you used any after-hours health services in the past 12 months? If yes which ones?

---

**Part 2: Questions about your mental health care**

---

13. Are you currently on any medication for your mental health? If yes, who makes changes to your prescriptions for your mental health medication? Who writes your repeat prescriptions for your mental health medication? And are there any issues regarding your medication that you would like to raise?
14. Who is currently involved in your mental health care and treatment?
15. What is .....role in your mental health care?
16. What is .....role in your mental health care?
17. What is .....role in your mental health care?
18. What is .....role in your mental health care?
19. What is .....role in your mental health care?

---

<sup>43</sup> The layout of this interview schedule has been condensed for inclusion in the thesis.

20. What is .....role in your mental health care?
21. How well do you consider these people/services meet your mental health needs?
22. How do these people work together regarding your mental health care?
23. How do you feel about this?
24. What input do you have into planning your mental health care?
25. How do you feel about this?
26. What are your costs for your mental health care? Have you had to pay to see a GP or practice nurse at all since you enrolled at NUHS? If yes, what were the circumstances you had to pay?
27. If you needed help for a mental health crisis how you would go about getting this help?
28. Are there any issues regarding your mental health care that you would like to raise?

---

Part 3: Questions about you

---

29. Thinking of your physical health, how would you rate it compared with a year ago - better, the same, worse?
30. Has the service provided by NUHS contributed in any way to (the improvement, the maintenance, the deterioration) of your physical health status over the last year - How Why or why not?
31. Thinking of your mental health, how would you rate it compared with a year ago - better, the same, worse?
32. Has the service provided by NUHS contributed in any way to (the improvement, the maintenance, the deterioration) of your mental health status over the last year - How Why or why not?
33. How old are you?
34. What is your ethnicity?
35. What suburb do you live in?
36. Do you have a Community Services Card?
37. Do you have a High Use Health Card?
38. Do you have a Prescription Subsidy Card?
39. Do you receive the Disability Allowance?
40. Do you have any questions you would like to ask me about the research

Thank you for participating in this interview. Would you like a copy of the report when it is complete.

**Community mental health team interview**

ID.....

**Instructions**

This interview wants to find out about your experience of different aspects of the pilot. The information will be analysed as group data only.

1. What do you consider are the achievements of the shared care pilot?
  2. What do you see still needs to happen for shared care to develop?
  3. Have shared care plans been developed for all patients in the pilot in your care?  
Yes [ ]                      No [ ]  
If no why not?
  4. Why do you think it has taken so long to get the care plans develop?
  5. As you are aware during the pilot the care plans have changed? What do you think of the headings and content of the latest care plans?
  6. What do you think about the care planning process (ie involving GP, CMHT and consumer)?
  7. How do use the care plans?
  8. What kind of system is needed in place to review care plans?
  9. The pilot has largely been lead from Wellington. How well do you think this has worked?
  10. Over the next few months management of the pilot is moving to Napier, who do you think should co-ordinate this?
  11. What have been the costs and benefits of the pilot project  
for CMH?  
for your clients?
  12. What do you consider are the strengths (if any) of the pilot?
  13. What do you consider are the weaknesses (if any) of the pilot?
  14. What do you consider are the changes (if any) that are required to improve the pilot?
  19. If the pilot was to be discontinued what impact would this have :  
On the CMH service?  
for your patients?
  20. What areas would you like the ongoing training programme to cover?
  21. Other comments
- Also ask about pilot for Maori and pilot in rural area

<sup>44</sup> The layout of this interview schedule has been condensed for inclusion in the thesis.

## *Appendix 6 – Hawke’s Bay information sheet and consent for evaluation*

### INFORMATION PAMPHLET ABOUT THE PILOT EVALUATION

This pamphlet contains information about the evaluation of the Napier and Wairoa primary mental health shared care pilot programme.

#### *What is the shared care project about?*

In Napier and Wairoa a number of general practitioners (GPs) will be funded under a contract arrangement with the Central Regional Health Authority that funds each of them to provide up to 15 consultations free per month for pre-identified patients with major long term psychiatric illness. Patients who are eligible for this free service will be identified by the community mental health team (CMHT). Care will be on a shared care basis. On entry to the scheme CMHT staff will complete baseline data on the patient for the GP and evaluation team. Patients will be asked at this point for their consent to participate in the pilot study. Records will be kept by health practitioners at all future consultations/visits with the patient.

The GPs, at their own discretion, will also be able to obtain an additional subsidy for 4 extended consultations with other patients. The GPs are expected to participate in an education programme as part of their commitment to the pilot.

#### *Who is carrying out the evaluation?*

This research is carried out by the Health Services Research Centre (HSRC). The principal researcher is Kathy Nelson, who is a nurse and currently works as a researcher at the Research Centre. Other researchers are Dr Peter Crampton, public health medicine registrar who works at the HSRC, Jacqueline Cumming, economist at the HSRC, Professor Peter Ellis, psychiatrist at the Wellington School of Medicine, Dr John Grigor, psychiatrist at Porirua Hospital, Professor George Salmond, director at the HSRC, and a nurse who is yet to be appointed by the Health Services Research Centre. Contact with the researchers can be made through Virginia MacEwan at the community mental health service in Napier 06 878 1602 ext 5384 or by phoning Kathy Nelson at the Health Services Research Centre in Wellington collect on 04 496 6565.

#### *What does the evaluation involve?*

The research design consists of five separate, but interrelated components. These are a **service description** that will describe how the pilot is organised; a **utilisation evaluation** that will involve an analysis of the contacts with the community mental health team (CMHT) and the general practitioner (GP) that clients in the pilot have. This analysis will describe who uses the service (eg males, females, younger people older people etc) how often and whom do they see at the service. An **evaluation of the cost** of the service which will use different methods of estimating the cost of providing the service; a **client evaluation** which will involve all participants in the pilot completing a questionnaire and a general health survey (SF 36) as well as some

attending an interview; and a **providers' evaluation** which involves interviewing the health professionals who work in the pilot, as well as other providers who work with the people involved in the pilot.

### *How is my confidentiality ensured?*

Once completed the data sheets, questionnaires and interviews will be filed in a locked cabinet at the Health Services Research Centre until analysis is completed. At the completion of the research, all data will be destroyed.

In the publication of the findings, individual details will not be published. Only group opinions will be used.

### *Why is the evaluation important?*

The Central Regional Health Authority (CRHA) would like to see GPs and CMHTs working closer together to provide better care for people who have a major mental illness. They have funded a group of GPs in Napier and Wairoa to provide a free service for a group of people with a major mental illness. It is important to see how this funding is used and if such funding meets the needs of the people it is aimed for. We believe a detailed description and evaluation could provide the information needed for extending or modifying the pilots, and for helping the CRHA decide the most appropriate services to purchase for those with a major mental illness.

### *How will this evaluation be published?*

All people who participate in the research will be offered a copy of the results. We also hope to publish the findings in several journals and to give presentations and talks on the findings in Napier and Wellington.

### *Who can provide additional information about the pilot and the evaluation?*

There is a pilot manual that has most information about about the pilot. This is available at GP surgeries as well as from the community mental health team. Virginia MacEwan, team leader at the community mental health service in Napier 06 878 1602 ext 5384 is also available to answer questions. You can also phone Kathy Nelson, the Project Manager, Collect, on 04 496 6565. If you have any concerns about the study, you may also contact the Central RHA Hawkes Bay Health Ethics Committee, Company Office, Napier Hospital, Tel (06) 878-1600 ext. 8190.



**Statement to be signed in the presence of a community mental health team member**

I have read the consent form and have had the opportunity for discussion.

I know that I may withdraw from the study at any time and I understand that my withdrawal will not affect my future health care in any way. If I withdraw from the study I understand that I will not be eligible for the free general practitioner consultations that have been available as part of the pilot.

I have been assured that my results will remain confidential and that no identifiable information about me will be revealed in any written or verbal reports about the study.

I understand that this study has been approved by the Central Regional Health Authority Hawkes Bay Health Ethics Committee and if I have any concerns about the study, I may contact the Ethics Committee, Company Office, Napier Hospital, phone 878-1600 ext 8190.

**I agree to take part in this study**

Signed: ..... (Participant) / / (date)

**Statement by community mental health team:**

I have discussed with ..... (Participant's name)  
the aims of and procedures involved in this study.

Signed: .....(Community mental health team)  
/ / (date)

**Three copies required: one retained by client; one retained by research team; one for CMHT records.**

*Appendix 7 – Example of baseline data gathered on roles in the Hawke’s Bay<sup>45</sup>*

**1. DATA COLLECTION: BASELINE DESCRIPTION OF GP SERVICES**

**General Practitioner Name:**.....

1. Are you in a solo practice? YES NO  
 If no, how many other GPs do you work with?

2. What other staff do you employ in your practice?

- Please circle:
- a. Practice nurse(s)
  - b. Reception staff
  - c. Practice manager
  - d. Social worker
  - e. Counsellors
  - f. Other, please specify

3. Is your practice computerised? YES NO

**If yes, proceed. If no, go to question 4**

3a. What type of software do you use?

3b. Are all your patients on your computer system? YES NO

**If no**, please also complete question 4

**If Yes,**

Do you include the NHI number in your records YES NO

Are you able to analyse your records to tell us the demographic details of your patients by:

number of patients	YES	NO
age	YES	NO
sex	YES	NO
ethnicity	YES	NO
CSC status	YES	NO

3c. Do you have a disease register code on your computer system? YES NO

**If yes**, What are the codes that you use for mental health?

Are you able to analyse your records to see how many patients you have with say schizophrenia? YES NO

3d. Do you have a recall system on your computer? YES NO

3e. Do you keep clinical notes on your computer? YES NO

**If yes**, Are you able to tell how many referrals you made to Community Mental Health over the past 3 months? YES NO

6 months? YES NO

12 months? YES NO

<sup>45</sup> The layout of this interview schedule has been condensed for inclusion in the thesis.

Are you able to tell how many referrals you made to other mental health agencies in the past	3 months?	YES	NO	No.
	6 months?	YES	NO	No.
	12 months?	YES	NO	No.

4. If you have a non-computerised record system, do you have a unique number for identifying patients YES NO

5. What after hours arrangements do you have with your patients?

1. Provide own
2. City Medical
3. Other, please explain

**6. INFORMATION ABOUT YOURSELF**

6a. What year did you graduate as a doctor?

6b. Which University did you do your undergraduate medical training?

6c. How many years have you worked in General Practice?

6d. Please list the post graduate qualifications you have

6e. Please list what post graduate experience you have had in psychiatry?

Thank you, please return to Kathy Nelson, Health Services Research Centre, PO Box 600, Wellington. A stamped addressed envelope is attached.

## **Information Sheet on Newtown Union Health Service Research**

The study is evaluating how the Newtown Union Health Service (NUHS) meets its goals for its primary mental health service.

### **The researchers**

This research is being carried out by a partnership involving the NUHS and the Health Services Research Centre (HSRC). The NUHS staff involved are: Kathy James (doctor), Joanna Davison (nurse), and Petra Van den Munckhof (manager) and the HSRC staff involved is Kathy Nelson (research fellow). The principal researcher is Kathy Nelson. Kathy has a background in nursing and sociology. She is currently enrolled in a PhD on models of care involving general practice in the care and treatment of people with on-going needs from mental illness. This research will contribute to Kathy's PhD. Kathy's PhD supervisor is Mr Stephen Uttley, Department of Social Policy, Victoria University.

### **Importance of this research**

This research is important for NUHS so as it can improve the service it offers to members(patients). NUHS wants to find out from members how they use the service, what works and identify what ways members would like to see the service improve. Also as NUHS has undertaken a different approach from most other general practices to how they deliver general practice services and how they work with people with on-going needs for mental health services, we believe a detailed description and evaluation could assist other general practices to learn from NUHS.

### **The research methodology**

The research is looking at how well the NUHS meets its goals for its primary mental health service. It consists of four separate, but interrelated components. These are:

1. A **service description** that will describe how the service has developed and changed, and how it is currently organised;
2. A **utilisation evaluation** that will involve an analysis of records of a sample of people with on-going needs for mental health services who are registered with the NUHS. This analysis will involve looking at:
  - who uses the service;
  - how often they use the service;
  - why they use the service; and
  - the staff they see at the service.
3. A **service user evaluation** that will involve interviewing people who use NUHS and asking them about their experiences with the service; and
4. An **other providers' evaluation** that involves interviewing other agencies who work with people who are registered at the NUHS.

### **The interviews with people who use NUHS**

Approximately 35 people who attend NUHS will be selected randomly and asked to participate in an interview for the service user evaluation component of the research. **Participation in the interviews is voluntary. NUHS staff do not know who has been approached to be interviewed. Only Kathy Nelson will know who has declined to participate.** Written informed consent will be obtained from those willing to participate. The interviews will take place at a time and place suitable to both the service user and the

interviewer. The interviews will be conducted by Kathy Nelson. The interviews will take approximately 30 minutes and will be taped if the person agrees, otherwise note-taking will be used. Kathy will ask people:

- about why they registered at NUHS,
- what has been their experience of the service given by NUHS,
- how NUHS could improve its service, and
- how NUHS care and treatment fits into their overall mental health care and treatment.

Some details such as age, sex, years enrolled at NUHS will be obtained to enable a description of those interviewed. Once completed the interviews will be transcribed or notes written up. All personal information such as people's names will be removed.

### **Confidentiality**

Apart from Kathy Nelson, the tapes will only be heard by a person who will transcribe them. The person transcribing the interviews will not know the identity of the people being interviewed. No-one else will listen to the tapes or have access to the full transcriptions. Kathy's supervisor, Stephen Uttley will be shown sections of the transcripts and interview notes. The tapes and interview notes will be locked in a filing cabinet at the Health Services Research Centre and will be destroyed three years after the completion of the research. People who are interviewed will be able to arrange for a copy of the transcription at the time of the interview. At no time will the research team be discussing individuals. The information collected from the interviews will be analysed collectively and will be published as group data. Some quotes from the interviews may be used, but at no time will details about individuals be published.

### **Publication**

All people who participate in the research will be able to arrange at the time of interview for a copy of the findings to be sent to them. Access to the findings will also be available through NUHS, the HSRC or the Wellington Mental Health Consumers Union. It is also hoped to publish the findings in several journals and to give presentations and talks on the findings in Wellington and other parts of New Zealand.

### **If you would like further information or you have concerns about the research you can contact:**

- Kathy Nelson, Health Services Research Centre, Rutherford House, Bunny Street, Wellington, Tel 463 6570, Fax 463 6568
- Petra Van den Munckhof, Newtown Union Health Service, Tel 389 2070
- Mental Health Consumers Union, 41 Dixon Street, PO Box 6228, Tel 801-7769
- The Wellington Ethics Committee, Wellington Hospital, Private Bag 7902, Wellington South, Tel 3855 3999 ext. 5185, Fax 385 5840

*Appendix 9 – Letter and form requesting people at NUHS be interviewed*

*Name*

*Address 1*

*Address 2*

*Address 3*

18 July 2000

Dear *Name*

Currently I am working with Newtown Union Health Service (NUHS) to carry out an evaluation of their service. The evaluation focuses on the work of NUHS with people who have or have had a mental illness. Details of the research are enclosed in the information sheet (see blue sheet) attached. The research includes interviewing 30-40 people who use NUHS. Names of people to be approached for interview have been selected randomly from the NUHS records. As your name has been selected, I am writing to invite you to be one of the people interviewed. Participation in the interviews is voluntary. NUHS staff do not know who has been approached to be interviewed.

I would like to undertake these interviews in August. The interview could take place at a venue suitable to you (eg your home, my office, the Clubhouse or NUHS) and you are able to bring a support person to the interview if you would like to. I am able to cover the costs of reasonable expenses to attend the interview (eg transport and childcare costs). The interview will ask you questions about your use and experience of NUHS. It will be tape-recorded (if you agree). If you do not want your interview taped, note taking will be used.

Please complete the yellow sheet attached or phone me on 463 6570 during the day to let me know if you are available to be interviewed. You will be asked to sign a consent form at the time of the interview. I will write to confirm the interview date and time once I have heard from you.

Thank you.

Yours sincerely

Kathy Nelson  
Research Fellow

Name:  
Address

### Newtown Union Health Service Interview Request Questionnaire

The questionnaire asks for information so as Kathy Nelson can arrange an interview with you. You can ask someone to help you complete it. The answers provided will remain confidential.

- 
1. Do you agree to be interviewed about the Newtown Union Health Service?  
 Yes  
 No → **Thanks for considering my request, could you please return this form in the envelop attached**
  
  2. Which day(s) of the week in September and October will you be available for an interview? The interview will take about half an hour.  
 Not available at all during September  
 Not available at all during October  
 Any day  
 Monday  
 Tuesday  
 Wednesday  
 Thursday  
 Friday  
 Saturday
  
  3. Which time(s) of the day would be suitable for the interview?  
 Anytime  
 Morning  
 Afternoon  
 Evening
  
  4. Where would you like this interview to take place?  
 My Office (Rutherford House, Bunny Street in Central Wellington)  
 Newtown Union Health Service  
 The Clubhouse, Riddiford Street  
 Your home *please provide your address if the address on this letter is incorrect*  
.....  
 Other  
*please provide suggestion*.....
  
  5. In addition to the letter I will send you about your interview time would you also like me to telephone you to confirm the time?  
 **Yes** → please write your telephone number here .....  
 **No**

Thank-you for completing this form, please return in the stamped addressed envelope attached to Kathy Nelson, Health Services Research Centre, PO Box 600, Wellington. Ph 463 6570

## *Appendix 10 – Letter to Wellington Ethics Committee*

C/o- Graduate School of Nursing and Midwifery  
Victoria University  
PO Box 600  
Wellington

6 September 2001

Sharron Cole  
Chairperson  
Wellington Ethics Committee  
Wellington Hospital  
Private Bag 7902  
Wellington

Dear Sharron

Re: Ethics Application – 95/116

Enclosed please find an update on where my research for my doctoral studies is now at. You may recall that in my letter to you last year I explained that I had had a series of family health crises that meant I needed to suspend the study for a while. Unfortunately these crises continued and my husband was diagnosed with cancer metastases. This meant that my planned study time had to be replaced with paid work.

At the time of his diagnosis I had completed all the interviews of the people with serious and on-going mental illness. Most but not all had been transcribed. I wrote to these interviewees advising that due to personal circumstances things were now behind. I have since sent the transcripts back for people to review. My husband is starting to get a bit better and has recently started some part time employment. This has meant that I have also been able to reduce my hours of paid employment and focus on the PhD.

In the meantime I have identified two people (one a union representative and the other a provider organisation) who would be interested and available to be interviewed about their early involvement with Newtown Union Health Service. I hope to complete those interviews in the next three weeks. These interviews would add some insight to the issue of representation and co-ordination. Apart from that the main task is analysis and writing up. I have kept Newtown and the Hawkes Bay informed of the delays and appreciate that they have been really tolerant and understanding of this. However for the work to be of most value I need to focus now and get it finished, no matter what the circumstances.

I have also had a supervisor change as Stephen Uttley has left the university. My new supervisor is Kevin Dew from the Department of Public Health at the Wellington School of Medicine. I have now commenced this and have a planned timetable for completion. My part time employment is with the Graduate School of Nursing and Midwifery at Victoria University. I can be contacted there on 463 6157 if need be.



Three ethical issues that I had not anticipated in my original ethics application have been encountered in the research. I will be discussing these issues in depth with my supervisor now that I am into the analysis and writing up phase of the research. However you might like to advise me from the Ethics Committee's perspective on these.

- i) One person interviewed did not want to sign the consent form for the interview as s/he "had experience of the health services including Newtown using such signatures against her/him". I explained at the time that that meant that the person couldn't really be interviewed. The person protested and wanted to be interviewed but to not have it taped. I undertook the interview and typed up the notes. The person then viewed and edited the notes and returned them to me at a second meeting where I had hoped that s/he would sign the notes. However this did not occur. I am therefore in a position of not having a signed consent, but because of the arguments presented by the person such as "their word" they "had voluntarily responded to the letter regarding the interview" and they "had something I (they) wanted share" have interviewed the person. The issue is whether I can actually use the material from this interview. On one level the steps that this person took to participate in the research indicated that they were a willing participant. A group of people who were posted letters to participate declined the invitation to be interviewed. Yet into the future I could be challenged. Having heard what they wanted to say I feel morally bound to include their experience and believe that in the analysis but from the written consent angle feel challenged. I would appreciate your guidance on this matter.
- ii) The second issue I encountered was that of interviewing a person who openly discussed how s/he supplemented their income by trading in marijuana. This came up prior to and during the interview when I was asking about the person's source of income. I have chosen to turn "a blind eye" to this, but would be open to any advice given.
- iii) One of the interviews contained some very graphic details about a person's lucky escape from a near fatal suicide attempt. After the transcriber had transcribed this tape I checked out whether the tape had raised any issues for her that she might like to discuss or would need assistance to resolve. She was taken a back and thanked me for inquiring. This woman has transcribed for many years and for many people and I was the first person she said that had checked out that she was safe and okay about what she was transcribing. I was surprised about this so discussed the matter with another person who also transcribe for different researchers. This person said that she ended up having "nightmares after transcribing for one particular research project". This possibility of "vicarious" trauma is something that people using transcribers need to recognise and should I believe be covered in the ethics applications where researchers identify potential risks to themselves and others part of is important. As I am not aware of discussion on this in the literature people may need to be advised of this.

In regards to the storage of my data I am currently in the process of moving some of it from Wellington Hospital (where I was recently employed) and from the Health Services Research Centre to a locked filing cabinet at the Graduate School of Nursing and Midwifery.

In summary my research is behind but I am now back working on it. I am committed to getting it finished. I would appreciate any advice or comment from the committee on the three issues identified above. Please do not hesitate to contact me if you require further

information about the matters raised. As I am only in part time employment I am best reached by leaving a message at my home on 383 7127 or by e-mail on [kathy.nelson@vuw.ac.nz](mailto:kathy.nelson@vuw.ac.nz).

Yours sincerely

A handwritten signature in black ink, appearing to read "Kathy Nelson". The signature is fluid and cursive, with a long, sweeping tail that extends to the right.

Kathy Nelson  
Researcher

CC- Dr Kevin Dew, Department of Public Health, Wellington School of Medicine  
Chairperson, Victoria University of Wellington Human Ethics Committee

## Appendix 11 – Response from Wellington Ethics Committee

14 September 2001

Our Ref 95/116

Please include the reference number and study title in all correspondence.

Kathy Nelson  
C/o-Graduate School of Nursing and Midwifery  
P.O. Box 600  
**WELLINGTON**

## Wellington Ethics Committee

Room 425, Fourth Floor  
Community & Support Services  
Wellington Hospital  
Private Bag 7902  
Wellington South  
Phone (04) 385 5999 ext. 5185  
Fax (04) 385 5840  
Email: claire.l@wec.org.nz

Dear Kathy

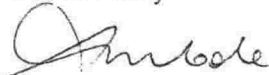
### 95/116 – Evaluation and Description of the Newtown Primary Mental Health Service

Thank you for your letter of 6 September, updating the Ethics Committee on your study. Your report was circulated to the Wellington Ethics Committee and was discussed at its September meeting. You asked for specific advice on three issues. The Committees response to each of these is as follows:

- i) It was this first issue that raised the most discussion. It is clear that you used a transparent consent process and recorded the consent, which in itself is legal. The form of recording consent is related to documentation rather than consent itself. However we did feel that there was some ambiguity about the consent and further the person in the future may wish to pull information from the study at a point where it may be inconvenient or even impossible for you to do so. It may also be wise to clarify as much as possible that the person has given informed consent to participate in the study. The Committee felt the best course of action is to send the person a copy of the material in the form that you wish to use it. You should then ask them if they approve its use and if so, have another person witness this approval and sign on their behalf. The person would thus never have to be identified or have their name recorded but both you and they are protected in the form of an independent of objective third party witnessing that the process of informed consent was valid.
- ii) The Committee would term this incident as an unintended consequence of research. You would only be obliged to act if there were serious or imminent harm. This is not the case here and you are under no obligation to take action.
- iii) The Committee was extremely interested in your third point. Your comments about the possibility of vicarious trauma are noted. The Committee asked me to both commend you for your response and to thank you for feeding this point back to us.

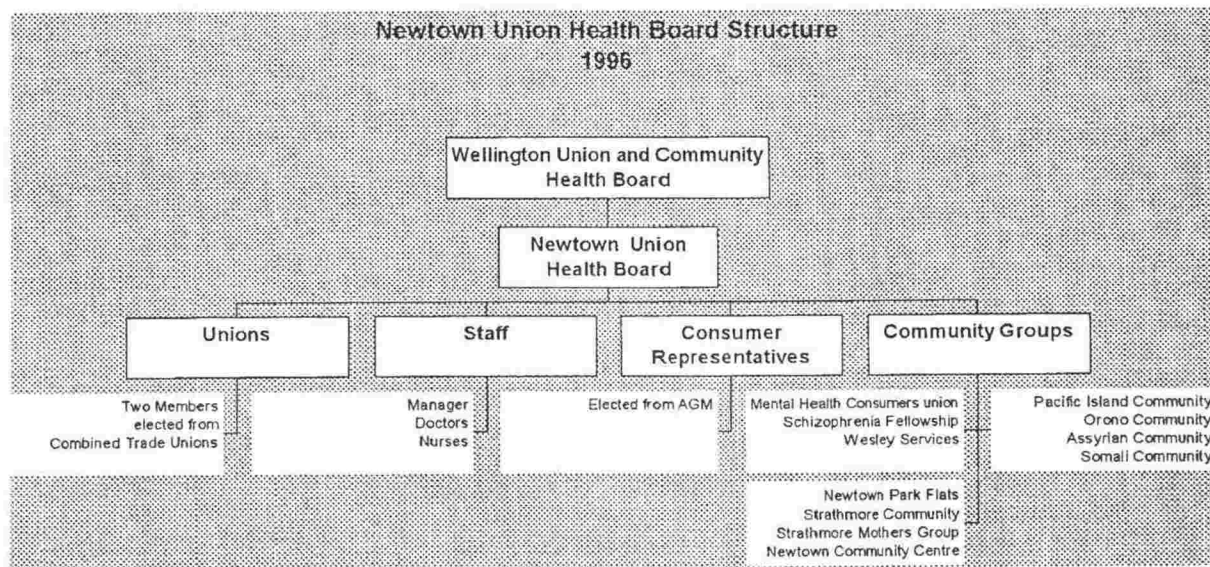
We understand the reasons are very valid reasons for the delay in the completion of your doctoral study and were pleased to learn that your husband is somewhat better. We hope you are able to complete your research in the near future. Many thanks for your letter and for the very useful feedback to the Ethics Committee.

Yours sincerely



Sharron Cole  
**CHAIRPERSON**

*Appendix 12 – Newtown Union Health Board Structure*



**Newtown Union Health Services Policy Board  
1997/98**

## *Appendix 13 - Newtown Union Health Service Primary Mental Health Team*

Draft - August 1992

### NEWTON UNION HEALTH SERVICE

### PRIMARY MENTAL HEALTH CARE TEAM

#### INTRODUCTION

The NUHS was established five years ago in an inner city suburb of Wellington. It has developed a model of primary health care based on the definition of Primary Health Care (PHC) at WHO conference at Alma Ata (September 1978). A priority was that the Service be affordable, acceptable, appropriate and of high quality.

Due to our geographic situation, and style of practise and our focus on low income workers, beneficiaries and unemployed, we attracted a large group of the chronically mentally ill (currently over 200 on the register).

Early on it became clear the needs of this group were large, and required special skills to meet. Not only is there an evaluation of their mental health and related issues, liaison with other agencies, but a careful review of physical health is also needed; many patients having chronic, serious underlying physical conditions too.

#### PRIMARY MENTAL HEALTH CARE TEAM

To meet these needs a doctor/nurse team was established to focus on this group and improve services to them. We set about this in a variety of ways:

- We contacted the Mental Health Consumer Union and advised them that our support and help were available if needed. We also advised them that our nurse ran well-women's health services. A member of their Union was on our management committee. We see consumer involvement in service planning essential.
- We established liaison with local hostels eg. Hanson House, Richmond Fellowship and self-help groups for the mentally ill ie. Schizophrenia Fellowship. Our nurse has run various health groups there on food, women's health etc.
- We developed links with psychiatric domiciliary nurses and attended the Moderate Clinic to liaise with other health workers in the psychiatric field.
- Individuals were offered nursing and medical support from NUHS, and many felt comfortable receiving assistance in a 'non psychiatric setting'.
- Our staff are tolerant, accepting and welcoming to a huge variety of people, with differing behaviour and ethnic backgrounds.

## GOALS

The doctor/nurse team in the clinic aim to:

- i. maintain people with psychiatric illnesses in the community
- ii. Liaise with relevant key psychiatric workers
- iii. detect deterioration early, and act appropriately, hopefully to avert admission, and prevent crisis occurring
- iv. attend to the multiple medical/social needs of the individual.

## ROLE OF PRACTICE NURSE IN THE PRIMARY MENTAL HEALTH CARE TEAM

Liaise with other agencies, community groups, care-givers of people with health problems in conjunction with designated NUHS medical practitioner by:

- providing health education services when required to these groups
- attending/initiating case conferences when necessary
- arranging meetings with the above groups as required
- attending outreach clinics/activities centres.

Is the Primary nurse in the Service for mental health clients by:

- maintaining an overview of all mental health clients
- being available within the clinic for support and follow-up
- using the recall system to ensure adequate follow-up
- home visiting when necessary
- appropriate referral to NUHS medical practitioner or to designated key mental health worker
- helping us to pick up on the non-attenders, those late with medication and to allow general physical review if needed.

## **THE SHARED CARE PILOT**

### *Where can I get more information about the pilot and the evaluation?*

If you would like more information about the pilot or the evaluation, copies of the pilot manual are available at Community Mental Health and with the GPs involved in the pilot. You can also contact Virginia MacEwan at Community Mental Health in Napier 06 878 1602 ext 5384 or Kathy Nelson, the Project Manager, on 04 496 6565. Kathy can also be contacted by writing to the Health Services Research Centre, Victoria University, PO Box 600, Wellington.

### *What is this pilot about?*

The Shared Care Pilot Project is a project funded by the Central Regional Health Authority that is starting in Napier and Wairoa in June 1996. The pilot aims to improve the health care of people with a major mental illness. It will achieve this by enabling people with a major mental illness to see their general practitioner (GP) for their mental health without having to pay. The pilot also funds the GP and the community mental health team (CMHT) to develop ways of working together in caring for the person with a major mental illness.

### *What is shared care?*

For the pilot, shared care means that a client will be cared for jointly by the CMHT and the GP. The care and treatment received by clients will ultimately fall along a continuum from care being predominantly provided by the CMHT, with little or no input by the GP for their mental health, through to CMHT/GP shared care, to predominantly GP only care for mental health.

### *How will care be organised for clients in the pilot?*

1. The CMHT will identify all clients whose GP is one who is participating in the pilot, or who do not have a GP. The CMHT will then discuss the pilot and the evaluation with the client and invite the client to participate.
2. Once a client has consented to participate, the client is asked to complete a questionnaire and a health survey. The CMHT completes a referral form which tells the GP the name of the client in the pilot, who in the CMHT is working with the client and what the goals and treatment are for this client. The CMHT also suggests ways the GP can participate in the care of the client.
3. Clients can then see the GP as well as the CMHT for their mental health, free of charge. After 3-6 months into the pilot (or sooner if appropriate) the client and their support people, GP, CMHT and others involved in working with the client will meet for a Case Review. At the Case Review an ongoing plan for care is developed. This plan will be formally reviewed as required or after twelve months.
4. The pilot is expected to run for two years. During this time clients will be asked to give feedback on the new arrangements for their mental health care.
5. The GP can also give a limited number of extended consultations for mental health to other clients s/he sees at the surgery.

### *How will the pilot affect the GP and the CMHT?*

The GPs and CMHT will be working together to provide a complementary service based on shared care for each client. They are expected to consult with clients and each other before major changes in a client's health care is made. The GP and CMHT will participate in an ongoing training programme and they will liaise to work out procedures and guidelines for improving mental health care and services in the Napier and Wairoa region.

### *How will the pilot be evaluated?*

Throughout the pilot information will be collected on clients' use of GP and CMHT services and what this involves. This will be analysed along with information obtained from the questionnaires, data on the use of health services and health outcome measures. The evaluation will also look at how the GP and CMHT work together. All information is treated confidentially and any reports written will not contain personal information. The evaluation has been approved by the Hawkes Bay Ethics Committee.



## References

- Abbott, A. (1988). *The system of professions: An essay on the division of expert labor*. Chicago: University of Chicago Press.
- Abbott, B., Jordan, P., & Murtaza, N. (1995). Interagency collaboration for children's mental health services: The San Mateo County model for managed care. *Administration and Policy in Mental Health*, 22(3), 301-313.
- Abbott, M. W., & Kemp, D. R. (1993). New Zealand. In D. Kemp (Ed.), *International handbook on mental health policy* (pp. 217-252). Westport, USA: Greenwood Press.
- Abrahamson, P. (2000). The welfare modelling business. In N. Manning & I. Shaw (Eds.), *New risks, new welfare: signposts for social policy* (pp. 57-78). Oxford: Blackwell Publishers Ltd.
- Allen, D., Harley, M., & Makinson, G. T. (1987). Performance indicators in the National Health Service. *Social Policy & Administration*, 21(1), 70 - 84.
- Allott, P., & Holmes, P. (1993). Involving service users. In C. Dean & F. Freeman (Eds.), *Community Mental Health* (pp. 119-122). London: Gaskell.
- Al-Shammari, S. A., Kohja, T. A., & Rajeh, S. A. (1996). Role of primary care physicians in the care of epileptic patients. *Public Health*, 110, 47-48.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders: DSM IV* (4th ed.). Washington: Author.
- Andrews, G., Peters, I., & Teeson, M. (1994). *The measurement of consumer outcome in mental health*: Australian Government Publishing Service.
- Annual General Meeting. (1988, 24 May). *Minutes of 1st Annual General Meeting of the Newtown Union Health Service*, Newtown Union Health Service Records.
- Annual General Meeting. (1989, November). *Minutes of 2nd Annual General Meeting of the Newtown Union Health Service*, Newtown Union Health Service Records.
- Annual General Meeting. (1990, May). *Minutes of 3rd Annual General Meeting of the Newtown Union Health Service*, Newtown Union Health Service Records.
- Anthony, W. A., Forbess, R., & Cohen, M. A. (1993). Rehabilitation-oriented case management. In M. Harris & H. Bergman (Eds.), *Case management for mentally ill patients: Theory and practice* (pp. 99-118). Chur: Harwood Academic Publishers.
- Armstrong, E. (1995). *Mental health issues in primary care: a practical guide*. London: Macmillan.
- Armstrong, N. (1994). State. In P. Spoonley et al., (Eds.), *New Zealand Society* (2nd ed., pp. 113-129). Palmerston North: The Dunmore Press Ltd.
- Arya, D. K., & North, N. (1999). Reorganising mental health services in New Zealand. *Health Manager*, 6(2), 11-15.
- Ashton, T. (1994). Managed care: The stepping stone into the future. *Mental Health News*(Winter), 13-14.
- Ashton, T., Beasley, D., Alley, P., & Taylor, G. (1991). *Reforming the New Zealand health system: Lessons from other countries*: Report of a study tour to Health Boards New Zealand Council.
- Ayling, R. (1999). The Joint Commissioning Officer's story. In R. Poxton (Ed.), *Working across the boundaries* (pp. 47-57). London: King's Fund Publishers.
- Bachrach, L. (1992). Case management revisited. *Hospital and Community Psychiatry*, 43(3), 209-210.
- Bagnall, C. (c.1988). Health care "in slippers". *Health Promotion Forum*, 2-3.
- Bailey, G. (1997, 18 August). GPs 'better' for patients' mental care. *The Evening Post*, pp. 3.
- Baldwin, S. (1993). *The myth of community care: An alternative neighbourhood model of care*. Glasgow: Chapman & Hall.

- Baldwin, S., & Parker, G. (1988/9). The Griffiths Report on community care. In M. Brenton & C. Ungerson (Eds.), *Social Policy Review 1988-9* (pp. 143-160). London: Longman.
- Balint, M. (1964). *The doctor, his patient, and the illness* (2nd ed.). London: Pitman Medical.
- Banta, D. (1981). Public policy and medical technology: Critical issues reconsidered. In C. Altenthaler (Ed.), *Innovation in health policy and service delivery* (pp. 57-85). Cambridge: Oelgeschlager, Gunn & Hain, Publishers Inc.
- Barclay, S., Todd, C., McCabe, J., & Hunt, T. (1999). Primary care group commissioning of services: the differing priorities of general practitioners and district nurses for palliative care services. *British Journal of General Practice*, 49, 181-190.
- Bares, E., & Linder-Pelz, S. (1990). *Health care issues* (2nd ed.). Sydney: Allen & Unwin Pty Ltd.
- Barnett, J. R., & Coyle, P. (1998). Social inequality and general practitioner utilisation: assessing the effects of financial barriers on the use of care by low income groups. *New Zealand Medical Journal*, 111, 66-70.
- Barnum, H., Kutzin, J., & Saxenian, H. (1995). Incentives and provider payment methods. *International Journal of Health and Management*, 10, 23-45.
- Bass, R. D., & Windle, C. (1972). Continuity of care: An approach to measurement. *American Journal of Psychiatry*, 129(2), 196-201.
- Bates, E., & Linder-Pelz, S. (1990). *Chronicity of ill-health* (2nd ed.). Sydney: Allen & Unwin.
- Bell, S. A., & Brookbanks, W. J. (1998). *Mental health law in New Zealand*. Wellington: Brooker's Ltd.
- Belmartino, S. (1994). The role of the state in health systems. *Social Science and Medicine*, 39(9), 1315-1321.
- Berringer, P. (1996). *New Zealand pharmaceutical management: analysis and prescription*. Paper presented at the Social Science and Health Seminar Series, Health Services Research Centre, Wellington.
- Bichan, H., & Mellis, G. (1987). The future of mental hospitals in New Zealand. *New Zealand Medical Journal*, 100, 709-711.
- Billingham, B., & Whitfield, M. (1993). Why do patients change their general practitioner? A postal questionnaire study of patients in Avon. *British Journal of General Practice*, 43, 336-338.
- Bindman, J., Johnson, S., Wright, S., Szmukler, G., Bebbington, P., Kuipers, E., & Thornicroft, G. (1997). Integration between primary and secondary services in the care of the severely mentally ill: patients' and general practitioners' views. *British Journal of Psychiatry*, 171, 169-174.
- Blackburn, G. (1999). The Social Services Team Manager's story. Towards an integrated health and social team. In R. Poxton (Ed.), *Working across the boundaries* (pp. 21-28). London: King's Fund Publisher.
- Board of Health. (1986). *Community mental health services: issues and implications*. Wellington: Board of Health, Mental Health Committee.
- Board of Health. (1987). *Barriers to (mental) health care: a call for reform*. Wellington: Board of Health, Mental Health Committee.
- Bogle, I., & Chislom, J. (1996). *Primary care: restoring the jewel in the crown*. British Medical Journal [Electronic version]. Retrieved 19 February, 2002.
- Boston, J. (1995a). Inherently governmental functions and the limits to contracting out. In J. Boston (Ed.), *The state under contract* (pp. 78-111). Wellington: Bridget Williams Books Ltd.
- Boston, J. (1995b). *The state under contract*. Wellington: Bridget Williams Books Ltd.
- Boston, J., & St John, S. (1999). Targeting versus universality: Social assistance for all or just for the poor? In J. Boston et al., (Eds.), *Redesigning the Welfare State in New*

- Zealand: Problems, policies, prospects* (pp. 93-113). Auckland: Oxford University Press.
- Bowie, R., & Shirley, I. (1994). Political and economic perspectives on recent health policy. In J. Spicer et al., (Eds.), *Social dimensions of health and disease* (pp. 298-322). Palmerston North: The Dunmore Press Ltd.
- Boyer, C. A. (1997). Meaningful linkage practices: challenges and opportunities. In D. Mechanic (Ed.), *Improving psychiatric treatment in an era of managed care* (Vol. 73, pp. 87-101). San Francisco: Jossey-Bass Inc.
- Boyle, P. J., & Callahan, D. (1995). Minds and hearts: priorities in mental health services. In P. Boyle & D. Callahan (Eds.), *What price mental health? The ethics and politics of setting priorities* (pp. 3-44). Washington: Georgetown University Press.
- Brand, D. J. (1996). General practice reform: the shared management model. *Medical Journal of Australia*, 164, 221-223.
- Bridgman, G. (1994). Dangerousness and psychiatric illness. *Mental Health News*(Autumn), 10-12.
- Bridgman, G. (1997). *Case management and service coordination in mental health services* (Research). Auckland: Contract to the Ministry of Health.
- Brunton, W. (2001). Mental health: the case of deinstitutionalisation. In P. Davis & T. Ashton (Eds.), *Health and public policy in New Zealand* (pp. 181-200). Auckland: Oxford University Press.
- Bryman, A. (1989). *Research methods and organizational studies*. London: Unwin Hyman Ltd.
- Burns, T., & Cohen, A. (1998). Item-of-service payments for general practitioner care of severely mentally ill persons: does the money matter? *British Journal of General Practice*, 48(July 1998), 1415-1416.
- Burns, T., Millar, E., Garland, C., Kendrick, T., Chisholm, B., & Ross, F. (1998). Randomized controlled trial of teaching practice nurses to carry out structured assessments of patients receiving depot antipsychotic injections. *British Journal of General Practice*, 48(437), 1845-1848.
- Butler, J. R. G. (1990). *Day surgery: Cost-reducing technological change* (Working Paper Number 14): National Centre for Epidemiology and Population Health, The Australian National University.
- Callahan, D. (1994). Setting mental health priorities: problems and possibilities. *The Milbank Quarterly*, 72(3), 451-470.
- Calnan, M., & Gabe, J. (1991). Recent developments in general practice: a sociological analysis. In J. Gabe et al., (Eds.), *The sociology of the health service* (pp. 140-161). London: Routledge.
- Carpenter, J., & Sbarini, S. (1997). *Choice information and dignity: involving users and carers in care management in mental health*. Bristol: the Policy Press.
- Carr, V. (1997a). The role of the general practitioner in the treatment of schizophrenia: general principles. *Medical Journal of Australia*, 188(20 January), 91-94.
- Carr, V. (1997b). The role of the general practitioner in the treatment of schizophrenia: specific issues. *Medical Journal of Australia*, 166(3 February), 143-146.
- Carr, V., Lewin, T., Walton, J., Faehrmann, & Reid, A. (1996). Consultation-liaison psychiatry in general practice. *Australian and New Zealand Journal of Psychiatry*, 31, 85-94.
- Carr, V. J., & Donovan, P. (1992). Psychiatry in general practice a pilot scheme using the liaison-attachment model. *The Medical Journal of Australia*, 156, 379-382.
- Carr-Hill, R., Rice, N., & Proland, M. (1996). Socio-economic determinants of rates of consultation in general practice based on fourth national morbidity survey of general practices. *British Medical Journal*, 312, 1008-1013.

- Carson, J., Glynn, T., & Gopaulen, J. (1993). The influence of normalization on psychiatric services. In M. Weller & M. Muijen (Eds.), *Dimensions of community mental health care* (pp. 261-276). London: W.B. Saunders.
- Cartwright, S. (1988). *The report of the committee of inquiry into allegations concerning the treatment of women with cervical cancer at National Women's Hospital and into other related matters*. New Zealand.
- Caygill, D. (c.1988). *Health a prescription for change*. Wellington: Ministry of Health.
- Central Regional Health Authority. (1994). *Implementation of a better life*. Wellington: Author.
- Central Regional Health Authority. (1996a). *Primary care services strategic plan for consultation*. Wellington: Author.
- Central Regional Health Authority. (1996b). *The shared care pilot manual*. Wellington: Author.
- Chapman, T., Goodwin, S., & Hennelly, R. (1991). A new deal for the mentally ill: progress or propaganda? *Critical Social Policy*, 32(Autumn), 5-20.
- Chetty, S. (1996). The case study method for research in small- and medium-sized firms. *International Small Business Journal*, 15(1), 73-85.
- Cheyne, C., O'Brien, M., & Belgrave, M. (1997). *Social policy in Aotearoa New Zealand: a critical introduction*. Auckland: Oxford University Press.
- Chiplin, J., Bos, V., Harris, C., & Codyre, D. (1998). *Clinical accountability within the mental health sector* (Review). Wellington: Mental Health Commission.
- Clinical Staff Meeting. (1993, 26 May). *Minutes of Newtown Union Health Services clinical staff planning meeting*, Newtown Union Health Service Records.
- Cockerill, R., & Barnsley, J. (1997). Innovation theory and its applicability to our understanding of the diffusion of new management practices in health care organizations. *Healthcare Management Forum*, 10(1), 35-38.
- Cohen, A. (Ed.). (2003). *Primary Solutions, an independent policy review on the development of primary care mental health services*. London: Sainsbury Centre for Mental Health.
- Cohen, A., & Hove, M. (2001). *Physical health of the severe and enduring mentally ill: A training pack for GP educators*. London: Sainsbury Centre for Mental Health.
- Cohen, A., & Singh, S. (2001). *A General Practitioner's guide to managing severe mental illness*. London: Sainsbury Centre for Mental Health.
- Collings, S., & De Groot, R. (1999). Shared care: the role of informal carers. In P. Ellis (Ed.), *Geigy Psychiatric Symposium 1977* (pp. 79-85). Wellington: Geigy.
- Conrad, D., & Shortell, S. (1996). Integrated health systems: Promise and performance. *Frontiers of Health Service Management*, 13(1), 3-40.
- Controller and Auditor-General. (1993). *Community care for people with mental illness*.
- Cooper, H., & Klewe, J. (1996). Insight and acceptance of the need for medication. *Primary Care Psychiatry*, 2 (Suppl 1), 1-3.
- Core Group Minutes. (1995, 18 April). *Minutes of Core Group Meeting, April*, Newtown Union Health Service.
- Corney, R. H. (1996). GP's views and use of adult health services in England and Wales: a survey investigating the effect of fundholding. *Journal of Mental Health*, 5(5), 489 - 499.
- Cornwell, N. (1992). Assessment and accountability in community care. *Critical Social Policy*, 36(Winter), 40-52.
- Corrigan, P. W., & Kayton-Weinberg, D. (1993). "Aggressive" and "problem- focused" models of case management for the severely mentally ill. *Community Mental Health Journal*, 29(5), 449-458.
- Coster, G., & McAvoy, P. (1996). Health reforms: a New Zealand perspective. *British Journal of General Practice*, 391-392.

- Coulter, A. (1991). Evaluating the outcomes of health care. In J. Gabe et al., (Eds.), *The sociology of the health service* (pp. 115-139). London: Routledge.
- Coulter, A. (1995). Shifting the balance from secondary to primary care. *British Journal of Medicine*, 311, 1447-1448.
- Coverdale, J., & Falloon, I. (1993). Home or hospital-based emergency care for chronic psychiatric patients. *New Zealand Medical Journal*, 106, 218-219.
- Craig, P. (1991). Costs and benefits: A review of research on take-up of income-related benefits. *Journal of Social Policy*, 20(4), 537-565.
- Crampton, P. (2001). Policies for general practice. In P. Davis & T. Ashton (Eds.), *Health and public policy in New Zealand* (pp. 201-218). Auckland: Oxford University Press.
- Crampton, P., & Brown, M. (1998). General practitioner funding policy: from where to wither? *New Zealand Medical Journal*, 111, 302-304.
- Crampton, P., Dowell, A., & Bowers, S. (2000). Third sector primary health care in New Zealand. *New Zealand Medical Journal*, 113(1106), 92-96.
- Crampton, P., Dowell, A., Woodward, A., & Salmond, C. (2000). Utilisation rates in capitated primary care centres serving low income populations. *New Zealand Medical Journal*, 113(1120), 436-438.
- Craven, M. A., & Bland, R. (2002). Shared mental health care: a bibliography and overview. *Canadian Journal of Psychiatry*, 47(Suppl 1), 1S - 103S.
- Croll, N. (1995). Community mental health policy. In H. Gardner (Ed.), *The politics of health* (2nd ed., pp. 483-509). Melbourne: Churchill Livingstone.
- Crompton, J. B. (1981). Northland and the health pilot scheme. In Moore (Ed.), *The reorganisation of the health service: A tribute to Ralph Brookes* (pp. 50-55). Wellington: N.Z. Institute of Public Administration.
- Crowson, J. T. (1993). *Reshaping mental health services* (Research 16). London: Kings Fund Institute.
- Cuffel, B. J., Snowden, L., Masland, M., & Piccagli, G. (1996). Managed care in the public mental health system. *Community Mental Health Journal*, 32 (2), 109-124.
- Cumming, J., & Mays, N. (1999). Shifting to capitation in primary care: What might the impact be in New Zealand? *Australian Health Review*, 22(4), 8-24.
- Cumming, J., & Salmond, G. (1998). Reforming New Zealand health care. In W. Ranade (Ed.), *Markets and health care: a comparative analysis* (pp. 122-146). Edinburgh Gate: Addison Wesley Longman Limited.
- Curtis, L. C. (1997). *New directions: international overview of best practices in recovery and rehabilitation services for people with serious mental illness-a discussion paper*. Wellington: Mental Health Commission.
- Daly, M., & Noble, M. (1996). The reach of disability benefits: an examination of the disability living allowance. *Journal of Social Welfare and Family Law*, 18(1), 37-51.
- Dangerfield, D., & Betit, R. (1993). Managed mental health care in the public sector. *New directions for mental health services*, 59(Fall), 67-80.
- Dash, D. (1997). *Problems of action research - As I see it* (Working Paper No 14 ed.): Lincoln School of Management.
- Datta, L. (1997). Multimethod evaluations. In E. Chelimsky & W. Shadish (Eds.), *Evaluation for the 21st century: a handbook* (pp. 344-359). Thousand Oaks, CA: Sage Publishers.
- Davies, B. (1994). Thinking long in community care. In N. Deakin & R. Page (Eds.), *Costs of Welfare* (pp. 200-266): Avebury: Ashgate.
- Davey, J. (2001). New Zealand: The myth of egalitarianism. In P. Alcock & G. Craig (Eds.), *International social policy: welfare regimes in the developed world* (pp. 85-103). Hounsmill: Palgrave.
- Davis, P., & Ashton, T. (Eds.). (2001). *Health and public policy in New Zealand*. Auckland: Oxford University Press.

- Davis, W. (1991). The innovators. In J. Henry & D. Walker (Eds.), *Managing innovation* (pp. 142-149). London: Sage Publications Ltd.
- Davison, J. (1999). Nurse practitioner in primary mental health. In K. James et al., (Eds.), *The Newtown Union Health Service primary mental health programme: a report for the THEMHS award* (pp. 11-12). Wellington: Newtown Union Health Service.
- Davison, J., & James, K. (1996). *Primary mental health care orientation manual*: Newtown Union Health Service.
- Deegan, P. E. (1996, September). *There is a person in here, but is there a person over there?* (audio tape). Paper presented at The 6th annual Mental Health Services Conference of Australia and New Zealand (THEMHS), Brisbane.
- deGruy, F. V. (1999). The primary care provider's view. *New Directions for Mental Health Services*, 81(Spring), 33-39.
- de Lacey, A. (1984). *Community groups working for health: issues and experiences*. Wellington: Department of Health.
- Department of Health. (1982). *Health services reorganisation: A discussion document*. Wellington: Author.
- Department of Health. (1983). *Survey of occupied psychiatric hospital beds and psychiatric day and outpatients, 1981* (Special Report Series 66). Wellington: Author.
- Department of Health. (c.1984). *Equitable funding of Hospital Boards*. Wellington: Issued by the Division of Hospitals, Department of Health.
- Department of Health. (1993). *Primary mental health care* (Discussion paper). Wellington: Author.
- Department of Health. (n.d.). *Health care charges and subsidies*: Department of Social Welfare and the Department of Health.
- Dingwall, R. (1992). 'Don't mind him - he's from Barcelona' Qualitative methods in health studies. In J. Daly et al., (Eds.), *Researching health care designs, dilemmas, disciplines* (pp. 161-175). London: Routledge.
- Disley, B. (1990). Planning in mental health services. *Community Mental Health in New Zealand*, 5(2), 16-29.
- Disley, B. (1991). The benefit cuts - what could this mean for the mental health of New Zealanders. *Mental Health News*(Autumn), 21-22.
- Disley, B. (1996). *Reducing the risk of mental disorder and suicide - Public health strategies* (Research report).
- Dowland, J., & McKinlay, R. (1985). *Caring, curing and controlling: An outsiders look at life and work in New Zealand psychiatric hospitals*. (Special Report 75). Wellington: Department of Health.
- Drucker, P. F. (1985). *Innovation and entrepreneurship*. New York: Harper & Row Publishers.
- Drucker, P. F. (1991). The discipline of innovation. In J. Henry & D. Walker (Eds.), *Managing innovation* (pp. 9-17). London: Sage Publications.
- Dyall, L. (1997). Maori. In P. Ellis & S. Collings (Eds.), *Mental health in New Zealand from a public health perspective* (pp. 85-103). Wellington: Ministry of Health.
- Egger, E. (2001). Health care leaders no longer can afford to wing it when it comes to finance. *Healthcare Strategic Management*, 12-13.
- Elston, M. A. (1997). Introduction: the sociology of medical science and technology. In M. Elston (Ed.), *The sociology of medical science & technology* (pp. 1-27). Oxford: Blackwell Publishers Ltd.
- Emanuel, E., & Emanuel, L. (1996). What is accountability in health care? *Annals of Internal Medicine*, 124(2), 229-239.
- English, B. (1997). Minister's Forward. In Ministry of Health (Ed.), *The national mental health standards* (pp. iii): Ministry of Health.

- Epstein, S. A., Gonzales, J. J., Stockton, P., Goldstein, D. M., & Green, B. L. (1996). Functioning and well-being of patients in a consultation-liaison psychiatry clinic. *General Hospital Psychiatry, 18*, 3-7.
- Essex, B., Doig, R., & Renshaw, J. (1990). Pilot study of records of shared care for people with mental illnesses. *British Medical Journal, 300*, 1442-1446.
- Etzioni, A. (1964). *Modern organizations*. Englewood Cliffs: Prentice-Hall Inc.
- Falloon, I., Ng, B., Bensemam, C., & Kydd, R. R. (1996). The role of general practitioners in mental health care: a survey of needs and problems. *New Zealand Medical Journal, 109*, 34-36.
- Farley, S. (1993). The community as partner in primary health care. *Nursing & Health Care, 14*(5), 244-247.
- Ferguson, B., Cooper, S., Brothwell, J., Markantonakis, A., & Tyrer, P. (1992). The clinical evaluation of a new community psychiatric service based on general practice psychiatric clinics. *British Journal of Psychiatry, 160*, 493-497.
- Flynn, R., Pickard, S., & Williams, G. (1995). Contracts and the quasi-market in community health services. *Journal of Social Policy, 24*(4), 529-550.
- Flynn, R., Williams, G., & Pickard, S. (1996). *Markets and networks contracting in community health services*. Buckingham: Open University Press.
- Foltz, A-M. (1996). The policy process. In K. Janovsky (Ed.), *Health policy and systems development: An agenda for research* (pp. 207-227). Geneva: World Health Organization.
- Foster, P. (1983). *Access to welfare*. Manchester: The Macmillan Press Ltd.
- Freeman, G., Weaver, T., Crawford, M., Low, J., & de Jonge, E. (2002, February). *Patients with severe mental illness (SMI): their experience of cross-boundary and interpersonal continuity of care*. Paper presented at the Best Practices and Developments in Integrated Care, Strasbourg.
- Freeman, R., Gillam, S., Shearin, C., & Pratt, J. (1997). *Community development & involvement in primary care: A guide to involving the community in COPC*. London: King's Fund.
- Fries, J., Koop, E., Beadle, C., Cooper, P., England, M. J., Greaves, R., Sokolov, J., Wright, D., & Health Project Consortium. (1998). Beyond health promotion: reducing need and demand for medical care. *Health Affairs, 17*(No. 2, March/April 1998), 70-84.
- Frost, B. R. (1997). Gatekeepers no more: family practitioners as power brokers and fence wanderers. *New Zealand Medical Journal, 110*, 129-130.
- Gallucci, G., & Lima, B. R. (1996). General health care. In W. Breakey (Ed.), *Integrated mental health services: modern community psychiatry* (pp. 276 - 285). New York: Oxford University Press.
- Gask, L., Sibbald, B., & Creed, F. (1997). Evaluating models of working at the interface between mental health services and primary care. *British Journal of Psychiatry, 170*, 6-11.
- Gauld, R. (2001a). Hospitals and associated services. In P. Davis & T. Ashton (Eds.), *Health and public policy in New Zealand* (pp. 219-236). Auckland: Oxford University Press.
- Gauld, R. (2001b). *Revolving doors: New Zealand's health reforms*. Wellington: Institute of Policy Studies and the Health Services Research Centre, Victoria University of Wellington.
- Gibbs, A. (1988). *Unshackling the hospitals: Report of the Hospitals and Related Services Taskforce*. Wellington: Hospitals and Related Services Taskforce.
- Gidlow, B., Perkin, H., Cushman, G., & Simpson, C. (1994). Leisure and recreation. In I. Shirley (Ed.), *New Zealand society* (2nd ed., pp. 253-270). Palmerston North: The Dunmore Press.

- Gilbert, N., Specht, H., & Terrell, P. (1993). *Dimensions of social welfare policy* (3rd ed.). Englewood Cliffs: Prentice Hall Inc.
- Gilbody, S., & House, A. (1999). Variations in psychiatric practice. *British Journal of Psychiatry*, 175, 303-305.
- Gillam, S., Plamping, D., McClenahan, J., Harries, J., & Epstein, L. (1994). *Community-oriented primary care*. London: Kings Fund.
- Ginsberg, L. (1994). *Understanding social problems, policies, and programs*. Columbia: University of South Carolina Press.
- Glascow, N. (1996). The gatekeeper controversy: why it exists and how it can be resolved. *New Zealand Medical Journal*, 109, 168-170.
- Gleeson, B., Hay, C., & Law, R. (1996). *The geography of mental health in Dunedin, New Zealand*. Unpublished manuscript.
- Glennerster, H. (1993). Paying for welfare: Issues for the nineties. In N. Deakin & R. Page (Eds.), *The Costs of Welfare* (pp. 13-28). Aldershot, U.K.: Avebury.
- Glennie, H. R. R. (1992). Down-sizing hospitals with effective community care. *New Zealand Medical Journal*, 105, 202-203.
- Godfrey, M., & Wistow, G. (1997). The user perspective on managing for health outcomes: the case of mental health. *Health and Social Care in the Community*, 5(5), 325-332.
- Goffman, E. (1961). *Asylums*. New York: Anchor.
- Goldberg, D., & Gournay, K. (1997). *The general practitioner, the psychiatrist, and the burden of mental health care*. London: Institute of Psychiatry.
- Gordon, P., & Plamping, D. (1996). Primary health care - its characteristics and potential. In P. Gordon & R. Hadley (Eds.), *Extending primary care* (pp. 1-15). Oxford: Radcliffe Medical Press.
- Gournay, K. (1994). Redirecting the emphasis to serious mental illness. *Nursing Time*, 90, 40-41.
- Gournay, K. (1996). Setting clinical standards for care in schizophrenia. *Nursing Times*, 92(7), 36-37.
- Gournay, K., & Brooking, I. (1994). Community psychiatric nurse in primary health care. *British Journal of Psychiatry*, 165(2), 231-238.
- GP Weekly. (1995, 21 June). Schizophrenia recovery rate much improved. *GP Weekly*.
- Graffy, J. (1990). Patient choice in a practice with men and women general practitioners. *British Journal of General Practice*, 40(January), 13-15.
- Green, D. G. (1996). *From welfare state to civil society*. Wellington: New Zealand Business Roundtable.
- Green, T., Hornblow, A., Sheerin, I., Marshall, T., & Robertson, N. (1992). Residential care for the long term mentally ill in Canterbury: Options, costs and funding sources. *New Zealand Medical Journal*, 105, 371-373.
- Greenley, J. (1992). Neglected organization and management issues in mental health systems development. *Community Mental Health Journal*, 28(5), 371 - 384.
- Gregory, R. (1989). Political rationality or 'incrementalism'? Charles E. Lindblom's enduring contribution of public policy making theory. *Policy and Politics*, 17(2), 139-153.
- Gribben, B. (1996). The community services card and utilisation of general practitioner services. *New Zealand Medical Journal*, 109(22 March), 103-105.
- Gribben, B., & Coster, G. (1999). A future for primary healthcare in New Zealand. *Australian Health Review*, 22(4), 118-134.
- Gummesson, E. (1991). *Qualitative methods in management research*. Newbury Park: Sage Publications Inc.
- Hadley, R., & McGrath, M. (1984). *When social services are local the Normation experiment*. London: George Ellen and Unwin.



- Haggard, L. (1997). Commissioning services to meet identified needs. In D. Hennessy (Ed.), *Community health care development* (pp. 62-85). Houndsmills: MacMillan Press Ltd.
- Haines, H. (1988). Research in focus. *Mental Health News*, 11-13.
- Hall, B. A. (1996). Analysis of its undermining effects on nursing in chronic mental illness. *Advanced Nursing Science*, 18(3), 16-26.
- Halliday, J. (1988). Community involvement in planning and implementing Auckland's mental health services. *Mental Health News*(Feb/March), 6-8.
- Ham, C. (1980). Approaches to the study of social policy making. *Policy and Politics*, 8(8), 55-71.
- Hammersley, M. (1995). *The politics of social research*. London: Sage Publications Ltd.
- Hansson, L. (1996). Sectorised services outcome research. In H. Knudsen & G. Thornicroft (Eds.), *Mental health services evaluation* (pp. 197-212). Cambridge: Cambridge University Press.
- Hardy, J. (1981). *Values in social policy - Nine contradictions*. London: Routledge & Kegan Paul.
- Harris, M., Samuels, L., & Penrose-Wall, J. (1997). *From projects to programs* (Draft): Integration Support and Evaluation Research Unit.
- Hartley, J. F. (1994). Case studies in organizational research. In C. Cassell & G. Symon (Eds.), *Qualitative methods in organizational research* (pp. 208-229). London: Sage Publications Ltd.
- Harvey, J. (1995). Up-skilling and the intensification of work: the 'extended role' in intensive care nursing. *The Sociological Review*, 43(4), 765 - 781.
- Hay, I. (1989). *The caring commodity*. New Zealand: Oxford University Press.
- Health and Disability Commissioner. (c.1996). *Your rights when receiving a health or disability service* [Pamphlet].
- Health Care Aotearoa. (2003). *About Te Wana*. Retrieved 6 February 2003, from [www.hca.org.nz/about.htm](http://www.hca.org.nz/about.htm).
- Health Care Aotearoa Inc. (1998, April). *Submission to the Ministerial Taskforce on Nursing*.
- Health Funding Authority. (1998). *The next five years in general practice* (Discussion). Auckland: Author.
- Healy, D. (1995). Involving users in mental health services in the era of the word-processor and the data base, *Community care: Evaluation of the provision of mental health services*.
- Healy, J. (1998). *Welfare options: delivering social services*. Sydney: Allen & Urwin.
- Hefford, M. (1998, June). *The Transitional Health Authority: Challenges and opportunities*. Paper presented at the Social Science and Health Seminar Series, Health Services Research Centre, Wellington.
- Heirich, M. (1998). *Rethinking health care*. Boulder, Colorado: Westview Press.
- Henwood, M., Wistow, G., & Robinson, J. (1996). Halfway there? Policy, politics and outcomes in community care. *Social Policy & Administration*, 30(1), 39-53.
- Hickman, M., Drummond, N., & Grimshaw, J. (1994). A taxonomy of shared care for chronic disease. *Journal of Public Health Medicine*, 16(4), 447-454.
- Hill, M. (1997). *Understanding social policy* (5th ed.). Oxford: Blackwell Publishers.
- Hinds, P. (1998, October). *"Input" isn't enough*. Paper presented at the Building Bridges Conference, Christchurch.
- Hogan, M. F. (1996). Managing the whole system of care. In M. Shore (Ed.), *Managed care, the private sector and Medicaid mental health and substance abuse services* (Vol. 72, pp. 13-24): Jossey-Bass.
- Hogwood, B. W., & Gunn, L. A. (1984). *Policy analysis for the real world*. Oxford: Oxford University Press.

- Holloway, F. (1994). Health of the nation: a critical appraisal of government policy on mental health. In J. Le Fanu (Ed.), *Preventionitis* (pp. 81-88). Suffolk: The Social Affairs Unit.
- Horowitz, A., V. (2002). Outcomes in the Sociology of mental illness: where have we been and where are we going? *Journal of Health and Social Behaviour*, 43(June), 143-151.
- Huby, M. (1992). The social fund: managing budgets, meeting needs? In A. Corden et al., (Eds.), *Meeting needs in an affluent society* (pp. 209-218). Aldershot: Avebury.
- Huby, M., & Whyley, C. (1996). Take-up and the Social Fund. *Journal of Social Policy*, 25(1), 1-18.
- Hudson, B. (1992). Community care planning: Incrementalism to rationalism? *Social Policy and Administration*, 26(3), 185-200.
- Huntington, A. (1993). Analysis of nursing practice in two union health clinics. In Matheson (Ed.), *Description of practice nursing service* (Volume 2). Wellington.
- Huxley, P. (1995). Can mental health specialism survive the NHS and community care reforms? *Journal of Mental Health*, 4, 323-327.
- Huxley, P., Hagan, T., Hennelly, R., & Hunt, J. (1990). *Effective community mental health services*. Aldershot: Gower Publishing Company Ltd.
- Income Support. (1997). *People with disabilities*. Wellington: Author.
- Issued by the conference participants. (1985). *Summary report*. Paper presented at the National conference on the role of the doctor in New Zealand: Implications for medical education, Palmerston North.
- Jackson, G., Gater, R., Goldberg, D., Tantam, Loftus, L., & Taylor, H. (1993). A new community mental health team based in primary care. *British Journal of Psychiatry*, 162, 375-384.
- Jacobs, K. (1997). A reforming accountability: GPs and health reform in New Zealand. *International Journal of Health Planning and Management*, 12, 169-185.
- James, K., Davison, J., Van der Munckhof, P., & Nelson, K. (1999). *The Newtown Union Health Service primary mental health programme: a report for the THEMHS award*. Wellington: Newtown Union Health Service.
- Jenkins, M., & Sullivan-Marx, E. (1994). Nurse practitioners and community health nurses. *Nursing Clinics of North America*, 29(3), 459-470.
- Jenkins, R. (1997). *Forward*. London.
- Jennings Jr., E., T., & Krane, D. (1994). *Coordination and welfare reform: the quest for the philosopher's stone* Public Administration Review. [Electronic version], Retrieved 19 February, 2002.
- Jick, T. D. (1979). Mixing qualitative and quantitative methods: Triangulation in action. *Administrative Science Quarterly*, 24, 602- 611.
- Jones, C. (1985). *Patterns of social policy: an introduction to comparative analysis*. London: Tavistock Publications Ltd.
- Jones, L. J. (1994). The contemporary politics of health care, *The social context of health and health work*. London: The Macmillan Press Ltd.
- Keen, J., & Packwood, T. (1995). Case study evaluation. *British Medical Journal*, 311, 444-446.
- Keks, N., Hartrick, J., Trauer, T., Goding, M., Sacks, T., & Katona, L. (1995). *Shared care in community psychiatry - Inner South East Melbourne*. Paper presented at The 5th Annual Mental Health Services Conference of Australia and New Zealand (THEMHS), Auckland.
- Kelsey, J. (1995). *The New Zealand experiment*. Auckland: Auckland University Press.
- Kemp, D. R. (1990). Deinstitutionalisation planning. *Community Mental Health in New Zealand*, 5(2), 2-15.

- Kendrick, T., Burns, T., & Freeling, P. (1995). Randomised controlled trial of teaching general practitioners to carry out structured assessments of their long term mentally ill patients. *British Medical Journal*, 311, 93-98.
- Kendrick, T., Sibbald, B., Burns, T., & Freeling, P. (1991). Role of general practitioners in care of long term mentally ill patients. *British Medical Journal*, 302, 508-510.
- Kennedy, E. (1997, 1 July). You can wear your slippers to the doctor. *The Dominion*, pp. 12.
- Kennett, P. (2001). *Comparative social policy*. Buckingham: Open University Press.
- Kerr, D., Malcolm, L., Schousboe, J., & Pimm, F. (1996). Successful implementation of laboratory budget holding by Pegasus Medical Group. *New Zealand Medical Journal*, 109, 334-337.
- Kettner, P. M., Morony, R. M., & Martin, L. L. (1990). *Designing and managing programs: An effectiveness-based approach*. Newbury Park: Sage Publications Inc.
- King, A. (2001). *The primary health care strategy*. Wellington: Ministry of Health.
- King, M., & Nazareth, I. (1996). Community care of patients with schizophrenia: the role of the primary care team. *British Journal of General Practice*, 46(April), 231-237.
- Klein, R., & Millar, J. (1995). Do-it-yourself social policy: Searching for a new paradigm? *Social Policy & Administration*, 29(4), 303-316.
- Klinkman, M. S. (1997). Competing demands in psychosocial care: A model for the identification and treatment of depressive disorders in primary care. *General Hospital Psychiatry*, 19, 98-111.
- Kraft, M. K. (1998). *Accountable welfare reform: what consumers think*. Public Administration Review [Electronic version] 58(5), 406-417. Retrieved 19 February, 2002.
- Kraus, A., & Pillsbury, J. B. (1994). *Streamlining intake and eligibility systems: agencies find ways to simplify the process for both clients and staff*. Public Welfare [Electronic Version] 52(3), 1-19. Retrieved 19 February, 2002.
- Kuno, E., Rothbard, A. B., & Sands, R. G. (1999). Service components of case management which reduce inpatient care use for persons with serious mental illness. *Community Mental Health Journal*, 35(2), 153-167.
- Kydd, R., & Simpson, S. (1997). From institutional to community care. *Health Manager*, 4(1), 3-6.
- Kydd, R. R., Nola, P. F., & Wright, J. J. (1991). Mental health needs in Auckland: 1982-6. An analysis using the Jarman index. *New Zealand Medical Journal*, 104, 255-257.
- Lang, F. H., Forbes, J. F., Murray, G. D., & Johnstone, E. C. (1997). Service provision for people with schizophrenia 1. Clinical and economic perspective. *British Journal of Psychiatry*, 171, 159-164.
- Lange, D. (1988). *Tomorrow's schools: the reform of educational administration in New Zealand*. Wellington: Government Printer.
- Laugesen, M., & Salmond, G. (1994). New Zealand health care: A background. *Health Policy*, 29, 11-23.
- Lawrie, S. M., Martin, K., McNeill, G., Drife, J., Chrystie, P., Reid, A., Wu, P., Nammery, S., & Ball, J. (1998). *General practitioners' attitudes to psychiatric and medical illness* [Electronic Version]. Psychological Medicine. Retrieved 5 March 1999.
- Lefley, H. (1996). Impact of consumer and family advocacy movements on mental health services. In B. Levin & J. Petrila (Eds.), *Mental health services: a public health perspective* (pp. 81-96). Oxford: Oxford University Press.
- Leonard, A. (1994). The new boundaries of health and welfare in collaborative care. *Social Policy Review*, 9, 162-183.
- Letter to Policy Board. (1995, 20 May). *Manager NUHS to Policy Board*.

- Lewis, J., & Boldy, D. (2002). Decision-making and the health service manager. In M. Harris (Ed.), *Managing health services: concepts and practice* (pp. 169-194). Sydney: MacLennan & Petty.
- Lindblom, C., & Cohen, D. (1979). *Usable knowledge: social science and social problem solving*. New Haven: Yale University Press.
- Lindblom, C. E. (1959). The science of muddling through. *Public Administration Review*, 19, 78-88.
- Lindblom, C. E. (1990). *Inquiry and change*. New York: Yale University Press.
- Lindblom, C. E., & Woodhouse, E. J. (1993). *The policy-making process* (3rd ed.). New Jersey: Prentice-Hall Inc.
- Linkage. (c.2000). *Linkage shared care pilot*. Hamilton: Linkage.
- Long, A. F. (1998). Health services research - a radical approach to cross the research and development divide? In M. Barker & S. Kirk (Eds.), *Research and development for the NHS evidence, evaluation and effectiveness* (2nd ed., pp. 87-101). Oxon: Radcliffe Medical Press Ltd.
- Luxton, J. (1991). *Housing and accommodation: Accommodation assistance*: New Zealand Government.
- MacDonald, J., Jackson, T., & Ellis, P. (1999). Did Wellington have too many acute psychiatric beds in 1996? *New Zealand Medical Journal*, 112(1092), 275-276.
- Macmillan, M., Hornblow, A., & Baird, K. (1992). From hospital to community: a follow up of community placement of the long term mentally ill. *New Zealand Medical Journal*, 105, 348-350.
- Majone, G. (1989). *Evidence, argument and persuasion in the policy process*. New Haven: Yale University Press.
- Malcolm, L. (1989). Bed availability as a significant influence on rates of committal to New Zealand's psychiatric hospitals. *New Zealand Medical Journal*, 102(860), 8-9.
- Malcolm, L. (1993). Trends in primary medical care related services and expenditure in New Zealand 1983-93. *New Zealand Medical Journal*, 106, 470-474.
- Malcolm, L. (1996). The development of independent practice associations and related groups in New Zealand. *New Zealand Medical Journal*, 109, 184-187.
- Malcolm, L. (1998). Capitated primary care: policy, problems & prospects. *Health Manager*, 5(3), 7-9.
- Maloney, W. A., Jordan, G., & McLaughlin, A. (1994). Interest groups and public policy: The insider/outsider model revisited. *Journal of Public Policy*, 14(1), 17-38.
- Management Committee. (1990, 10 December). *Minutes of the Management Committee*.
- Management Committee. (1991, 28 January). *Minutes of Management Committee*.
- Management Committee. (1992, 29 January). *Minutes of Management Committee*.
- Management Committee. (1993, 11 January). *Minutes of Management Committee*.
- Management Committee Working Party. (1992, 20 November). *Minutes of M. Comm. Working Party on financial strategies*, Newtown Union Health Services Records.
- Mandiberg, J. M. (1999). The sword of reform has two sharp edges: Normalcy, normalization, and destruction of the social group. *New Directions for Mental Health Services*, 83(Fall), 31-44.
- Manning, N., & Shaw, I. (2000). Introduction: the millennium and social policy. In Manning & Shaw (Eds.), *New risks, new welfare: signposts for social policy* (pp. 1-11). Oxford: Blackwell Publishers Ltd.
- Marshall, M., Gray, A., Lockwood, A., & Green, R. (1998). *Case management for people with severe mental disorders*: The Cochrane Library, University of South Australia.
- Marshall, T., & Hounsell, D. (1994). The place of general practice. In Taskforce on Strategic Planning (Ed.), *Report of the Taskforce on strategic planning for the future of general medical practice* (pp. 14-19): Ministry of Health.

- Mason, K., Johnston, J., & Crowe, J. (1996). *Inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services* (Ministerial Inquiry): Ministry of Health.
- Mason, K. H., Ryan, A. B., & Bennett, H. R. (1988). *Report of the Committee of Inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients* (Inquiry). Wellington: Ministry of Health.
- Matheson, D. (1991a, 11 March). *Letter to Management Committee re Medical Practitioners Disciplinary Committee*.
- Matheson, D. (1991b, 2 January). *NUHS News NUHS News*.
- Matheson, D. (1992a). The general practice contract scheme: was it targeted? *New Zealand Medical Journal*, 105, 35-36.
- Matheson, D. (1993a). Cost of provision of practice nursing services. In D. Matheson (Ed.), *Description of practice nursing service*. Wellington: NUHS.
- Matheson, D. (1993b). *Description of practice nursing services* (NUHS PUCH Managed Care project Volume 2). Island Bay, Wellington.
- Matheson, D. (1993c). Proposed contract for comprehensive targeted provision of practice nurse services. In D. Matheson (Ed.), *Description of practice nursing service*. Wellington.
- Matheson, D. (Ed.). (1992b). *Health where it hurts*. Wellington: Roger Steele.
- Matheson, S. (2002). *Psychiatric/mental health nursing: positioning undergraduate education* (Research Paper): Graduate School of Nursing and Midwifery, Victoria University of Wellington.
- Maunsell, R. (c.1997). *Shared care in mental health, the way forward?* Unpublished manuscript.
- May, C., & Purkis, M. E. (1997). Editorial: exploring relationships between professionals, patients and others. *Health and Social Care in the Community*, 5(1), 1-2.
- Mays, N. (1993). Innovations in health care. In B. Davey & J. Popay (Eds.), *Dilemmas in health care* (pp. 103-120). Oxford: Oxford University Press: Milton Keynes.
- Mays, N. (1994). Changing clinical behaviour: Do we know how to do it? In A. Harrison (Ed.), *Health Care UK, 1993/94* (pp. 102-117). London: King's Fund Institute.
- Mays, N., & Pope, C. (1995). Rigour and qualitative research. *British Medical Journal*, 311(8 July), 109-112.
- McAvoy, B., Davis, P., Raymont, A., & Gribben, B. (1994). The Waikato medical care (WaiMedCa) survey 1991-1992. *New Zealand Medical Journal Supplement*, 107(986 part 2), 386-433.
- McCabe, S., & Unzicker, R. E. (1995). Changing roles of consumer/survivors in mature mental health systems. In L. Stein & E. Hollingsworth (Eds.), *Maturing mental health systems: new challenges and opportunities* (Vol. 66, pp. 61-73). San Francisco: Jossey-Bass Publishers.
- McCarthy, M. (Ed.). (1989). *The new politics of welfare: an agenda for the 1990s?* Basingstoke: MacMillan.
- McGeorge, P. (1993). Developments in Auckland, New Zealand. In C. Dean & H. Freeman (Eds.), *Community mental health care: International perspectives on making it happen* (pp. 49-60). Auckland: Gaskell & The Centre for Mental Health Services Development.
- McGrath, F. (1989). *The union health centres initiative: An evaluation* (Special report 79). Wellington: Health Services Research and Development Unit.
- McKinlay, J. (1981). From "Promising report" to "Standard procedure": Seven stages in the career of a medical innovation. *Milbank Memorial Fund Quarterly: Health and Society*, 59(3), 374-411.

- McKinlay, J. (n.d.). *Evaluating medical technology in the context of a fiscal crisis: the case of New Zealand*. Massachusetts: Department of Sociology, Boston University and Massachusetts General Hospital (Harvard Medical School).
- McLennan, L. J. (1981). *A survey of the fully subsidised general practice nurse in New Zealand*. Wellington: Wellington Research Committee. Wellington Faculty Royal New Zealand College of General Practitioners.
- Mead, S., & Bradley, H. (n.d.). *Bargaining reform in the health service*: State Services Commission.
- Meadows, G. (1997). *The CLIPP project*. Paper presented at The 7th Annual Mental Health Services Conference of Australia & New Zealand (THEMHS), Sydney.
- Meadows, G. (1998). Establishing a collaborative service model for primary mental health care. *Medical Journal of Australia*, 168, 162-165.
- Meadows, G., Nelson, K., & Wilhelm, K. (1999). A conceptual model for containing approaches to collaborative work in primary mental health care. In P. Ellis (Ed) *Geigy Psychiatric Symposium 1997*, (Vol XVIII, pp.35-39) Wellington.
- Mechanic, D. (1991). Strategies for integrating public mental health services. *Hospital and Community Psychiatry*, 42(8), 797-801.
- Mechanic, D. (1996). Changing medical organization and the erosion of trust. *The Milbank Quarterly*, 74(2), 171-189.
- Mechanic, D. (1997). The challenges of managed care. In D. Mechanic (Ed.), *Improving psychiatric treatment in an era of managed care* (Vol. 73, pp. 1-10). San Francisco: Jossey-Bass Inc.
- Mechanic, D. (2002). Socio-cultural implications of changing organizational technologies in the provision of care. *Social Science & Medicine*, 54, 459-467.
- Mellsop, G., Taumoepeau, B., & Smith, D. (1993). Mental health services in New Zealand. *International Journal of Mental Health*, 22(1), 87-100.
- Memo. (1993, 10 July). *Memo to Management Committee re membership and members costs*, Newtown Union Health Service Records.
- Mental Health Commission. (1997). *Blueprint for mental health services in New Zealand*. Wellington: Author.
- Mental Health Commission. (1998a). *Blueprint for mental health services in New Zealand How things need to be*. Wellington: Author.
- Mental Health Commission. (1998b). *Report on the promulgation and use by Crown Health Enterprises of the Privacy Guidance Notes for mental health professionals*. Wellington: Author.
- Mental Health Commission. (1998c). *We're on the road*.
- Mental Health Commission. (c.1998). *A travel guide for people on the journeys towards equality respect and rights for people who experience mental illness*. Wellington: Author.
- Mental Health Commission. (2000). *Realising recovery Through the education of mental health workers* Retrieved 5 January, 2002, from [www.mhc.govt.nz](http://www.mhc.govt.nz).
- Mental Health Commission. (c.2001). *Consumer participation*. Retrieved 5 January, 2002, from [www.mhc.govt.nz](http://www.mhc.govt.nz).
- Mental Health News. (1991). Survey of general practitioners in the Bay of Plenty. *Mental Health News*(Autumn), 23-24.
- Mental Health Services Research Consortium. (1994). *Barriers to mental health care in the community: Towards an economic model*. Wellington: Author.
- Midgley, S., Burns, T., & Garland, C. (1996). What do general practitioners and community mental health teams talk about? Descriptive analysis of liaison meetings in general practice. *British Journal of General Practice*, 46, 69-71.

- Miles, M., & Goetz, R. R. (1999). Gatekeeping and authorization. *New Directions for Mental Health Services*, 81(Spring), 65-73.
- Millar, B. (1996). Private view. *Health Services Journal*(7 March), 14.
- Miller, W. L., & Crabtree, B. F. (1992). Primary care research: A multimethod typology and qualitative road map. In B. Crabtree & W. Miller (Eds.), *Doing qualitative research* (pp. 3-28). Newbury Park: Sage.
- Minichiello, V. (1995). Community care: economic policy dressed as social concern? In H. Gardner (Ed.), *The Politics of Health: The Australian Experience* (2nd ed., pp. 453-482). Melbourne: Churchill Livingstone.
- Ministerial Taskforce on Nursing. (1998). *Report of the Ministerial Taskforce on Nursing*. Wellington: Ministry of Health.
- Ministry of Health. (1994). *Looking forward - Strategic directions for mental health services*. Wellington: Author.
- Ministry of Health. (1995). *A guide to effective consumer participation in mental health services*. Wellington: Author.
- Ministry of Health. (1996a, May). *Managed care*, Wellington.
- Ministry of Health. (1996b). *Towards better mental health services: The report of the National Working Party on Mental Health Workforce Development*, Wellington: Author.
- Ministry of Health. (1997a). *Moving Forward*. Wellington: Author.
- Ministry of Health. (1997b). *The national mental health standards*. Wellington: Author.
- Ministry of Health. (2001). *The primary health care strategy*. Retrieved 3 April, 2003, from [www.moh.govt.nz](http://www.moh.govt.nz).
- Ministry of Health. (2002). *Primary health care nursing innovation funding shortlist announced*. Retrieved 6 February, 2003, from [www.moh.govt.nz/moh/nsf/](http://www.moh.govt.nz/moh/nsf/).
- Ministry of Health. (c.1997). *GP Visits*. Retrieved 1 September, 2002, from [www.moh.govt.nz/moh/nsf/](http://www.moh.govt.nz/moh/nsf/)
- Ministry of Health. (c.2002). *National screening unit, National cervical screening*. Retrieved 9 September, 2003, from [www.moh.govt.nz/moh/nsf/](http://www.moh.govt.nz/moh/nsf/)
- Minutes. (1994). Minutes of Primary Psychiatric Care Meeting, 21 November.
- Minutes. (1995a). Minutes of Primary Psychiatric Care Meeting, 24 January.
- Minutes. (1995b). Minutes of the Primary Psychiatric Care Meeting, 22 August.
- Minutes. (1995c). Minutes of the Primary Psychiatric Care Meeting, 23 May.
- Mirowsky, J., & Ross, C. E. (2002). Measurement for a human science. *Journal of Health and Social Behaviour*, 43(June), 152-170.
- Montgomery, J. (1992). Rights to health and health care. In A. Coote (Ed.), *The welfare of citizens* (pp. 83-107). London: Rivers Oram Press.
- Moore, S. (1994). Understanding innovation in social service delivery systems. *Health Marketing Quarterly*, 11(3-4), 61-73.
- Moore, S. T., Kelly, M. J., & Lauderdale, M. (1998). Three fundamentals of service quality in welfare reform. *Family and Community Health*, 21(1), 1-13 [Electronic Version] Retrieved 19 February, 2002.
- Morten, C., James, K., & Matheson, D. (1993). The Newtown Union Health Services primary mental health care team. In Department of Health (Ed.), *Primary mental health care: a discussion paper on current issues and service provision* (pp. 70-91). Wellington: Department of Health.
- Morten, C., James, K., & Matheson, D. (1992). Psychiatric services. In Matheson (Ed.), *Health where it hurts* (pp. 28 - 31). Wellington: Newtown Union Health Service.
- Muijen, M. (1993). Mental health services: what works. In M. Weller & M. Muijen (Eds.), *Dimensions of community mental health care* (pp. 39-61). London: WB Saunders Company Ltd.

- National Health Committee. (1996). *Guidelines for the treatment and management of depression by primary healthcare professionals*: Author.
- Nazareth, I., King, M., & Davies, S. (1995). Care of schizophrenia in general practice: the general practitioner and the patient. *British Journal of General Practice*, 45, 343-347.
- Nazareth, I., King, M., Haines, A., Rangel, L., & Myers, S. (1993). Accuracy of diagnosis of psychosis on general practice computer system. *British Medical Journal*, 307, 32-34.
- Nazareth, I., King, M., Haines, A., See Tai, S., & Hall, G. (1993). Care of schizophrenia in general practice. *British Medical Journal*, 307, 910.
- Nelson, K., & Cumming, J. (1999, February). *The evaluation of the Hawkes Bay shared care pilot*. Paper presented at the Social Science and Health Seminar series, Health Services Research Centre, Wellington.
- Nelson, K., Cumming, J., Duncanson, M., & MacEwan, V. (1997). Policy and practical issues in setting up shared care for people with on-going needs from mental health services. In THEMHS (Ed.), *7th Annual Mental Health Services Conference of Australia & New Zealand*, (pp. 209-214). Sydney: Conference Proceedings THEMHS.
- Nelson, K., Cumming, J., & MacEwan, V. (1997). Early lessons in shared care: Experience from a pilot involving general practitioners in the care and treatment of people with on-going needs for mental health services. In P. Ellis (Ed.), *Shared Care Geigy Symposium 1997* (Vol. XV111, pp. 71-77). Wellington: Novartis Australia Pty.
- Nelson, K., Cumming, J., & Peterson, D. (1998). *Evaluation of the Hawkes Bay shared care pilot Report for the Health Funding Authority*. Wellington: Health Services Research Centre.
- Nelson, K., Duncanson, M., & Cumming, J. (1997). *Interim evaluation of the Hawkes Bay shared care pilot project. A report to the Central Regional Health Authority* (Research report). Wellington: Health Services Research Centre.
- Nelson, K., Fowler, S., Cumming, J., Peterson, D., & Phillips, B. (2003). *Evaluation of mental health/primary care shared services*. Wellington: Mental Health Research and Development Strategy.
- Nelson, K., & MacEwan, J. (1998). Does shared care provide consumers with choice and empowerment? In S. Robertson et al., (Eds.), *Making History: Shaping the future, Contemporary TheMHS in Mental Health Services* (pp. 394-399). Hobart: Conference Proceedings 1998, TheMHS Conference.
- Nelson, K., Peterson, D., Bos, V., & Cumming, J. (2000). *Consulting the GP without paying - findings from a mental health pilot*. Paper presented at the Public Health Association Conference, Palmerston North.
- New Zealand Government. (1974). *A health service for New Zealand*. Wellington: Author.
- News revised. (1990). News revised general practice contracts. *New Zealand Medical Journal*, 103(12 September), 438.
- 'Newtown Union'. (1987, October). *Newtown Union Health Service Nursing Report*, Regan, NUHS Personal Records.
- Nickels, M. W., & McIntyre, J. S. (1996). A model for psychiatric services in primary care settings. *Psychiatric Services*, 47(5), 522-526.
- Noble, M., Platt, L., Smith, G., & Daly, M. (1997). The spread of the Disability Living Allowance. *Disability & Society*, 12(5), 741-751.
- Nocon, A., & Qureshi, H. (1996). *Outcomes of community care for users and carers*. Buckingham: Open University Press.
- Norris, P. T. (1993). *The negotiation and re-negotiation of occupational control: a study of retail pharmacy in New Zealand 1930-1990*. Unpublished Doctor of Philosophy Thesis, Victoria University of Wellington, Wellington.
- NUHS Constitution. (1987, 13 November). *Newtown Union Health Service Incorporated*, Newtown Union Health Service Records.



- Nurcombe, B. (1997). The future of psychiatric hospitalization for children and adolescents. In L. Bickman & D. Rog (Eds.), *Children's mental health services* (pp. 101-116). Thousand Oaks: Sage Publications.
- Nursing Liaison Minutes. (1990, 13 August). *Minutes of the combined Newtown and Southern suburbs nurses liaison meeting, August*, Hanson House.
- NZMA Newsletter. (1996). NZMA Newsletter Issue (a). *New Zealand Medical Journal*, 109(14 June), 4.
- O'Connor, N., & Willcock, S. (1997). *A shared care model of mental health care: Idealism meets reality*. Paper presented at The 7th Annual Mental Health Services Conference of Australia & New Zealand (THEMHS), Sydney.
- O'Grady, J. C. (1996). Community psychiatry: Central policy, local implementation. *British Journal of Psychiatry*, 169, 259-262.
- O'Hagan, M. (1986). From taking snapshots to making movies. *Community Mental Health in New Zealand*, 3(1), 31-49.
- O'Hagan, M. (1993). The international user-movement. In C. Dean & H. Freeman (Eds.), *Community mental health care: International perspectives on making it happen* (pp. 90-122). London: Gaskell on behalf of the Centre for Mental Health Services Development.
- O'Hagan, M. (1999). *Realising recovery Six challenges to the mental health sector*. Retrieved 12 December, 2002, from [www.mhc.govt.nz/speeches/RR\\_Papers/CP1realising\\_recovery.htm](http://www.mhc.govt.nz/speeches/RR_Papers/CP1realising_recovery.htm)
- Oliver, H., & Francis, L. (1995). *Funding of primary health - the next wave of reforms*. Wellington: NZ Council of Trade Unions Health Sector Standing Committee. NZ Council of Trade Unions.
- Oliver, M. (1996). *Understanding disability: From theory to practice*. New York: St. Martin's Press, Scholarly and Reference Division.
- Oliver, S. (1997). Exploring lay perspectives on questions of effectiveness. In A. Maynard & I. Chalmers (Eds.), *Non-random reflections on health services research: on the 25th anniversary of Archie Cochrane's Effectiveness and efficiency* (pp. 272-291). Oxford: BMJ Publishing Group.
- O'Neil, O. (2002). *A question of trust: The BBC Reith Lecture Series 2002*. Cambridge: Cambridge University Press.
- Onyett, S., Standen, R., & Peek, E. (1997). The challenge of managing mental health teams. *Health and Social Care in the Community*, 5(1), 40-47.
- Opiate Addiction Proposal. (1993, 10 June). *Proposal for PHC management of opiate addiction Newtown Union Health Service*.
- Orton, P. (1994). Shared care. *The Lancet*, 344, 1413-1415.
- Owen, J. M. (1993). *Program evaluation: forms and approaches*. St Leonards: Allen & Unwin.
- Parry, O., & Pill, R. (1994). 'I don't tell him how to live his life': the doctor/patient encounter as an educational context. In M. Bloor & P. Taraborrelli (Eds.), *Qualitative Studies in Health and Medicine* (pp. 5 - 21). Aldershot: Avebury.
- Parsons, T. (1978). *Action, theory and the human condition*. New York: Free Press.
- Parsons, W. (1995). *Public policy: An introduction to the theory and practice of policy analysis*. Aldershot: Edward Elgar Publishing Ltd.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (Second edition ed.). Newbury Park: Sage.
- Paxton, R. (1995). Goodbye community mental health teams - at last. *Journal of Mental Health*, 4, 331-334.
- Pearson, A. W. (1991). Managing innovation: an uncertainty reduction process. In J. Henry & D. Walker (Eds.), *Managing innovation* (pp. 18-27). London: Sage Publications.

- Pearson, M. (1995). The boundary between health care and social care. *British Medical Journal*, 311, 208-209.
- Peck, E. (1995). On the team. *Health Services Journal*(6 April), 28-29.
- Pederson, L. I., & Leese, B. (1997). What will primary care led NHS mean for GP workload? The problem of lack of an evidence base. *British Medical Journal*, 314, 1337-1341.
- Peterson, D., & Thompson, T. (1999). *Roadworks on journeys towards equality, respect and rights for people who experience mental illness: Excavation work around notions of danger in the mental health sector*. Paper presented at The 9<sup>th</sup> Annual Mental Health Services Conference of Australia and New Zealand, Melbourne, Australia.
- Pilgrim, D., & Rogers, A. (1993). *A sociology of mental health and illness*. Buckingham: Open University Press.
- Pilgrim, D., & Rogers, A. (1999). *A sociology of mental health and illness* (2nd ed.). Buckingham: Open University Press.
- Pincus, H. A. (1990). Assessing the effects of physician payment on treatment of mental disorders in primary care. *General Hospital Psychiatry*, 12, 23-29.
- Pingitore, D., & Sansone, R. A. (1998). *Using DSM-IV primary care version: a guide to psychiatric diagnosis in primary care*. American Family Physician October 15 [Electronic Version]. Retrieved 12 April, 2003.
- Policy Board Minutes. (1995a, 27 April). *Minutes of Policy Board Meeting, April*.
- Policy Board Minutes. (1995b, 30 March). *Minutes of Policy Board Meeting, March*.
- Pollack, D. A. (1999). The mental health provider's view. *New Directions for Mental Health Services*, 81(Spring), 25-32.
- Pomare, E., Keefe-Ormsby, V., Ormsby, C., Pearce, N., Reid, P., Robson, B., & Watene-Haydon, N. (1995). *Hauora; Maori health standards III*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare.
- Pope, C., & Mays, N. (1995). Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *British Medical Journal*, 311(1 July), 42-45.
- Practice nurse. (c.1988). *Practice nurse role in the maternal and child health team*, Regan, NUHS Personal Records.
- Pratt, J., & Adamson, L. (1996). Boundaries in primary health care. In P. Gordon & J. Hadley (Eds.), *Extending primary care* (pp. 17 - 35). Oxford: Radcliffe Medical Press.
- Prebble, K. (2001). On the brink of change? Implications of the review of undergraduate education in New Zealand for mental health nursing. *Australian and New Zealand Journal of Mental Health Nursing*, 10(3), 136-144.
- Preamble, L., & Fountain, B. (1996, 24 July). Shipley praises IPAs as best kept secret. *NZ Doctor*.
- Prescott, P., & Soeken, K. (1989). The potential use of pilot work. *Nursing Research*, 38(1), 60-62.
- Pritchard, P. (1995). Learning to work effectively in teams. In P. Owens et al., (Eds.), *Interprofessional issues in community & primary care* (pp. 205-232). Houndmills, Hampshire: Macmillan Press Ltd.
- Pritchard, P., & Hughes, J. (1995). *Shared care: The future imperative*. London: Royal Society of Medicine Press.
- Raphael, B., & Hugh, G. (1997). What will preventive psychiatry prevent, and how? In V. Carr (Ed.), *Geigy Psychiatric Symposium Twenty-twenty vision; Mental health in the 21st Century* (pp. 84-95). Newcastle, Australia: Novartis Australia Pty Limited.
- Rapp, C. (1996). *Principles of strengths model: "there is a 'great' person in there"*, (Audio-tape). Paper presented at The 6th Annual Mental Health Services Conference of Australia and New Zealand (TheMHS), Brisbane.

- Raymont, A. (1992). *General practice - consultation and outcome: a social analysis of the patient practitioner encounter*. Unpublished Doctor of Philosophy, University of Auckland, New Zealand.
- Regan, G. (1988, December). *Overview of the NUHS from the Nursing Co-ordinator point of view*.
- Regan, G. (1991a). Health for the people. *New Zealand Nursing Journal*, 84(5), 20-21.
- Regan, G. (1991b, 19 December). *Notes for the Minister of Health*, Regan, NUHS Personal Records.
- Rein, M. (1970). *Social policy: Issues of choice and change*. New York: Random House.
- Rein, M. (1983). *From policy to practice*. London: The Macmillan Press Ltd.
- Review (news). (1989). Funds released for community mental health services. *New Zealand Doctor*(September 4), 10.
- Ridsdale, L., Robins, D., Cryer, C., Williams, H., & Epilepsy Care Evaluation Group. (1997). Feasibility and effects of nurse run clinics for patients with epilepsy in general practice: randomised controlled trial. *British Medical Journal*, 314, 120-122.
- Rikihana, D. (1997). Welcome. *National programme to counter stigma and discrimination associated with mental illness* (December), 2-3.
- Rist, R. C. (1994). Influencing the policy process with qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 545-557). Thousand Oaks California: Sage.
- Roach, J. (1993). Clinical case management with severely mentally ill adults. In M. Harris & H. Bergman (Eds.), *Case management for mentally ill patients: Theory and practice* (pp. 17-40). Chur: Harwood Academic Publishers.
- Robinson, G. K., & Toff-Bergmen, G. (1989). *Choices in case management: current knowledge and practice for mental health programs*. Washington, DC: Mental health policy resource centre.
- Rodenberg, H., Daly, C., & Fenton, S. (1998). *Working together at the primary/secondary interface in the Wellington primary care liaison programme*. Paper presented at the Building Bridges Hanga Piriti Community Mental Health Conference, Christchurch.
- Rodgers, B., Doron, A., & Jones, M. (1979). *The study of social policy: A comparative approach*. London: George Allen & Unwin.
- Rogers, E. M. (1995). *Diffusion of innovation* (4th ed.). New York: The Free Press.
- Rohland, B., Rohrer, J. E., & Culica, D. (1999). Substitution of psychiatric care by primary care physicians: Impact of the Iowa Medicaid managed mental health care plan. *Administration and Policy in Mental Health*, 26(5), 369-371.
- Ross, F. (1997, August 5). Mental health funds 'sat on'. *The Dominion*, p. 18.
- Royal Australian College of General Practitioners & Royal Australian and New Zealand College of Psychiatrists. (c.1997). *Primary care psychiatry The last frontier* (Joint consultative committee): National Mental Health Strategy.
- Royal College of Psychiatrists & Royal College of General Practitioners. (1993). *Shared care of patients with mental health problems*. London: Royal College of General Practitioners.
- Royal New Zealand College of General Practitioners. (1998). *Book 10 Mental health*. Wellington: Author.
- Ruscher, S. M., de Wit, R., & Mazmanian, D. (1997). Psychiatric patients' attitudes about medication and factors affecting noncompliance. *Psychiatric Services*, 48(1), 82-85.
- Rutz, W., von Knorring, L., & Walinder, J. (1992). Long-term effects of an educational program for general practitioners given by the Swedish Committee for the Prevention and Treatment of Depression. *Acta Psychiatrica Scandinavica*, 85, 83-88.
- Sabatier, P. (1986). Top-down and bottom-up approaches to implementation research: a critical analysis and suggested synthesis. *Journal of Public Policy*, 6(1), 21-48.

- Sackett, D. (2000). *Evidenced based medicine - how to practice and teach EBM* (2nd ed.). Edinburgh: Churchill Livingstone.
- Sainsbury Centre for Mental Health. (2001). *Setting the standard: the new agenda for primary care organisations commissioning mental health services*. London: Author.
- Salmond, G., Mooney, G., & Laugeson, M. (1994). Introduction to health reform in New Zealand. *Health Policy*, 29(1,2), 1-3.
- Salter, B. (1995). The private sector and the NHS: redefining the welfare state. *Policy and Politics*, 23(1), 17-30.
- Saltman, D. C., Sengoz, A., Spencer-Herrera, L., Needham, L., & Whittington, V. (1993). Community health and medical practitioners scheme: providers evaluate a pilot program of integration of services. *The Medical Journal of Australia*, 159(16 Aug), 246-248.
- Samson, C. (1995). The fracturing of medical dominance in British psychiatry. *Sociology of Health and Illness*, 17(2), 245-268.
- Sandelowski, M. (2000). Combining qualitative and quantitative sampling, data collection, and analysis techniques in mixed-method studies. *Research in Nursing & Health*, 23, 246-255.
- Sauber, S. R. (1983). *The human service delivery system*. New York: Columbia University Press.
- Schmidt-Posner, J., & Jerrell, J. (1998). Qualitative analysis of three case management programs. *Community Mental Health*, 34(4), 381-392.
- Schram, S. F. (1995). *Words of welfare: the poverty of social science and the social science of poverty*. Minneapolis: University of Minneapolis Press.
- Schulz, R., & Greenley, J. (Eds.). (1995). *Innovating in community mental health : international perspectives*. Westport, CT: Praeger Publishers.
- Scott, A., Shiell, A., & King, M. (1996). Is general practitioner decision making associated with patient socio-economic status. *Social Science and Medicine*, 42(1), 35-46.
- Scott, C. (2001). *Public and private roles in health care systems*. Buckingham: Open University Press.
- Scott, C., Fougere, G., & Marwick, J. (1986). *Choices for health care*. Wellington: Report of the health benefits review.
- Sedden, T. D. S. (1988). General practitioners in hospital: a move toward medical workforce integration. *New Zealand Medical Journal*, 101(25 May), 266-268.
- Sederer, L., & Bennett, M. (1996). Managed mental health care in the United States: a status report. *Administration and Policy in Mental Health*, 23(4 March), 289 -306.
- Seed, P., & Kaye, G. (1994). *Handbook for assessing and managing care in the community*. London: Jessica Kingsley Publishers Ltd.
- Sharrock, J., & Happell, B. (2001). An overview of the role and function of a psychiatric consultation liaison nurse: an Australian perspective. *Journal of Psychiatric and Mental Health Nursing*, 8, 411-417.
- Shaw, I. (2000). Resources for social policy. In N. Manning & I. Shaw (Eds.), *New risks, new welfare: signposts for social policy* (pp. 24-35). Oxford: Blackwell Publishers Ltd.
- Shilling, C. (2002). Culture, the 'sick role' and the consumption of health. *The British Journal of Sociology*, 53(4), 621-638.
- Shipley, J. (1995/6). *Policy guidelines for Maori Health Nga aratohu kaupapaahere hauora Maori*. N.Z. Government.
- Shipley, J. (c.1996). *Health services 1996*: New Zealand Government.
- Shirley, I. (1994). Social policy. In P. Spoonley et al., (Eds.), *New Zealand society* (2nd ed., pp. 130-146). Palmerston North: The Dunmore Press Ltd.
- Sibthorpe, B. (2000). *Models of primary health care: The New Zealand experience*. New Doctor, No. 74 [Electronic version]. Retrieved April 6, 2002.

- Signpost. (1996). Where is the government going? Public sector strategic result areas can tell us. *Signpost*(3), 3.
- Simon, H. A. (1957). *Administrative Behaviour* (2nd ed.). New York: Free Press.
- Skegg, D. (1994). Foreword. In Durham (Ed.), *A strategic direction to improve and protect the public health* (pp. i). Wellington: Public Health Commission.
- Sklair, L. (1970). *The sociology of progress*. London: Routledge and Kegan Paul Ltd.
- Slade, M., Powell, R., & Strathdee, G. (1997). Current approaches to identifying the severely mentally ill. *Social Psychiatry Psychiatric Epidemiology*, 32, 177-184.
- Slay, J. D., & Glazer, W. (1995). 'Carving in,' and keeping in, mental health care in the managed care setting. *Psychiatric Services*, 46(11), 1119-1125.
- Smith, G., & May, D. (1980). The artificial debate between rationalist and incremental models of decision making. *Policy and Politics*, 8(2), 147-161.
- Special Meeting. (1992a, 10 November). *Minutes of 2nd special meeting re financial position*.
- Special Meeting. (1992b, 9 November). *Minutes of special meeting re financial position*.
- Special Options. (1991, 13 February). *Minutes of Special Options Meeting*.
- Spicker, P. (1988). *Principles of social welfare: an introduction about thinking about the welfare state*. London: Routledge.
- Spoonley, P., Pearson, D., & Shirley, I. (Eds.). (1994). *New Zealand Society* (2nd ed.). Palmerston North: Dunmore Press Ltd.
- St John, P. (1996, 24 July). CHE chief says mental health report timid. *New Zealand Doctor*.
- Stake, R. E. (1994). Case studies. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 236-247). Thousand Oaks: Sage Publications Inc.
- Stake, R. E. (1995). *The art of case study research*. Thousand Oaks: Sage Publication.
- Steele, K. (1992). Patients as experts: consumer appraisal of health services. *Public Money & Management*, 12(Oct/Dec), 4.
- Stevenson, C., & Barker, P. (1996). Negotiating boundaries: reconciling differences in mental health teamwork. In N. Cooper et al., (Eds.), *Integrating perspectives on health* (pp. 47-56). Buckingham: Open University Press.
- Stewart, A. L., Grumbach, K., Osmond, D. H., Vranizan, K., Komaromy, M., & Bindman, A. B. (1997). Primary care and patient perceptions of access to care. *The Journal of Family Practice*, 44(2), 177-185.
- Stocking, B. (1997). Commentary. *International Journal of Technology Assessment in Health Care*, 13(3), 458-459.
- Stocking, B., & Morrison, S. (1978). *The image and the reality*. Oxford: Oxford University Press for Nuffield Provincial Hospitals Trust.
- Strathdee, G. (1993). Primary care and community psychiatric services: changing patterns and responsibilities. In M. Weller & M. Muijen (Eds.), *Dimensions of community mental health care* (pp. 62-81). London: W.B. Saunders Co Ltd.
- Strathdee, G., & Jenkins, R. (1996). Purchasing mental health care for primary care. In G. Thornicroft & G. Strathdee (Eds.), *Commissioning mental health services* (pp. 71-83). London: HMSO.
- Strauss, J. (1996). *The person and mental illness: the nature of disorder and treatment*. Paper presented at The 6th Annual Mental Health Services Conference of Australia & New Zealand (THEMHS), Brisbane.
- Street, A., & Walsh, C. (1996). *"Not a rubber stamp": nurses as Duly Authorised Officers in New Zealand*. Wellington: Department of Nursing and Midwifery, Victoria University of Wellington.
- Submission. (c.1987). *Submission for 100% Nurse subsidy and capitation subsidy for Newtown Union Health Service*, Regan, NUHS Personal Records.
- Swain, D. (1994). Family. In P. Spoonley et al., (Eds.), *New Zealand Society* (2nd ed., pp. 11-25). Palmerston North: The Dunmore Press Ltd.

- Sweeney, K. G., & Gray, D. P. (1995). Patients who do not receive continuity of care from their general practitioner - are they a vulnerable group? *British Journal of General Practice*, 45, 133-135.
- Szasz, T. (1971). *The myth of mental illness*. New York: Harper & Row.
- Taft, S. H., & Seitz, P. (1994). Innovations in human service technologies. *International Journal of Technology Assessment in Health Care*, 10(2), 214-226.
- Tait, D. (1996). Why we must address the ballooning cost. In PHARMAC (Ed.), *Annual review for the year ended 1996* (pp. 3-5). Wellington: PHARMAC.
- Tansella, M., & Ruggeri, M. (1996). Monitoring and evaluating a community based mental health service: the epidemiological approach. In M. Peckham & R. Smith (Eds.), *Scientific basis of health services* (pp. 160-169). London: BMJ Publishing Group.
- Taskforce on Strategic Planning. (1994). *Report of the Taskforce on strategic planning for the future of general medical practice* (Strategic): Ministry of Health.
- Taylor, C., & Meads, G. (1997). The development of primary care. In D. Hennessy (Ed.), *Community health care development* (pp. 86-105). London: Macmillan Press.
- Te Puni Kokiri. (1995). *Ma te Maori E puri to maimoatanga Maori - Managed care by Maori* (Discussion). Wellington: Author.
- Te Puni Kokiri. (1998). *Progress towards closing social and economic gaps between Maori and non-Maori* (A report to the Minister of Maori Affairs). Wellington: Author.
- Te Puni Kokiri. (1993). *Nga ia o te oranga hinengaro Maori - Trends in Maori mental health: A discussion document* (Discussion). Wellington: Author.
- Thompson, M., & Thompson, T. (1997). *Discrimination against people with experience of mental illness* (Discussion paper). Wellington: Mental Health Commission.
- Toews, J., Lockyer, J., Addington, D., McDougall, G., Ward, R., & Simpson, E. (1996). Improving the management of patients with schizophrenia in primary care: assessing learning needs as a first step. *Canadian Journal of Psychiatry*, 41, 617-622.
- Tones, K., & Tilford, S. (1994). *Health education effectiveness, efficiency and equity* (2nd ed.). London: Chapman & Hall.
- Tracey, J., Young, B., & Sayers, A. (1988). The management of diabetes in general practice. *New Zealand Medical Journal*, 101(13 July), 450-453.
- Triggs, S., Johnston, G., O'Connor, P., & Wong, R. (1995). *Patients in profile*. Wellington: Ministry of Health.
- Truman, K. M. (1984). *Development of mental health services in the Wellington Region 1945-1978*. Unpublished Master of Arts, Victoria University of Wellington.
- Tugrul, K., & Cizinsky, G. (1996). Extrapyramidal side effects and compliance. *Primary Care Psychiatry*, 2(Supplement 1), 9-12.
- Tylee, A. T., Freeling, P., & Kerry, S. (1993). Why do general practitioners recognize major depression in one patient yet miss it in another? *British Journal of General Practice*, 43(August), 327-330.
- Tyrer, P., Ferguson, B., & Wadsworth, J. (1990). Liaison psychiatry in general practice: the comprehensive collaborative model. *Acta Psychiatr Scand*, 359-363.
- Upton, S. (1991). *Your health & the public health*. Wellington: Ministry of Health.
- Uttley, S. (1991). *Technology and the welfare state: the development of health care in Britain and America*. London: Unwin Hyman Ltd.
- Uttley, S. (1994). Professionals 'moving down': Rationalisation, routinisation and displacement. In School of Social Work (Ed.), *Advances in social work and welfare education* (pp. 182-194). Perth: University of Western Australia.
- Vedung, E. (1997). *Public policy and program evaluation*. New Brunswick: Transaction Publishers.
- Vercoe, B. (1995, 23 June). GP training essential in mental health care. *New Zealand Doctor*, 17.

- Wagner, E. H., Austin, B. T., & Von Korff, M. (1996). Organizing care for patients with chronic illness. *The Milbank Quarterly*, 74(4), 511-544.
- Walker, R. (1997). Public policy evaluation in a centralized state. *Evaluation*, 3(3), 261-279.
- Walkup, J. (1997). The psychiatric unit comes to the general hospital: a history of the movement. In D. Mechanic (Ed.), *Improving inpatient psychiatric treatment in an era of managed care* (Vol 73, pp. 11-24). San Francisco: Jossey-Bass.
- Wall, A. (1996). Mine, yours or theirs? Accountability in the new NHS. *Policy and politics*, 24(1), 73-84.
- Walt, G. (1996). Policy analysis: An approach. In K. Janovsky (Ed.), *Health policy and systems development: An agenda for research* (pp. 225-241). Geneva: World Health Organization.
- Waltham Medical Centre. (1993). Primary mental health care: Waltham medical centre: A primary mental health provider. In Department of Health (Ed.), *Primary mental health care: a discussion on current issues and service provision* (pp. 93-104). Wellington: Department of Health.
- Walton, V., Romans-Clarkson, S., & Herbison, G. P. (1990). Variety and views in general practice. *New Zealand Medical Journal*, 103, 287-290.
- Ward, H., DeLisle, H., Shores, J., Slocum, P., & Foresman, B. (1996). Chronic fatigue complaints in primary care: incidence and diagnostic patterns. *Journal of the American Osteopathic Association*, 96(1), 34-46.
- Ward, J., & Asher, B. (1984). Organisation and financing health care. In C. Wilkes & I. Shirley (Eds.), *In the public interest Health, work and housing in New Zealand society* (pp. 90-101). Auckland: Benton Ross Ltd.
- Wear, A. N., & Peveler, R. C. (1995). Use of primary care services by chronically mentally ill patients. *Journal of Mental Health*, 1, 199-204.
- Webster, G. (1995). Public participation in health: Empowerment or control? In S. Edgell et al., (Eds.), *Debating the future of the public sphere: Transforming the public and private domains in free market societies* (pp. 113-124). Aldershot: Avebury.
- Weiss, C. (1979). The many meanings of research utilization. *Public Administration Review*, 39, 426-431.
- Wells, K. B., Astrachan, B. M., Tischler, G., L., & Unutzer, J. (1995). Issues and approaches in evaluating managed mental health care. *The Milbank Quarterly*, 73(1), 57-75.
- Wenley, S. (1997, 19 November). GPs primary part of mental health services. *GP Weekly*, p. 3.
- White, K., Roy, D., & Hamilton, I. (1997). *ABC of mental health: Community mental health services*. *British Medical Journal*, 314:1817 (21 June). [Electronic Version] Retrieved 23 August, 2002/
- Wilhelm, K., Redenbach, J., Savellis, J., Hume, F., MacDonald, P., & Pugh, S. (1999). *The evolution of a mental health shared care project in Eastern Sydney*. In P. Ellis (Ed.), *Geigy Psychiatric Symposium 1977* (pp. 57-69). Wellington: Geigy.
- Wilkinson, G. (1998). Psychiatry in general practice. In G. Stein & G. Wilkinson (Eds.), *General Adult Psychiatry* (Vol. 2, pp. 1334-1392). London: Gaskell.
- Wilkinson, G., Falloon, I., & Sen, B. (1985). Chronic mental disorders in general practice. *British Medical Journal*, 291, 1302-1304.
- Wilkinson, G., & Wright, A. (1994). Research potential in general practice. In I. Pullen et al., (Eds.), *Psychiatry and general practice today* (pp. 360-370). Great Britain: The Royal College of Psychiatrists and The Royal College of General Practitioners.
- Williams, P., & Balestrieri, M. (1989). Psychiatric clinics in general practice Do they reduce admissions? *British Journal of Psychiatry*, 154, 67-71.
- Wilson, H. T. (1984). *Tradition and innovation*. London: Routledge & Kegan Paul.

- Wilson, J. (1997). The national mental health strategy - is it making a difference? *Health Manager*, 4(1), 7-10.
- Wilson, K., & Dunn, R. (1996). Psychiatric care: change means opportunity. *Australian Nursing Journal*, 3(9), 36-38.
- Wing, J., Curtis, R., & Beevor, A. (1996). *HoNOS Health of the nation outcomes scale Brief Report*. London: Royal College of Psychiatrists.
- Wing, J. K. (1996). Research designs for the evaluation of services. In H. Knudsen & G. Thornicroft (Eds.), *Mental Health Service Evaluation* (pp. 37-49). Cambridge: Cambridge University Press.
- Wing, J. K., Beevor, A. S., Curtis, R. H., Park, S. B. G., Hadden, S., & Burns, A. (1998). Health of the nation outcome scales (HoNOS). *British Journal of Psychiatry*, 172, 11-18.
- Winn, S. (1997). The role of the primary health care team in the care of people with HIV and AIDS. *Health and Social Care in the Community*, 5(6), 408 - 417.
- Wolfe, R., & Stafford, A. (1997). Shared care in mental health. *Open Mind*, 85, 7.
- Wood, J. (1984). Patient participation in general practice. In R. Maxwell & N. Weaver (Eds.), *Public participation in health* (pp. 63-72). London: King Edward's Hospital Fund for London.
- Woogh, C. (1986). A cohort through the revolving door. *Canadian Journal of Psychiatry*, 31(3), 214-221.
- World Health Organisation. (1990). *The introduction of a mental health component into primary health care*. Geneva: Author.
- World Health Organisation. (1992). *ICD-10: International classification of diseases and related health problems* (10th Revision ed.). Geneva: Author.
- Wright, A. F. (1995). People with long-term mental illness: making shared care work (Editorial). *British Journal of General Practice*(July), 338-339.
- Wykes, T. (1995). The toxicity of community care. In P. Tyrer & F. Creed (Eds.), *Community psychiatry in action: Analysis and prospects* (pp. 97-111). Cambridge: Cambridge University Press.
- Yin, R. K. (1989). *Case study research design and methods* (Revised ed.). California: Sage Publication.
- Yin, R. K. (1994). *Case study research* (2nd ed.). Thousand Oaks: Sage Publications Ltd.
- Young, P. D. (1997). *Psychiatrically useful drugs*. Retrieved 1 September, 2002 from <http://campus.houghton.edu/depts/psychology/antidepressants/tsld019.htm>.