More than Brief Relief: The Rural Canterbury PHO Brief Intervention Coordination (BIC) Service

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The Rural Canterbury Primary Health Organisation (RCPHO) Brief Intervention Coordination (BIC) service provides adults with mild to moderate mental health concerns up to five sessions of free psychological intervention in their GP practices or local communities within the catchment area of the RCPHO (Ashburton, Waimakariri, and Banks Peninsula Districts).

Objective: The objective of this project was to evaluate whether the BIC sessions were effective and beneficial for their clients during the first 15 months (March 2006 to May 2007) of operation.

Method: Access and the time taken after referral to contact clients were recorded. Clinical outcomes were measured using Kessler-10 client rated scores pre and post BIC interventions. Eighty randomly selected BIC clients were asked to complete a service satisfaction survey. Ten RCPHO GPs were randomly selected to take part in the BIC GP satisfaction survey.

Results: Results indicate that there was a high referral rate and service demand and that all clients were contacted within one working month of their referral. Kessler-10 scores at the end of three or more BIC sessions were significantly lower for both the severe and moderate distress groups. Clients were very satisfied with the BIC service and highly rated being treated with dignity and respect and being listened to. The ten GPs in the survey were satisfied with access and timing, quality of support and care, BIC feedback, and with the service overall.

Discussion: BIC service improvements include more consistent use of the client rated Kessler-10 outcome measure, more client and GP satisfaction surveys, and better reporting of community linkages.

This section focuses firstly on the prevalence of mild to moderate mental health concerns in the general practice population, on primary care and Primary Health Organisations (PHOs) and their role in providing mental health services, and on the usefulness of brief psychological intervention work. Secondly, it addresses the development and implementation of the Brief Intervention Coordination (BIC) service in rural Canterbury based on service models and best practice / quality management principles.

There are discrepancies in estimates of the prevalence of mild to moderate mental health concerns ranging from 17-75% of patients attending their GPs. The Mental Health and General Practice Investigation (MaGPIe) Group reported that one third of patients attending their GPs had experienced a DSM-IV psychiatric disorder (diagnosed using a structured interview) during the previous 12 months (MaGPIe, 2003). Wells, Oakley-Browne, Scott, McGee, Baxter & Kokaua (2006) estimate that 17% of the New Zealand population have mild to moderate mental health concerns. International reports suggest that between 19-40% (Vines, Richards, Thomson, Brechman-Toussaint, Kluin, & Vesely, 2004) and 20-75% of patients attending their GP have a diagnosable mental disorder (Murphy & Bertolote, 2001; Kessler, Lloyd, Lewis, & Gray, 1999).

Some argue that primary care and PHOs are the ideal setting for providing more integrated mental health service delivery (e.g., Ministry of Health, 2005 ,MaGPIe 2003). The MaGPIe study acknowledged that general practice provides the largest mental health service in New Zealand by far and that it was actually quite proficient at identifying mental health problems (especially anxiety and depression).

A number of studies have shown that primary care provides an effective, efficient and economical service for patients allowing easy access and reducing long term mental health difficulties (Hickie & Groom, 2002; Kathol & Clarke, 2005) and severity of symptoms and improving quality of life (Morley, Pirkis, Sanderson, Burgess, Kohn, Naccarella et al., 2006, cited in Fitzgerald, Galyer, & Ryan, 2007). It is typically the first service that adults go to for health-related advice (Boland, Drummond, & Kaner, 2008).

PHOs are seen as an ideal vehicle to develop services that address the mental health needs of their enrolled population who present with mild to moderately severe mental health problems or concerns (Ministry of Health, 2004). Brief psychological intervention, particularly cognitive

behaviour therapy (CBT) based work, can be beneficial for people with mild to moderate mental health concerns (Boland *et al*., 2008). Bower, Rowland, Mellor, Heywood, & Godfrey (2007) argue that counselling for psychological concerns is better than regular GP care in the short term. Vines *et al*. (2004) found that psychotherapy integrated into primary care settings led to significant improvements in symptoms and general well being for primary care patients.

Cognitive behaviour therapy refers to a psychotherapy based on modifying everyday thoughts and behaviours, with the aim of positively influencing emotions. This mode of therapy has been widely researched and shown to be effective for a number of psychological conditions, particularly the treatment of mild to moderate depression and anxiety in primary care (Miranda & Munoz, 1994, Blackburn, Bishop, & Glen, 1981). Bloom (2002) found a decrease in anxiety symptoms with as little as four one-hour sessions of brief CBT. Lang (2003) provided an effective CBT intervention to a group of 35 patients with co-morbid anxiety and depression.

The Rural Canterbury Context: BIC Services

The Rural Canterbury Primary Health Organisation (RCPHO) was established in October 2001 as a result of the Government's Primary Health Care Strategy (Ministry of Health, 2001). It is funded on an enrolled population basis through the Canterbury District Health Board (CDHB) to provide support for primary care services within general practices in Ashburton, Banks Peninsula and Waimakariri. There are 43 GPs registered in RCPHO with a total enrolled population of 68,197.

In September 2003 a major service gap was identified by rural Canterbury GPs and community groups for adults with mild to moderate mental health concerns in the Ashburton, Banks Peninsula and Waimakariri districts as residents were not receiving an adequate service (if at all). RCPHO submitted an application outlining their Mental Health in Primary Care Demonstration Model, which was accepted and funded by the Ministry of Health in June 2005 and later extended until June 2009 to allow for sufficient evaluation.

The Demonstration Model comprises three strands of delivery: (i) the provision of the BIC Service; (ii) access to a clinical psychologist for general practice teams and supervision, clinical support and professional development for the BIC staff; and (iii) the opportunity for GPs to claim an extended consultation fee.

Developing the new BIC Service.

The RCPHO service provided an experienced Brief Intervention Coordinator for adults (18yrs+) with mild to moderate mental health concerns for up to five free sessions of psychological intervention delivered at both GP practices and resource centres in the local communities.

In the first 15 months the BIC service team consisted of the Project Manager / Clinical Psychologist, and the Brief Intervention Coordinators:

- a registered psychologist who worked in Ashburton and districts (0.5 full-time equivalent (FTE))
- a registered psychiatric nurse (RPN) who covered Banks Peninsula (0.3FTE)
- one RPN based in the Waimakariri district (0.5FTE) who resigned during this time.

The Brief Intervention Coordinators each had 5+ years work experience in specialist mental health services and were selected for their skill base and connections with the local communities. The BIC staff provided short-term CBT informed intervention and education and were regularly supervised by the clinical psychologist to ensure consistency in the development of their CBT skills.

Best practice principles and service models.

One of the first considerations in the delivery of the BIC service was to review and incorporate best practice principles and international service models. These have been summarised in the *Service Development Toolkit for Mental Health* (Ministry of Health, 2004). This document highlights the importance of partnerships between primary care professionals and specialist mental health services. Best practice principles include the provision of good information in referrals from primary care, comprehensive assessments, primary care staff who are knowledgeable about mental health, workforce development, and improving links with other agencies.

This toolkit also identifies three main shared care models including the *Consultation - Liaison Model* - consultant psychiatric staff link to the primary care provider, the *Shifted Outpatient Model* - psychiatric professionals run specialist clinics within GP practices so that accessibility and acceptability for clients is higher, and the *Formal Shared Care Model* - responsibility for mental health care is shared between different providers. Literature on the evaluation of these models (Bower & Gilbody, 2005; Jackson-Bowers & Wilson, 2004; Gask & Croft, 2000) highlights that their success is mixed, is often context specific to a particular practice and locality, and that services rarely fall neatly into any one model. Conclusions regarding their applicability to other settings are, therefore, limited.

The Shifted Outpatient Model perhaps best illustrates the way the BIC service operated, as the Brief Intervention Coordinators were not employed by specialist mental health services and were viewed as part of the extended primary care team.

Quality management

The BIC project team consulted widely with the Specialist Mental Health Service management and CDHB Quality personnel to ensure the quality management principles were integral in the development, implementation and ongoing operation of the service. Stakeholder buy-in or commitment to the BIC service, especially from GPs, was recognised as being one of the key drivers for its success. The RCPHO GPs identified four key areas for evaluating BIC service effectiveness including access and timing, quality of support and care, feedback from the BIC worker to GPs, and overall satisfaction.

The importance of adopting a continuous quality improvement approach was acknowledged and the Plan-Do-Check-Act cycle was applied.

Method

The Ministry of Health contract and Service Provision Framework required the RCPHO to report on referral rates

and access times for the BIC Service, as well as clinical outcomes following BIC interventions. In addition, RCPHO wanted to evaluate the impact of introducing their new service, so two satisfaction surveys were developed, one for clients and one for GPs.

Procedures Undertaken

BIC staff – The BIC staff provided short term CBT informed intervention and education. CBT training occurred four times between March 2006 and May 2007 to ensure consistency in approach.

Clients of the BIC service – Inclusion criterion for this service were 18 to 65-year-old adults enrolled in the RCPHO who fit the DSM-IV-TR categories in the mild to moderate range of symptom severity and were not being seen by specialist mental health services. Clients were generally referred with depression and/or anxiety or life adjustment difficulties, for example, bereavement or marital separation. The clients were initially screened by their GPs and this was later confirmed (or not) in a 50 minute assessment by BIC staff.

BIC sessions – BIC sessions were held in the GP practice or in community resource settings in the local communities. Clients were offered up to five free sessions of 50 minute duration.

Measures Used

Service Profile - The RCPHO wanted to develop a profile of the users of the BIC service. The aim of the profile was to identify which groups were the greatest users of the BIC service and what the major presenting problems were for the clients.

Access and Waiting Times - An essential part of the service framework was that clients were to be seen by a BIC worker within a month of referral. This data was captured by working out the time difference between the date the referral was sent to the BIC service and the date of the first contact or appointment.

Clinical Outcome Measure - The clinical outcome measure, Kessler-10 (K-10), was implemented in consultation with the Primary Care Mental Health Project Evaluation team based in Wellington. It was chosen due to ease of administration, its focus on anxiety and depression, its psychometric properties, and the fact that other projects were using it so that data could be compared nationally, if required. The K-10 clinical outcome tool is a self-rating scale which measures non-specific psychological distress and has been validated as an outcome measure for primary care patients (Kessler, Andrews, Colpe, Hiripi, Morczek, Normand, Walters, &Zaslavsky, 2002) and has been shown to be sensitive and specific in detecting depression and other mental health concerns (Spies, Stein, Roos, Faure, Mostert, Seedat & Vythilingum, 2009). Kessler-10 scores range from 10-30+. Adults who score 10-15 are likely to be experiencing mild distress while adults scoring 16-30 are likely to be in the moderately distressed category. People who score 30 or over on the K-10 are likely to be severely distressed. Scores usually decline with effective treatment.

Client Satisfaction Survey - This survey was developed by the Project Manager in conjunction with the BIC team. Some of the questions were adapted from the CDHB Specialist Mental Health Services Satisfaction Survey (2006). Fourteen questions were asked with a Likert scale of 1-5 (5 being *very much* or a *great deal*) for the first four questions covering timely support, value of support, feeling listened to, and treated with dignity and respect. Questions on learning more about their difficulties, possible community support groups and culturally appropriate approaches were asked. A final section of qualitative questions on overall benefit and satisfaction (liked best, liked least, and one suggested improvement) was also included.

GP Satisfaction Survey – This sample included GPs who had referred to the BIC service regularly as well as one GP who had not used the service. Questions related to the four areas of service delivery identified by RCPHO GPs in the initial service development consultation phase including overall satisfaction with the BIC service (liked best, liked least, and one improvement). Questions on their knowledge of the service, number of referrals, reasons for not using the service and where they had referred the BIC clients prior to the service starting, were also asked. A brief pilot testing of the GP satisfaction questionnaire was carried out informally with three RCPHO GPs during April 2007.

The two surveys were reviewed by a University of Otago Senior Lecturer and Research GP from SouthLink Health, and the Chairs of both the Christchurch and the Rural Canterbury PHO Clinical Governance Group.

Data Collection and Analysis Procedures

Demographic data on the clients and their presenting problems were collected by the BIC service on a summary sheet. This information was initially entered onto a spreadsheet and later on a database at HealthSouth Link (umbrella employer at the time) and analysed using standard summary sheet analysis. Data on waiting times was collected from the same service profile summary sheet and similarly analysed. Clients were invited to complete the K-10 forms at their first and last BIC sessions. Only the data from clients who had K-10 scores before and after at least three BIC psychological intervention sessions was analysed. The completed forms were put on a separate database at SouthLink Health with pre and post intervention scores, and the computerised analysis was sent through to RCPHO.

Individual BIC workers invited former clients via a covering letter to participate in the survey, to offset any concerns about breaches in confidentiality when a client is recontacted. The covering letter and client satisfaction survey were sent out to 80 randomly selected clients who had been discharged from the BIC service within the 6 months of December 2006 - May 2007 and had had three or more BIC sessions. Thirty one questionnaires were sent to Ashburton BIC clients, 18 to Banks Peninsula clients, and 31 to Waimakariri clients. The clients were under no obligation to complete the questionnaire and no incentives were offered. The data was initially summarised and analysed manually and later put on a database for ease of ongoing access.

In early May 2007, 10 randomly selected (names out of a hat) RCPHO GPs

(out of a possible 43 in rural localities) were contacted by telephone at their practice by the clinical psychologist. They were informed that they had been selected to participate in a BIC satisfaction survey and a suitable time to interview them was negotiated. All ten GPs were willing to be interviewed and seven were interviewed face-to-face and three on the telephone. The data was initially summarised and analysed manually and later put on a database at SouthLink Health for ease of ongoing access.

Results and Findings

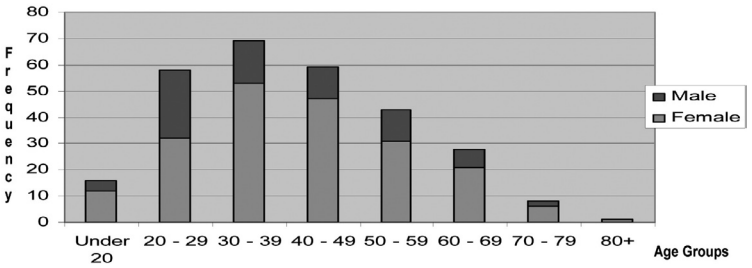
The quantitative impact of this new BIC service can be shown by the high number of GP referrals to each of the localities.

Referral Rate and Service Profile

As shown in Figure 1, there was a consistent level of referrals to the BIC service over the first fifteen months of delivery. In total, there were 446 referrals made to the BIC service by RCPHO GPs or an average of 28 adults monthly, with the Ashburton locality receiving the greatest number of referrals. The only decline in referral rate was due to the Waimakariri position being vacant from May to September 2006. This high number of referrals, particularly in Ashburton and Waimakariri prompted RCPHO to apply for additional funding and to appoint two further 0.5 FTE positions in these two localities in late 2007.

Although 446 referrals were made to the BIC service, data on only 278 clients for this time period was captured.

Figure 2. Age and gender of clients using the BIC Service (n=278)



The reasons for the data on the 168 (38%) adults not being recorded were,

- it was early in the BIC service roll-out and they may have been seen but their data was not recorded
- some may have been seen for a one-off BIC session but they were not meeting the DSM-IV-R categories or were deemed not appropriate and the data not recorded
- clients did not attend or proceed after the initial referral from the GP
- there was an overload of referrals for the 0.5 FTE BIC staff member in Ashburton
- there was a gap in Waimakariri as the position was vacant for a period of time
- referrals were made in May 2007 but not seen until June 2007.

The collection of data for those referred and seen by the BIC service was subsequently tightened up by the introduction of electronic recording and the increased FTE positions.

Profile of the BIC Clients

The ethnicity for the 278 clients who used the BIC service between March 2006 and May 2007 includes 93.2% identified as European, 3.6% as Māori, and 3.2% as other ethnicities including Pacific and Asian peoples. It is important to note that the RCPHO Māori population is 4.6% of the total enrolled. Therefore the results of this analysis would indicate that Māori access to the service is almost proportional to their numbers in the enrolled population. Information on the age and gender of the clients using the BIC service in this time period is outlined in Figure 2.

The 278 clients seen by the BICs had a total of 978 contacts with the workers, an average of 3.5 sessions per client; 72% of clients using the service were female. The ages of clients using the service ranged from under 20 years (2.9%) to one female aged over 80. The average age of our clients was 40.5 years. Younger males used the service more and adults over 50 years of age used the service less.

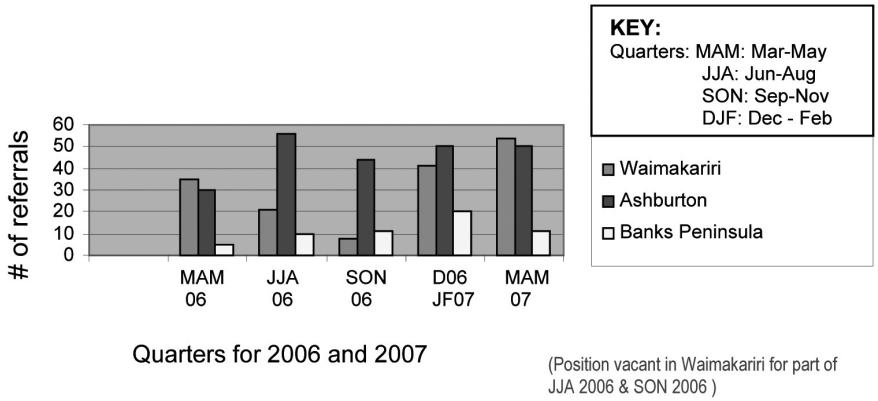
Table 1 shows the breakdown of the mild to moderate mental health concerns or presenting problems of the clients using the BIC service.

As outlined in Table 1, 73% of the clients using the BIC service had symptoms of depression. Over half had symptoms of anxiety (142) and in many cases this was in combination with depression. The BIC service also helped people to manage a wide range of other problems (68) including marital distress and stress related problems. Of interest was the number of clients with more than one presenting problem, which highlights the complexity of the mental health concerns of our client group. Most adults referred to the BIC service had a high level of co-morbidity. Only 17.6% of the BIC clients had physical health co-morbid presenting problems.

Access and Waiting Times

A review of the time it took for the client to be seen from date of referral

Figure 1. Number of referrals to the BIC Service by quarter (n=446)



Mental Health Presenting Problem	Times this problem was present
Depression	202
Anxiety	142
Alcohol/Drugs	19
Psychosis	2
Other	68
Total presenting problems	**433**

Physical Health Presenting Problem	Times this problem was present
Asthma	9
Cardio Vascular Disease	8
Diabetes	7
Chronic Obstructive Pulmonary Disease	1
Other	24
Total presenting problems	**49**

to date of first appointment in the three localities was completed. Average waiting times were 15 working days for Ashburton, five days for Banks Peninsula, and 18 days for Waimakariri. All clients within the three localities were seen within the one month (20 working days) specified in the service contract. Extended waiting times in Ashburton and Waimakariri were a result of high service demand for a 0.5 FTE allocation. Of the GPs interviewed, 80% said they did not experience any difficulties in accessing the BIC Service when they needed it.

Clinical Outcome Measures

Only 31% of adults seen by the BIC workers completed both sets of the K-10 scale. During 2006 this was a function of high service demand and overworked BIC staff. Kessler-10 scores at the end of three or more BIC sessions were substantially lower than scores recorded at the start for both the moderate and severe distress groups. Thirty-six percent of the clients who completed the K-10 at the two time periods scored at the *severely distressed* level (n=33, mean = 36.48, SD = 5.73). After three or more sessions these individuals recorded a mean score of 20.5 (moderate level of distress). Fifty-four percent of the clients completed the K-10 scored at the moderately distressed level (n=49, mean = 24.2, SD = 4.17), and after three or more sessions recorded a mean of 16.7. Ten percent scored at the mildly distressed level (n=3, mean = 12.3, SD = 2.08) and shifted to a mean of 12.

Client Satisfaction Survey Results

Eighty satisfaction surveys were sent out in April 2007 to people discharged from the BIC service for the period December 2006 to May 2007. Thirty nine responses were obtained giving a 48.7% response rate. Seven questionnaires were returned due to changes in clients' addresses. Seventeen completed questionnaires were returned from Ashburton (43.6%), 16 from Waimakariri (41%) and 6 from Banks Peninsula (15.4%). Most of respondents were female (90%), 66% were aged between 35 and 65 years of age, and 89% were NZ European with 11% indicating they were 'Other European'. There were no Māori or Pacific respondents to the client satisfaction survey.

Overall the surveyed clients were satisfied with the BIC service with an average rating of 4.4 (with 4 being *quite satisfied* and 5 being *very satisfied*). The overall perceived benefit for the surveyed group was self-rated at 4.3. The highest client ratings were for being treated with dignity and respect (4.6) and being listened to (4.5). Support and care appropriate to their culture was not rated as highly (4.0).

When respondents were asked if they had learnt more about their difficulties, 87% said they had. One person commented "*she got me out of my hole,"* while another said "(it) *gave me a good insight about my personality,*" and another said "*I found how to let go of things*."

When asked what they liked best about the BIC service, 33% mentioned having someone they could talk easily to; 31% stressed that they felt listened to at all times; 31% of responses related to the non judgmental, welcoming, respectful way they were treated; and 28% of responses were very specific about what had actually helped for them.

Comments indicated that the BIC workers had, "*offered insights I was unaware of,"* "*helped me to see my life a bit more objectively and then I was able to make appropriate changes,*" "*explained depression, what it was and how it effects different people,*" and finally that "*I understood my feelings when I didn't understand what was going on myself*."

When asked what they liked least, 28% said nothing at all. One commented, "*it took 3 years to be offered this service.*" Others made personal comments about their own fear of talking or feelings around taking too much time.

Suggestions for improvements were made by one third of respondents. Their suggestions ranged from more sessions, to a follow up session months later, to getting a "*timer that goes off, maybe 3 minutes prior to finish,*" or developing some written guidelines that could be used to remind the person of progress made.

GP Satisfaction Survey Results

Ten GPs were randomly selected to be interviewed and discuss their level of satisfaction with the BIC service. Five GPs were from Waimakariri, three from Ashburton and two were from Akaroa / Banks Peninsula. Three GPs were female, including one who had not referred anyone as she had completed psychiatric training and stated that she was able to provide the psychological services herself. Collectively, the 9 GPs had referred 145 people to the service in the past 16 months or an average of 16 each. This suggests that this group of GPs were knowledgeable about the service and who it was established for.

BIC Service: Where were clients sent previously?

When GPs were asked where they had sent people prior to having the BIC service, the replies ranged from having dealt with the people themselves (5 responses); Presbyterian Support Services (4 responses); private counsellors or therapists (4 responses) but cost was a limiting factor; public system (4 responses); and Ashburton mental health team (2 responses). With regard to sending people to the public services, one GP stated "*I made attempts for secondary referral but they were not helpful as had long wait lists*," and another said "*half didn't get seen and festered on sickness benefits and they*

did not get the help they needed."

Quality of support and care

All nine GPs who referred people to the BIC service thought the support and care was of value to their patients and that their patients had learnt more about their mental health concerns. One GP said "*half or 15/30 of* (his) *referrals would have needed mental health service contact later without the BIC,*" and another said *"many people who in the past went to psych services ... are now happy with BIC service ... there is a definite reduction in referrals to mental health services."*

The BIC clients feedback to their GPs included: "*patients appreciated no cost, easy access service,"* that the *"whole thing was therapeutic (grief help),"* and that one client had been experiencing a *"bad time there and helped me turn the tide."*

Feedback from BIC worker to GP

The GPs were asked to comment on how timely, specific and useful the feedback from their BIC worker was for the clients they had referred to the service. The GPs were asked to rate these aspects on a scale of 1 to 10 (*very happy* with that aspect). The usefulness of feedback was rated at 7.5; specific feedback received by GPs was rated at 7.3, and timeliness received a mean rating of 6.0. Comments regarding the usefulness of feedback included, "*things I'm not aware of, and that was good to know, such as family history and dynamics,*" and "*when we get the report, it is a good summary.*"

What the GPs liked best and least about the BIC Service

Overall the things the GPs liked most about the BIC service were the affordability (8 responses), followed by speed and timeliness of contact (4), relief and support for GP (4), availability (3), locally based (3), outside secondary care (3), covers a wide net of problems (3), flexibility (2) and time limited sessions (2). Three GPs commented on the value of the service being in primary care as it has "*less stigma*" and "*stops people being bandied around in secondary care*." One GP boldly said that the BIC service was, "*one of the best things the PHO has provided.*"

The features the GPs liked least focused around the mid 2006 temporary BIC vacancy with all of the effected Waimakariri doctors mentioning it. The wait list was mentioned by three GPs.

Suggestions for improvements were minimal with two GPs mentioning more workers or expanding the service, while two GPs wanted "*computerised documentation,"* and two wanted to see a Youth BIC worker. Finally, one GP said "*please don't stop the service. We find the service great. My colleagues comment on this as well."*

Discussion

The results show that the BIC service provided a useful psychological intervention that achieved positive clinical outcomes and service satisfaction for the clients with mild to moderate mental health concerns in the RCPHO area.

Overall the new and initially small BIC team had to deal with 446 referrals with a total 1.3 FTE staff, which was an early indication that the service was needed. The MaGPIe study (MaGPIe, 2003) acknowledged that GPs were quite proficient at identifying the mental health problems (especially anxiety and depression) although a screening tool such as the General Health Questionnaire 12 (GHQ-12) could improve detection rates and thus the likelihood of adults accessing treatment (Davis, Galyer, Halliday, Fitzgerald, & Ryan, 2008).

In this project, over half of the BIC clients had symptoms of anxiety and for half this was in combination with depression, and these concerns were identified by the RCPHO GPs on their referral forms. It was interesting to note that less than 20% of the BIC clients had physical health co-morbid presenting problems, which may suggest that these adults had visited the GP for mental health concerns alone and not in conjunction with their physical health problems.

Some authors (e.g., Kathol & Clarke, 2005, Hickie & Groom, 2002) argue that primary care provides an effective, efficient and economical service for clients allowing easy access and reducing long term difficulties. Those referred to the RCPHO BIC service received an efficient, easily accessible (all seen within one month) and effective (K-10 score reductions and positive outcomes) service. The severity of symptoms for this client group was also reduced (Morley et al., 2006; Vines et al., 2004). However independent clinician rated measures were not taken so these findings cannot be corroborated.

GPs surveyed liked the BIC workers being based locally and not being attached to the secondary mental health services. The use of CBT was also beneficial for clients as indicated in their qualitative comments.

The Shifted Outpatient Model generally describes the BIC service although it is not fully compatible as the BIC clients were often being seen by a mental health worker for the first time and were not outpatients of specialist mental health service. The BIC service aimed to have good information in their referrals and comprehensive assessments as is best practice (Ministry of Health, 2004).

The review process reported here has provided valuable feedback for the BICs and furnished an objective measure of the quality of their work over the first 15 months of the project. It developed a service profile of who has been using their services so they could target other groups, particularly older male adults and those from different cultural groups.

The time of referral to first appointment met the standard of one month or 20 working days. However it must be noted that the data was missing for almost 38% of clients who were referred but either not seen by a BIC worker or their data were not recorded, and steps have since been taken to improve data capture. This may be due to barriers for the adults themselves as they may be reluctant to attend therapy (Davis et al., 2008), or not be ready or understand the need to see a BIC worker (CDHB, 2006).

The review process highlighted the value of the K-10 outcome scale for providing feedback on benefits for clients and clinical efficacy. Results would suggest that the greatest gains were for those who rated themselves on the more severe level of distress at the beginning of the BIC sessions. Overall,

there were decreases in the level of reported distress for almost all clients at the time of discharge from the BIC service. The lack of completed sets of Kessler scores was a major concern and barriers to completing the scores may have included clients not returning for or missing final sessions, or administration or work overload problems. BIC workers are now encouraged to ensure these score sheets are completed.

Overall the clients responding to the survey were satisfied with the BIC service. They reported that the service was of benefit and value to them, particularly when they felt listened to and were treated with dignity and respect. The support and care appropriate to their culture was less highly rated. They had been seen by their BIC worker within a month of referral, and almost 90% said they had learnt more about their difficulties.

Overall the GPs surveyed were very satisfied with the BIC service, with two GPs saying it was the best thing to come out of the PHO. They did not experience any ongoing difficulties with access to the service and the speediness and timeliness of the service was most appreciated. The quality of the care and support provided by the BIC workers was also valued. GPs found the BIC workers' skills with respect to developing more insight into the client's problem(s), and dealing with grief and coping strategies, to be of great benefit. A comment was made that computerised notes may be useful.

Currently data is being collected on the community agencies that BIC clients are referred on to. The development of these community links is another best practice principle (Ministry of Health, 2004). However this data was not actively recorded at SouthLink Health, an omission that has since been addressed.

Future Direction

This strand of the Demonstration Model was recognised at the CDHB Quality and Innovation Awards (2007) and awarded prizes for the Community Based Services Category and the overall Supreme Award. Training and development for primary care mental health workers in this new role is still a key concern for this organisation and is part of best practice principles (Ministry of Health, 2004). BIC training and development requirements are currently maintained by fortnightly supervision and local training resources. However, there is lack of provision for this on a national level. This organisation looks for guidance from national bodies (e.g., Ministry of Health, professional colleges, private providers) to produce workshops and training that fit the brief intervention model and ensure that professional standards are maintained.

The BIC service as it currently stands may evolve from face-to-face interview work in a GP setting to more community based settings including marae, workplaces and home visits. The desired direction is that the BIC service model be fully adopted and accepted throughout the primary care sector in Canterbury, both in the rural and urban communities. This direction is also consistent with the recommendations made in the CDHB (2006) Primary Mental Health Positioning Paper.

References

Blackburn, L. M., Bishop, S., & Glen, A. L. (1981). The efficacy of cognitive therapy in depression: A treatment trial using cognitive therapy and pharmacotherapy, each alone and in combination. *British Journal of Psychiatry, 139,* 181-189.

Bloom, B. L. (2002). Brief interventions for anxiety in psychiatric disorders: Clinical outcome studies. *Brief Treatment and Crisis Intervention*, *2*, 235-339.

Boland, B., Drummond, C., & Kaner, D. (2008). Brief alcohol interventions – everybody's business. *Advances in Psychiatric Treatment*, *14*, 469-476.

Bower, J., & Gilbody, S. (2005). Managing common mental health disorders in primary care: Conceptual models and evidence base. *British Medical Journal, 330*, 839-847.

Bower, P., Rowland, N., Mellor, C., Heywood, P., & Godfrey, C. (2007). *Effectiveness and cost effectiveness of counselling in primary care.* Cochrane Review.

Canterbury District Health Board (2006). *Primary Mental Health Positioning Paper*. Christchurch, NZ: CDHB Publications.

Davis, J., Galyer., K., Halliday, T., Fitzgerald, J., & Ryan, J. (2008). Identifying psychological distress in New Zealand primary care: The General Health Questionnaire – 12 (GHQ-12) as a screening instrument. *New Zealand Family Physician, 35*, 86-90.

Fitzgerald, J., Galyer, K., & Ryan, J. (2007). *Brief Mental Health Interventions in Primary Care: The Coordination and Evaluation of Primary Mental Health Counselling Initiatives. Final Report.* Hamilton, New Zealand: The Psychology Centre.

Gask, L., & Croft, J. (2000). Methods of working with primary care. *Advances in Psychiatric Treatment, 6*, 442-449.

Hickie, I., & Groom, G. (2002). Primary care led mental health service reform: an outline of the better outcomes in mental health care initiative. *Australasian Psychiatry*, *10*, 376-382.

Jackson-Bowers, E., & Wilson, I. (2004). *GPs and Psychiatrists working together: Literature Review, Primary Mental Health Care*. Australian Resource Centre.

Kathol, R. G., & Clarke, D. (2005). Rethinking the place of psyche in health: Toward the integration of health care systems. *Australian and New Zealand Journal of Psychiatry*, *39*, 826-835.

Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S.-L. T., Walters, E. E., & Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalence and trends in non-specific psychological distress. *Psychological Medicine, 32*, 959-976.

Kessler, D. A., Lloyd, K., Lewis, G., & Gray, D. P. (1999). Cross-sectional study of symptom attribution and recognition of depression and anxiety in primary care. *British Medical Journal, 318*, 436-439.

Lang, A. J. (2003). Brief intervention for co-occurring anxiety and depression in primary care: A pilot study. *International Journal of Psychiatry in Medicine*, *33*, 141-154.

MaGPIe Research Group (2003). The nature and prevalence of psychological problems in New Zealand primary healthcare: A report on Mental Health and General Practice Investigation (MaGPIe). *The New Zealand Medical Journal*, *116*, 379-394.

Ministry of Health (2001). *The Primary Care Strategy*. Wellington, NZ: Ministry of Health.

Ministry of Health (2004). *Primary Health Organisations: Service development toolkit for mental health services in primary health care.* Wellington, NZ: Ministry of Health.

Ministry of Health (2005). *Te Tahuhu: Improving Mental Health (2005-2015). The 2nd Mental Health and Addiction Plan*. Wellington, NZ: Ministry of Health.

Miranda, J., & Munoz, R. (1994). Intervention

for minor depression in primary care patients. *Psychosomatic Medicine, 56,* 136-141.

Morley, B., Pirkis, J., Sanderson, K., Burgess, P., Kohn, F., Naccarella, L., & Blashki, G. (2006). *Evaluating the access to allied psychological services component of the better outcomes in mental health care programme. Eight interim evaluation report. Consumer outcomes. The impact of different models of psychological service provision*. University of Melbourne, Australia: Program Evaluation Unit.

Murphy, R., & Bertolote, J. (2001). *World Health report: Mental Health: New understanding, new hope.* Geneva: World Health Organisation.

Spies, G., Stein, D. J., Roos, A., Faure, S .C., Mostert, J., Seedat, S., & Vythilingum, B. (2009). Validity of the Kessler-10 (K-10) in detecting DSM-IV defined mood and anxiety disorders among pregnant women. *Archives of Women's Mental Health*, *12*, 69-74.

Vines, R. F., Richards, J. C., Thompson, D. M., Brechman-Toussaint, M., & Kluin, M., & Vesely, L. (2004). Clinical psychology in general practice: A cohort study. *Medical Journal of Australia*, *181*, 74-77.

Wells, J. E., Oakley Browne, M. A., Scott, K. M., McGee, M. A., Baxter, J., & Kokaua, J. (2006). Te Rau Hinengaro. The New Zealand mental health survey: Overview of methods and findings. *Australian and New Zealand Journal of Psychiatry*, *40*, 835-844.

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