Te Tumu Waiora: The integrated primary mental health and addiction model

This article describes the three new roles in the integrated primary mental health and addiction model – health improvement practitioners, health coaches and Awhi Ora support workers. It also gives "a day in the life" vignettes for each role and explains how they work with the existing GP and nurse workforce to provide primary care focused on holistic wellbeing

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For further details, refer to page 36

The GP–nurse team model of primary care evolved over 100 years ago, when most healthcare need was assessment and treatment of medical conditions. However, with improved prevention, detection and treatment of medical conditions over the past 50 years, along with lifestyle changes and increased lifespan, the preponderance of health need now relates to mental health, addiction and long-term medical conditions – the area of health need described in the US as "behavioural health".

Reflecting this change, when I (first author) began working in primary mental health 18 years ago, I asked GPs, "What would help you better meet your patients' mental health needs?" The answer was invariably, "A mental health clinician to work as part of my team," and/or "A social worker to address patients' social needs."

At the time, and for most of the years since, funding for primary mental health was limited – a little over 2 per cent of the national mental health and addictions spend to address up to 75 per cent of the moderate and serious mental health need.[1] Annual prevalence of any moderate or serious mental health disorder is 13.6 per cent of the population, while annual access rates to DHB mental health and addiction services are about 3.5 to 4.0 per cent of the population.

Given the limited funding, focus was on "high-needs populations" – Māori, Pacific and quintile 5 communities. All PHOs used this funding for extended GP/nurse consults and referral-based packages of talking therapies (typically three to six sessions of cognitive behavioural therapy [CBT]).

People who accessed these services generally did well, and an evaluation published in 2009 showed good improvement rates.[2] Differentially, Māori access rates were greater than overall population rates. However, for people who were not high needs but nevertheless unable to afford to pay for services, unmet need remained. Over time, several significant issues with this referral-based model became clear:

- In high-needs communities, only 35–40 per cent of people referred were seen, the remainder either being hard to reach, declining care, or not turning up to an appointment. Those not seen often had the greatest complexity and need (ie, who GPs were most worried about).
- Access rates for Pacific peoples and youth and young adults remained low, despite these two groups having high levels of need.
- A full-time therapist delivering three to six-session packages can only provide care to 225–250 people per year. Even if funding had been greatly increased, there was not the workforce to meet need.
- Despite readier access to talking therapies, prescription of antidepressants continued to climb (Figure 1, next page). GPs knew the evidence suggested antidepressants were only effective for severe, persistent depression; however, when confronted with a distressed patient, knowing they could refer was of comfort, *but* they were aware there would be a wait of some weeks to be seen and felt they had to do something in the meantime.
- Many people seen in primary care had stress/distress secondary to issues that were essentially social, related to the determinants of wellbeing (eg, income, housing, social isolation, family violence), where therapy and support alone was not going to meet this need.
- Increasing numbers of people also struggle to manage and live well with lifestyle-related, long-term conditions (eg, type 2 diabetes), many of whom also have social and/or mental health issues.

Do you need to read this article?

Try this quiz

1. **The "missing middle" refers to a group of people for whom services to meet their moderate to severe mental health needs have been missing. True/False**
2. **The integrated primary mental health and addiction model will be rolled out nationally to all GP practices by 2023. True/False**
3. **New Zealand's health improvement practitioner role is based on the US behavioural health consultant model. True/False**
4. **Anyone can train to work as a HIP. True/False**
5. **Awhi Ora is a community-based wellbeing support service. True/False**

Answers on page 35

Creating an alternative to referral-based service for the 'missing middle'

Nationally, the limitations of the existing primary mental health services were recognised. In particular, that there was a group of people with moderate to severe persisting needs, often with complexity and mixed mental health and substance use issues. As they aged, early onset and greater severity of long-term medical conditions added to a background of early life adversity.

This group came to be referred to as the "missing middle", although it was not they who were missing, but the services to meet their needs! Even if they made it to referral-based primary mental health services, they had needs that could not readily be met in a brief intervention model, and they did not meet access criteria for secondary services.

In recognition of these limitations, from 2013 to 2017 a number of initiatives evolved in metro Auckland as collaborations of PHOs, DHBs and mental health NGOs.

The first of these – Awhi Ora – evolved out of an extensive co-production process with the high-needs Tāmaki community. It identified social issues as a significant cause of distress in many people attending GPs. A collaborative formed to test the concept of introducing people to NGO peer and community support services from primary care.

The second began as a response to the needs of a group of people who were frequent presenters to hospital due to poorly managed long-term conditions. It resulted in testing and adaptation of the health coach role developed by the Center for Excellence in Primary Care.[3]

Evaluations of these initiatives showed generally improved outcomes and good patient experience. These initiatives also showed that for many of the so-called missing middle, providing responsive, personalised services focused on "what matters to you" resulted in significant improvements in wellbeing with relatively little support.

The team that tested the health coach model came to frame their approach as "patient voice, patient choice". When this was done well, most often, less was more.

In response to the issues with referral-based talking therapies, there was also a process of looking overseas for evidence-based models of primary mental health. In particular, the behavioural health consultant model developed and evaluated in the US drew attention.[4]

Fit for the Future

In 2017, a request for proposal came from the Ministry of Health for Fit for the Future pilots of services to better meet the moderate to severe need of the missing middle. The proposal submitted by an Auckland collaborative of DHBs, NGOs and PHOs to pilot an "extended multidisciplinary primary care team" was successful.

From 2017 to 2018, the model was piloted in seven Auckland high-needs community GP practices. This provided an opportunity to test integration of the Awhi Ora and health coach roles into primary care teams, along with testing of the behavioural health consultant model – using health improvement practitioners (HIPs) – in an Aotearoa New Zealand context (Figure 2).

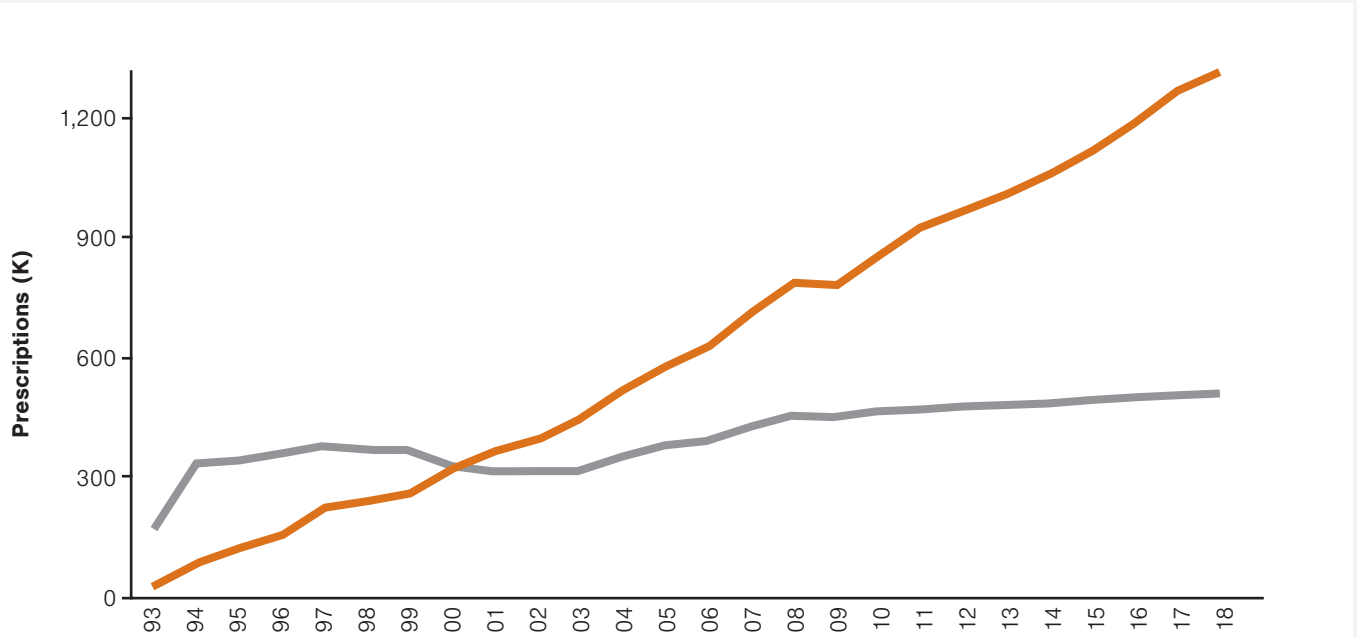
The independent evaluation undertaken by Synergia showed very positive outcomes of this pilot:[5]

- Access rates increased from 35–40 per cent to over 90 per cent.
- Access rates were significantly increased for Māori and young adults, and moderately increased for Pacific peoples.
- Intake wellbeing scores confirmed that the people accessing this service were those intended – half rated as having severe difficulties.
- The immediate access to support was highly valued by patients, and usefulness of the service was rated over 9/10.
- Six-month follow-up showed significant sustained improvement in holistic wellbeing (mental, physical and social health) for over half of patients, with the greatest improvement seen in Māori (Figure 3).
- Prescribing of antidepressants was significantly reduced.

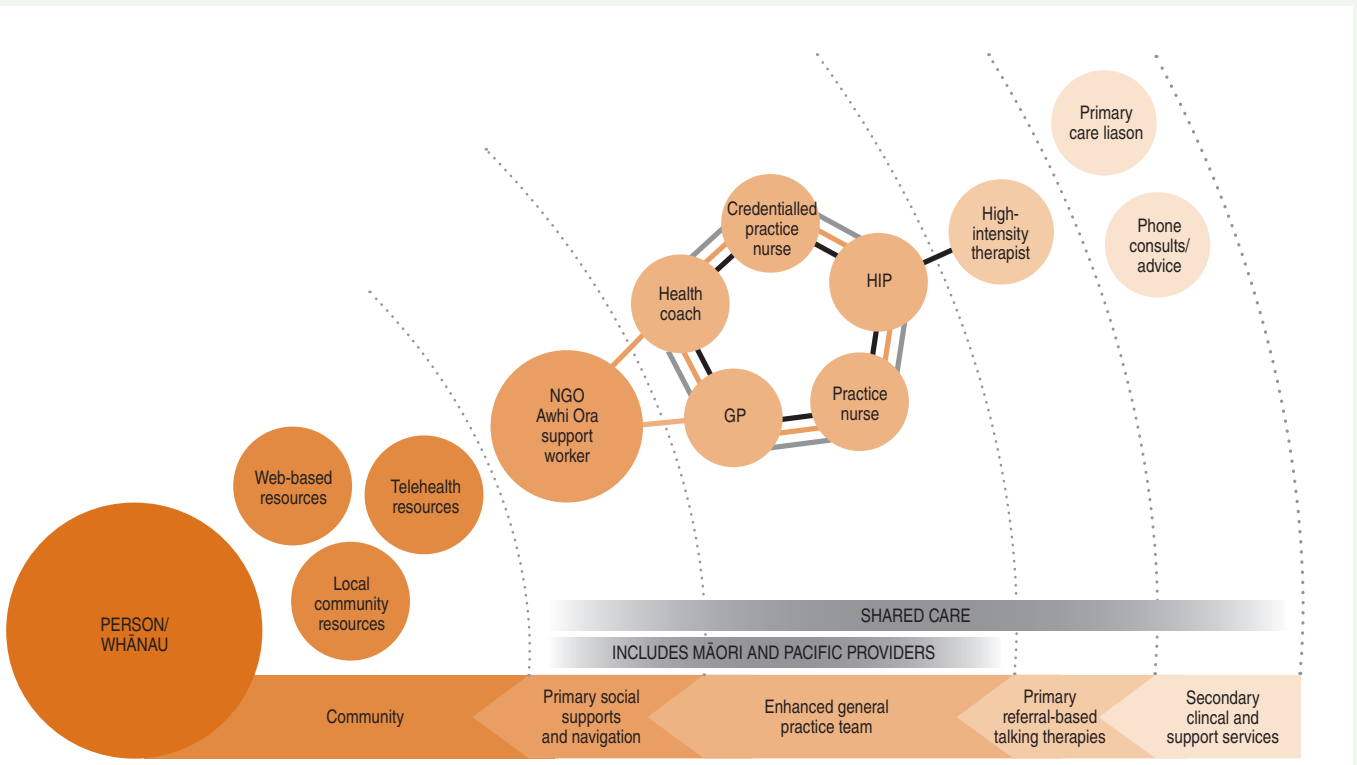
Te Tumu Waiora

Based on the extremely positive outcomes seen, along with recommendations of the Government Inquiry into Mental Health and Addiction (He Ara Oranga),[6] the Government announced, in its May 2019 Wellbeing Budget, funding to roll out this model nationally to all GP practices from 2019 to 2024/2025.

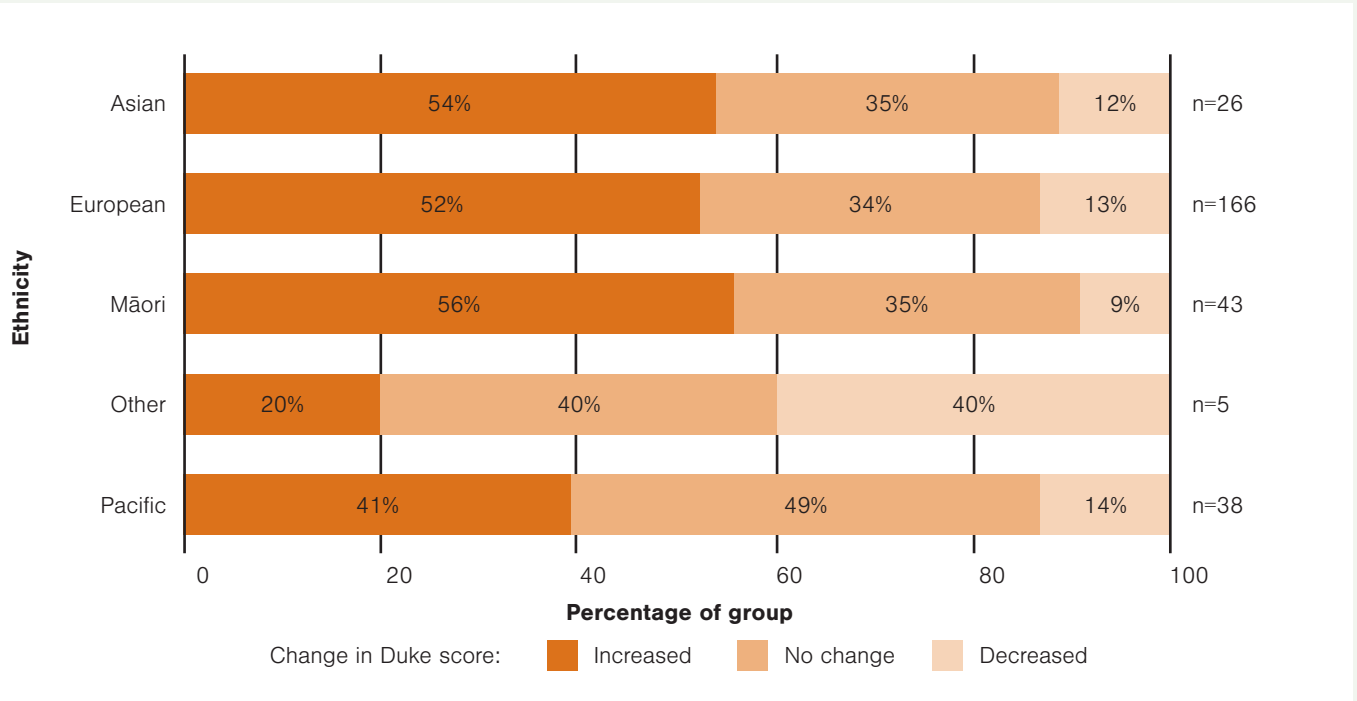
Funding through to June 2021 will see the model operating in 54 large high-needs Auckland GP clinics, and over 100 clinics nationally. As it continues to roll out, it will adapt to regional needs and improve cultural "fit", especially for Māori and Pacific peoples, while also retaining fidelity to the core models tested.



▲ **Figure 1. Pharmac data on antidepressant prescribing each year. New antidepressants (orange) include selective serotonin reuptake inhibitors, mirtazapine and venlafaxine. Old antidepressants (grey) include cyclic and related agents, and monoamine oxidase inhibitors**



▲ **Figure 2. The integrated primary mental health and addiction model puts mental health and wellbeing at the heart of general practice**



▲ **Figure 3. Pilot evaluation showing category change in Duke Health Profile score by ethnicity (n=278).[5] The Duke score measures function/ dysfunction across three wellbeing domains – physical, mental and social. There was less improvement in the wellbeing of "other" ethnicities, but this was based on ratings from only five people**

Health improvement practitioners: Busy but hugely rewarding work

A pre-requisite to being accepted for HIP training is that you must be a registered health professional with some experience and training in evidence-based talking therapies, such as CBT, acceptance and commitment therapy, and focused ACT. HIPs come from a range of professional backgrounds and include psychologists, nurses, occupational therapists, social workers and dapaanz (addiction) counsellors.

Training consists of a four-day classroom-based training programme, where new HIPs learn the tools necessary to practise in primary care behavioural health. The HIP trainee then spends one day observing an experienced HIP and one day with their trainer/mentor in the clinic where they will be working. A six-month practicum follows, which provides the new HIP with ongoing mentor support, peer supervision, webinars and observed practice.

HIPs are trained in the primary care behavioural health consultant model, which aims to improve and promote overall health within the general population. They work to empower people to make positive changes in their lives by generating and trying out behavioural plans.

HIPs are not co-located therapists who carry their own caseloads; they work as *integrated* members of the primary care team using a consultation model. They use evidence-based brief interventions and provide timely (preferably same-day) feedback to the patient's GP about the action plans they generate with the patient.

The acronym GATHER is used to outline aspects of the HIP role (Panel 1).

HIPs provide group education on behavioural interventions to both patients and members of the practice team

A day in the life of a HIP

8.30am – I arrive at the clinic. After logging in to the practice management system, I see I have three people booked in and a group session scheduled. I pop in to see each GP working today to let them know I will be available. One GP thinks it may be helpful for a patient who attends regularly with chronic pain to see me today.

9.00am – my first patient is a young woman with anxiety who I have seen a few times – most recently, two months ago. She says she has been practising the skills we use in our sessions and has completed her plan of re-enrolling in university. Things are going well for her, and our session is completed in 15 minutes.

9.20am – I get a call from a GP who wants me to meet a new patient. David is a 58-year-old Samoan man who lost his job during the COVID-19 lockdown and has come in asking for something to help him sleep. The GP suggests we meet to see if I can help David with some strategies around stress management and sleep. I spend 25 minutes with David, and we come up with a plan that he takes away to try before seeing his GP again next week.

10.00am – I have a booked appointment with Miriama, a 40-year-old Māori woman who has just been diagnosed with pre-diabetes and is quite shocked as her mother died from complications of diabetes. Miriama wants to talk about her fear and anxiety around her new diagnosis, but she also feels ready to start making some lifestyle changes. We come up with a plan, and I introduce her to our health coach, who takes Miriama to start setting some lifestyle goals.

10.30am – a GP knocks on my door and introduces Angela, whose husband of 50 years died a couple of weeks ago. Angela has been tearful during their session and is grateful to be able to talk with me about her loss and sadness. The GP appreciates being able to offer her more than he could in his 15-minute session.

11.00am – my next patient is a man in his 50s with some complex mental and physical health challenges, including high health anxiety. HIPs see a small number of "continuity patients", and he is one of these. He had been presenting acutely to his GP several times a week and to the emergency department almost every week before he was referred to me. I see him weekly for about 15 minutes to help him develop skills to relieve his anxiety. My input has resulted in a significant drop in the amount of GP and nurse time he requires, and he is feeling much more confident in managing his health.

11.25am – I get another warm handover – a woman with four-year-old triplets who is finding it difficult to cope. We develop a plan that involves introducing some self-care strategies, and we look at connecting her with some community supports.

12.00pm – I break for lunch in the clinic lunchroom, which is a good place to connect with my practice colleagues. Today, the GPs who referred patients to me in the morning are there, so I give them brief feedback on the plans we came up with.

12.30pm – at a recent meeting with the GPs and nurses, we identified sleep problems as a common issue, so I have invited six patients to a one-hour group session titled "Tips for getting better sleep". Five of them arrive and are keen to learn about CBT for insomnia – an evidence-based intervention for improving sleep.

1.30pm – I take half an hour for admin and a cup of tea, then spend an hour with the health coach and Awhi Ora support worker. This is a weekly meeting to catch up, discuss patients we want to introduce to the support worker, and get feedback on patients.

3.00pm – the GP who mentioned her patient with chronic pain calls to ask if I can come to meet him briefly, which I do. I walk out to the front desk with him, give him a handout with my details on it, and invite him to book an appointment with me.

> The HIP sees any person enrolled in the clinic, of any age, for any issue that is impacting on their health and wellbeing

3.35pm – a GP asks me to drop into his office to see 35-year-old Tony. During their consult, Tony revealed that he is concerned about how much alcohol he is drinking. He doesn't want to engage with Community Alcohol and Drug Services but is willing to talk with me. I take him back to my room, and we discuss triggers for drinking and strategies for reducing or quitting. He's keen to give moderating a try, so we agree to meet again in a week to see how he goes.

4.00pm – the last hour of the day allows me to finish off notes and connect with any other GPs who have handed off patients to me today. The practice manager drops in to discuss our plans for a pathway for patients with diabetes and high HbA1c. We also talk about my plan to provide a 15-minute lunchtime teaching session on stress management and self-care for clinic staff. By the end of the day, I have seen 12 patients in individual and group sessions.

Panel 1
GATHER describes aspects of the HIP role

Generalist
The HIP sees *any person* enrolled in the clinic, of *any age*, for *any issue* that is impacting on their health and wellbeing. There are no referral criteria, and a GP or nurse can introduce anyone to the HIP who they feel may benefit. Reasons for referral include anxiety, low mood, stress, sleep problems, relationship difficulties, lifestyle changes (eg, weight gain or smoking), grief and loss, persistent pain, or coping with a new health diagnosis or chronic illness.

Accessible
While appointments with HIPs can be pre-booked, half of all time slots must be left free for same-day appointments, preferably "warm handovers". In a warm handover, a GP or nurse can bring a patient to the HIP's room or they can call the HIP and ask them to come to the GP's room to meet the patient. HIPs are willing to be interrupted for a warm handover, even if they are with a patient.

Team-based
HIPs prefer to have a room in the middle of the clinic where they can regularly interact with other team members. They keep all their notes in the practice management system and keep no "secondary notes". They try to attend all team meetings and huddles. One of the primary goals of the HIP is to be helpful to the team, so they actively look for things to do if they are not seeing patients.

High productivity
A new HIP aims to see approximately eight patients a day, while a more experienced HIP aims for about 10 patients a day. These numbers can increase when group sessions are added.

Educator
Providing education in behavioural interventions to all members of the practice team is a core part of the HIP role. Because general practice is a busy place, education tends to be delivered informally and quickly – for example, brief (15 minute) lunchtime drop-in sessions, posters and handouts.

Routine pathways
The HIP helps the team develop pathways or protocols that target high-impact groups routinely needing HIP support, such as frequent attenders or those with chronic pain.

Health coaches: Supporting people on the journey to better health

Walking groups provide a great opportunity to review people's progress with their self-management goals

Anyone can train to work as a health coach. The main requirements are to be a people person who loves helping others, a team player, and someone who thrives on variety and being busy. Like HIPs, health coaches work on site as part of the clinic team, providing same-day self-management support to people struggling with long-term health issues.

While some health coaches have a clinical background, they sit beside people as a peer or equal. They are ideally someone who speaks the same language or is from the same culture as the people served in the clinic. Experience from the original pilots was that health coaches who had their own experience of living and managing well with a long-term medical and/or mental health and addiction issue developed the competencies for the role quickly, and were particularly effective in engaging people who had previously been hard to reach.

Like HIPs, health coach trainees complete initial classroom-based training – in this case, five days – the core of which is instruction in the health coach competencies, followed by observed role-playing of each competency and feedback. This is followed by one to two days of in-practice shadowed experience, when the role is introduced into the practice team and the trainee is assessed against the core health coach competencies. This is followed by three to six months of combined webinars and peer review supervision, and another one to two days of shadowed practice. Training is complete when the trainee is assessed as meeting or exceeding all competencies.

This model of health coaching and associated training is that tested and evaluated in the pilots. In commissioning the health coach training, Te Pou contracted two health coach training agencies; the other has a different training and support process that trains health coaches into a primarily mental health support role. However, in Auckland, mental health support is provided by NGO Awhi Ora support workers.

As a non-registered workforce, health coaches work within a clearly defined scope of practice. They do not give clinical advice and defer any clinical issues or questions (including risk) back to clinicians.

Health coaches support people to gain the knowledge, skills and confidence to become informed, active participants in their own healthcare. Working closely with the clinicians on the team, they provide support and information in keeping with the team's advice and guidelines. They help people understand their healthcare team's advice, find out how the person feels about that advice, and support them to think about what they will work on first.

They provide a mix of individual/whānau support services and group programmes, sometimes in partnership with their HIP colleague(s). Some health coaches also run US Self-Management Resource Center group education programs (selfmanagementresource.com) in their local community. The combination of individual/whānau and group-based support has been found to be especially effective.

Health coaches work beside people using evidence-based processes and trusted health education materials and resources, to collaborate with them as they gain ideas and confidence to put healthy steps into practice. As for HIPs, the goal is to activate people through developing and trying out behaviour change plans. With phone calls and future visits, the health coach supports the person's self-management goals. Health coaches also support connection to other health and community services, and programmes such as Awhi Ora.

The underpinning philosophy of health coaching is captured well by the proverb "give a person a fish and you feed them for a day; teach them to fish and you feed them for a lifetime". Health coaches do not do things for people, but rather support and build their confidence to do for themselves. The acronym HEALS is used to outline aspects of the health coach role (Panel 2).

Panel 2
HEALS describes aspects of the health coach role

Helpful
Provide practical help and support to patients and the clinic team, based on "doing what it takes" to support people and their whānau to make healthy changes.

Educators
Provide evidence-based information regarding health issues in ways that people can understand and make sense of.

Available
Provide support most often on the same day the person comes to the clinic.

Link
Connect people back to other team members, follow up on agreed actions and plans, and connect people to other health and support services in the community.

Support
Provide practical support to help people progress their self-management goals.

The combination of individual/whānau and group-based support has been found to be especially effective

A day in the life of a health coach

8.00am – I arrive at the clinic, log in to the practice management system to see what I have scheduled, then check my emails.

8.50am – the HIP and I have a huddle with each of the nurses working that day. We discuss anyone who is coming in to see the nurse and/or GPs who may need to see me or the HIP.

9.30am – five people arrive for the walking group, each of whom has a goal of increased physical activity, and we go for a 45-minute walk. This is also a great opportunity to review their progress. I complete the paperwork for each patient, then have morning tea with some of the nurses – a great chance to maintain relationships and get feedback about patients they have handed off to me.

10.30am – I have a booked appointment with a 20-year-old man who injured his knee six weeks ago. He has gained some weight but wants to get back into playing rugby. We discuss his eating habits and make a plan for healthy eating.

10.50am – a patient knocks on my door on his way out from seeing his GP. Brian is a 71-year-old I met a few months before, who had been wanting to lower his HbA1c, lose weight and get into a healthy routine. He is happy to inform me that he is swimming for about an hour most days, has cut down his carbohydrate intake, and is feeling great. He has lost some weight, but most importantly, his HbA1c has come down from 102 to 66mmol/mol. Seeing this kind of progress makes my day!

11.30am – I have a meeting with a new staff member. We discuss the groups that are provided and how the HIP, health coach and Awhi Ora roles work in the clinic.

12.00pm – I have a booked appointment with a 55-year-old woman I have seen several times. She has "a lot going on", and we discuss the issues causing her stress. We both decide an introduction to our Awhi Ora support worker would be beneficial, so I email the introduction. We then make a plan for her eating and drinking for the next week and book an appointment with the HIP.

12.30pm – a 63-year-old woman does not show up for her appointment, so I give her a call. She apologises for forgetting, we have a quick chat about her diabetes, then make an appointment for her to see me the next day.

1.00pm – I head to the office lunchroom. The practice manager is there, so we have a quick chat about the diabetes group the HIP and I are planning to start. Then, a nurse mentions a patient she missed during our morning huddle who is struggling to control her diabetes. She asks if I can see her this afternoon.

2.00pm – I make two follow-up phone calls. The first is answered and we discuss the plan we made the week before – the 23-year-old woman has started taking her metformin as prescribed and cut out fizzy drinks. The second call is not answered, so I leave a voice message and send a text message.

2.20pm – the nurse calls to say her patient is here and happy to see me for diabetes education and to make an action plan. Ana is 36 and has had diabetes for six years. For the last year, she has not taken her medication as prescribed as there has been a lot of stress at home. She has previously seen the HIP, so I advise her that she can see the HIP again if she wants too – she declines for now. Ana tells me she eats whatever she wants and does not find time to exercise much. She decides to work on taking the medication as prescribed for now, then work on eating habits in the next few weeks.

3.00pm – I make two more follow-up phone calls. Both patients are quitting smoking, and these are their weekly (for four weeks) follow-up phone calls. Both patients answer. One has not had a cigarette since our last phone call – well done! The other has cut down from 15 to five cigarettes per day. He only smokes at work, so we discuss other things to do instead of smoking.

3.30pm – a GP calls about a patient. I go to meet 34-year-old Marcus, who has a flare-up of gout, has diabetes and is overweight. I introduce myself and my role. He says that he is unable to stay today, so we book him an appointment to see me.

4.00pm – my patient does not arrive. I leave a voice message and send a text message to invite them to make another appointment. The HIP is free, so we spend some time planning the groups we intend to start running in the clinic. I leave work at 5.00pm having supported 14 patients through individual, phone and group sessions.

Awhi Ora support workers: The link to support and services in the community

We like to describe Awhi Ora as "walk alongside support". It is a flexible and person-centred wellbeing support service, which helps people to identify and work on the challenges important to them. The service is free and provided by a collaborative of mental health NGOs, which specialise in providing community, cultural and peer support for people with mental health and wellbeing needs.

This community-based support service takes a preventive, early-intervention approach, broadening access to people experiencing distress or life challenges, as well as those with a diagnosed mental health or addictions illness who are not under secondary care.

Awhi Ora walk alongside support is designed as a brief intervention service of less than three months. For some people, a few support sessions are enough to address their issues and goals; for others, support may continue for several months.

The types of support offered may be navigation of social services, advocacy, peer support, coaching, support to develop plans and work on personal goals, budgeting and housing support. It may include supporting the person in gaining employment and improving community or whānau connection. Other support may include:

- physical health or healthy lifestyle goals (including behavioural plans agreed with the HIP or health coach)
- emotional health and mental wellbeing
- social engagement
- support and advocacy with Work and Income
- support to access long-term disability services
- support to address money matters, including linkage to budgeting assistance
- family/whānau issues
- managing drug use, drinking or gambling.

Awhi Ora has its own whakapapa dating back to the co-production process in 2013 in the Tāmaki region. During this process, the community identified access to support to address "life challenges" as a key need, and they identified how they would like this support to be provided. In describing the service they wanted to experience, people stated that they wanted:

- to be talked to in language they can easily understand
- to be referred to as people, not clients or patients
- support that was relational, not transactional.

They did not want to be referred as this was a very impersonal process, and referrals commonly fell through. Rather, they wanted a more personal connection or introduction. On this basis, the agreed term for the process was "introduction".

Based on the outcomes of the co-production process, a set of Awhi Ora principles of practice were developed and tested. The resulting service was found to deliver support that was both highly valued and effective for the people using it.

Quiz answers

1. True **2.** False **3.** True **4.** False **5.** True

A day in the life of an Awhi Ora support worker

8.30am – I arrive at my office, check my notes on our practice management system and print out some updates on progress with people I am supporting, which I intend to give to the HIPs and health coaches I meet every week. I also check my inbox for any new introductions that I have not picked up in person – I try to contact the person needing support within 48 hours. I drive to my first appointment at the local supermarket.

9.45am – the person I am supporting has been introduced by the health coach for support making some lifestyle changes in response to their pre-diabetes diagnosis, as she had felt too overwhelmed to take these on herself. Today, the plan is to walk with her around the supermarket, learn how to read food labels and talk about healthy food options. While we shop, we talk about how she had been experiencing some fear and anxiety, and I discuss some mindfulness and breathing techniques to help ground her when worried – we agree to practise some of these when we next meet.

> The service is free and provided by a collaborative of mental health NGOs, which specialise in providing community, cultural and peer support

11.00am – I go back to the car and write up my notes on my laptop while it is all fresh in my head, then I head to my next support session.

11.30am – I have been working with Chris for several weeks. He has been concerned about his weight, so we have made a plan and been meeting each week to go for a walk in his neighbourhood, as a starting point. It has been going well, and the goal for Chris to walk independently at least twice a week, without me, has been a success. On the walk today, we talk about possibly linking him with a local walking group or investigating a green prescription. He sounds really keen, so I will bring some forms to him next week. Then, I will look to "farewell" Chris out of my support and back to the clinic.

12:30pm – I take some time to write up my notes for the last session and break for lunch, then head to one of the GP clinics I support.

1.30pm – I have my weekly meeting with the HIP and health coach at the GP clinic. I give them the notes I prepared earlier in the day for each of the people I support, so they can add them to the clinical records. They give me four new introductions, and we have a kōrero about their Duke Health Profile scores and what the support for each person might be. They also let me know when and how people would like to be contacted (eg, phone, text, email).

2.15pm – I contact the new introductions to arrange an initial meeting and discuss what they might like support with. Two of them are Māori, so I ask whether they would like to be supported by one of our Kaupapa Māori organisations. They both would like that, so I make the onward introductions.

2.35pm – I phone another couple of people to check how they are going. The first is a person I supported to visit the local Men's Shed to meet people and volunteer on community projects. He has been going regularly and really enjoying it. We agree that we will meet next week to do a final wrap-up before I farewell him back to the clinic for future support.

2.40pm – the second call is to a woman I have been supporting, who tells me her Kāinga Ora – Homes and Communities application, to repair her kitchen and toilet after flooding, has been turned down. She is quite upset about it. We discuss her feelings, and I give her some breathing techniques to try. I also agree to meet her later this week, so we can follow up with her case manager at Kāinga Ora to see what other options might be available.

3.00pm – the person I am supporting lost their job during the COVID-19 lockdown. He said he felt "really unmotivated", so the HIP introduced him to me for some employment support. My organisation has training called "Employment as a health intervention", which has given me confidence in supporting people looking for employment. We started a few weeks ago by looking at the Work and Income website, where we found some templates for resumes and cover letters. He has been working on these between our sessions and now has a good resume.

At today's session, we look at places online to find work. I show him the Seek website, Trade Me and others, and we talk about the types of things he would like to do and the skills he has. He will keep looking until we meet next week, and flick me a text message if he finds any jobs he really likes. That way, we can talk through the application process over the phone, or I will try to make time to help him with an email application.

4.00pm – I head back to my office to drop off my work car and write up my notes. Based on the conversation I had with the HIP and health coach, I also need to update a couple of the plans I have with people. I have supported three people face-to-face and two by phone, as well as making initial contact with four new introductions. All in all, it was a good day's mahi and I will soon be able to farewell a couple more people I am supporting – I love that feeling!

New model improves access and wellbeing, but implementation is complex

This article highlights the extremely practical focus of all three new roles in Te Tumu Waiora. Assessments are not in-depth, as in more traditional mental health services, but rather concentrate on the here and now: "What do you most need support with today?"

The intention of all support sessions is that the person leaves with a practical plan of actions they set for themselves. All three roles share the view that, generally, solutions that come from within the person are more effective than those that come from support services.

For most people seeing a HIP or health coach, sessions are brief (typically less than 30 minutes), and follow-up sessions are not booked. Rather, there is an open door to return, be it in a day, a week, a month, or not at all. The mode number of contacts with HIPs and health coaches is one, and the average is two to three, but there is no limit on sessions. In our local experience, we have people who have been seen 20 or more times.

Despite the typically low number of contacts, the pilot evaluation showed improvements in wellbeing were robustly maintained at six-month follow-up. This aspect of the model is key to our goal of significantly increasing access to support for people with need.

In the case of HIPs and health coaches, once the model is operating as intended, one full-time equivalent can provide services to over 700 people per year (a typical primary care therapist can provide brief intervention services to 225–250 people).

In the first author's PHO in 2019, we provided services to 1.75 per cent of our patient population. In 2020, despite gradual implementation over the year to having the service available to approximately 30 per cent of our population, access rates increased to 3.75 per cent.

Pre-existing services remain key

Pre-existing primary mental health services remain key to optimal operation of this model. For many people, the integrated model provides what they need, but for others, access to a package of talking therapies or group support programmes is required.

Extended GP and nurse consultations remain critical to allow the time to get beyond the patient's often multiple physical symptoms, to the distress that sits behind them. Then, a warm handover is made to a HIP or health coach, or an introduction to an Awhi Ora colleague.

Experience with the model to date has confirmed the experience during the pilots – the three new roles are extremely complementary. Clinics that do not have one of the roles tend to struggle with that area of need until all three roles are integrated.

GPs and nurses quickly come to love the new roles and wider team. They say it is a "load off their shoulders" to be able to provide access "in the moment" to the holistic supports their patients need. One of the senior GPs in the initial pilot commented that the new model was the most significant innovation and improvement he had seen in primary care in his 30-year career.

GPs and nurses talk of significantly reduced stress levels and increased enjoyment of their work once the model is working well. Over time, they also talk of having increased confidence and capability to work with distress and mental health need. The intention of the roles is not to take over this area of support from the GPs and nurses, but to both strengthen GP and nurse skills and provide direct support.

Integration of roles is complex

Integration of these new roles is, however, a complex process requiring significant changes in practice for GPs and nurses, and for mental health clinicians taking up HIP roles. Some pilot clinics found that it took a full year to transform into a truly multidisciplinary primary care team.

With every patient, GPs and nurses must remember to think how their HIP, health coach or Awhi Ora colleagues might help meet that person's needs – some get there sooner than others.

For mental health clinicians, letting go of in-depth assessments and the sacred 50-minute therapy session is a huge change. HIP and health coach sessions tend to be quite structured and, to a degree, scripted. Further, as a non-regulated workforce, health coaches have very defined boundaries around their practice. All this requires adjustment.

Awhi Ora support workers, most of whom come from secondary mental health contexts, have to become far more flexible and let go of the longer-term relationships they have had with clients, to focus on work to achieve one or two life goals. The pay-off is the satisfaction inherent in seeing people make progress, then being able to say goodbye because they no longer need you.

Underestimate the complexity of the implementation and change process at your peril. The training and support required for the whole team is significant, and it takes time to get the multidisciplinary team roles and functions working as intended. This is why the national rollout of the model is scheduled over four to five years.

A unique model

To our knowledge, integration of three such roles into primary care teams is unique internationally. The closest model we are aware of is the Southcentral Foundation's Nuka System of Care in Alaska (scfnuka.com).

While the Nuka model transforms a whole health system, not just primary care, it is viewed internationally as a highly successful exemplar and leads the US on all measures of health system success. Nuka leaders talk of their equivalent roles as being key to achieving better patient and family outcomes.

Most of the work to improve New Zealand's Te Tumu Waiora model, to ensure optimal experience and outcomes for all priority groups, remains ahead of us. The other major challenge is to develop an evaluation approach that can robustly test the hypothesis that we *can* be the first nation to achieve improvements in population wellbeing via investment in integrated, accessible and holistic support services in primary care and community settings. ■

Go to ELearning at nzdoctor.co.nz for the references to this article

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