

**ORIGINAL RESEARCH**

A mental health brief intervention in primary care: Does it work?

An onsite adjunctive service appears to improve the care of patients with mental health disorders.

ABSTRACT

Objective ▶ In 2005, a district health board in New Zealand established the Mental Health Brief Intervention Service (MHBIS)—a government-funded initiative that allows primary care practitioners (PCPs) to refer patients with mild-to-moderate mental health problems to a mental health clinician for up to 4 sessions per year at no additional cost. Our goal was to evaluate the impact that MHBIS had on primary care practice referrals to secondary mental health services and patient outcomes in New Zealand.

Methods ▶ We used a survey questionnaire and focus groups for primary care physicians, practice nurses, and MHBIS clinicians (nurses, social workers, and an occupational therapist). A total of 49 surveys were returned from a sample of 96 physicians, practice nurses, and MHBIS clinicians. We conducted focus groups with 21 members of the sample. The MHBIS database provided information from 474 referrals.

We coded quantitative responses to the questionnaires and entered them directly into the Statistical Package for the Social Sciences program (SPSS) for analysis. We thematically coded data collected in the focus groups and the responses made in the comment section of the questionnaire. The data were transformed into quantitative variables and entered into SPSS for further analysis.

Results ▶ MHBIS improved outcomes by facilitating treatment for patients with depression.

Physicians prescribed fewer psychotropic drugs and said they did so “more effectively.” In addition, patient use of MHBIS reduced the need for primary care referrals to Secondary Mental Health Services, reserved for patients with severe mental health disorders.

Conclusion ▶ The study supports the use of a collaborative model of care. This approach allows for the effective treatment of mild-to-moderate mental disorders by supporting practitioners with a brief intervention in addition to usual care.

The Rau Hinengaro, a New Zealand Mental Health Survey,¹ provided the first comprehensive review of data on the extent of mental health issues in New Zealand. This survey revealed that many people who self-reported mental health symptoms that would have met criteria for illness in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV, 1994) did not seek treatment.² The survey also found that a number of years may elapse between the onset of symptoms and a request for help.

Primary care practitioners (PCPs)—that is, physicians and practice nurses—are in a position to identify patients with mental health disorders and assist them in accessing appropriate treatment.³ However, such patients often have substantial impairment requiring a level of assistance not easily offered within a time-limited PCP consultation.⁴

In our survey of PCPs, we sought to eval-

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**Ease of access
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uate the Mental Health Brief Intervention Service (MHBIS)—a government-funded initiative that allows PCPs to refer patients with mild-to-moderate mental health problems to a mental health clinician for up to 4 sessions per year at no additional cost to patients. We wanted to determine whether the program helped patients cope with their mental health disorders and whether it resulted in more effective treatment prescribing.⁵

BACKGROUND

In New Zealand, the Ministry of Health launched an initiative to provide mental health services within primary care practices, assess patients for mild-to-moderate mental health disorders, and conduct psychoeducation and counseling, as needed.⁶ (Secondary Mental Health Services [SMHS] provide care for those in the general population identified with severe mental health disorders [3%].)⁴

MHBIS was established in 2005 as a South Canterbury District Health Board (SCDHB) initiative to assist practices in providing mental health care for the estimated 17% of the population¹ with mild-to-moderate mental health disorders. Although many of these patients have symptoms that do not meet full DSM-IV criteria, they are nevertheless at risk of developing a major depressive disorder.² The MHBIS works with 28 primary care practices, including those in rural areas serving a population of approximately 55,000 patients. MHBIS receives government health funding administered through South Link Health and provides services to which PCPs can refer patients at no additional cost. Nurses, social workers, and an occupational therapist are employed as MHBIS clinicians (5 altogether), each of whom is assigned to work with specific PCPs.

PCPs may refer patients with mild-to-moderate mental health problems for up to 4 sessions per year with a mental health clinician. Usual reasons for referral are depression, anxiety, stress, grief, and distress from life events. Referrals are received electronically or by fax, and patients are contacted within 24 hours and offered an appointment. The referring PCP receives initial assessment notes electronically after the first MHBIS

appointment and updates after every subsequent patient visit. MHBIS clinicians generally see patients in PCP offices, allowing for continuity of service for patients and opportunities for immediate discussions with the PCP, if needed.

MHBIS interventions, using a recovery-focused approach, are based on the needs of patients, including education, monitoring of medication, counseling, strategies to enable change, and goal setting. If necessary, MHBIS will refer patients to other community services.

Previous annual surveys⁷ have indicated that most patients believed MHBIS aided their recovery by assisting them in developing behavioral strategies and in improving their lives. The intent of our study was to get the PCPs' view of MHBIS: What kind of effect did they think it had on patient outcomes and their practice's relationship with secondary services? Our main hypotheses were that MHBIS contributes to improving the mental health status of patients in primary care practices and enhances the interface between PCPs and SMHS by either facilitating referral as needed or averting the need for it in many instances.

METHODS

We used mixed methods for this study to enable triangulation of data and to increase confidence in the research findings.⁸ We collected data using a questionnaire specifically designed for this study. To gain a more in-depth understanding of the impact of MHBIS on general practice, we also used a semi-structured interview format in 5 focus groups with a subset of participants. We extracted 6 months' worth of data for 474 patient referrals from the MHBIS database, including the number of sessions attended, referrals to other services, and clinical and demographic information.

The total sample of 96 practitioners included the 39 physicians and 52 practice nurses (PNs) in the 28 general practice centres in the South Canterbury District Health Board and 5 MHBIS clinicians.

We coded the questionnaires so that responses could be directly entered onto Statistical Package for the Social Sciences (SPSS, version 16) for analysis. We themati-

TABLE

Demographics of patients referred to and seen by MHBIS (n=474)

Age group, years	Female	Male	NZE	Maori	Pacific peoples	Other
<18	15	5	15	3	–	2
18-24	50	25	64	5	–	6
25-44	139	52	162	7	–	22
45-64	95	36	118	2	1	10
≥65	41	16	52	1	–	4
Total (%)	340 (72%)	134 (28%)	411 (86.7%)	18 (3.8%)	1 (0.2%)	44 (9.3%)

MHBIS, Mental Health Brief Intervention Service; NZE, New Zealand European.

cally coded written responses in the free text sections of the questionnaires and from the transcribed focus groups to detect emerging themes, and recoded them until a saturation point was reached.⁹ We transformed emerging themes into quantitative variables and entered them into SPSS for further analysis.

Ethics approval was granted through the South Link Health Ethics Committee, the Upper South Regional Health and Disability Ethics Committee, and the Ngai Tahu Ethics Committee.

Completed questionnaires were returned by 54% of physicians (n=21), 44% of PNs (n=23), and 100% of MHBIS clinicians (n=5). Twenty-one members of the sample participated in the focus groups.

Of the 474 patients MHBIS saw between January 1 and June 30, 2008, 340 (72%) were female and 134 (28%) male (TABLE). Patients <18 years accounted for 4% of referrals; 18 to 24 years (16%); 25 to 44 years (40%); 45 to 64 years (28%); and ≥65 years (12%). Of referrals seen, 411 (86.7%) identified themselves as New Zealand European (NZE), 18 (3.8%) as Maori; 1 (0.2%) Pacific peoples, and 44 (9.3%) as “other” ethnicity.

Most patients were seen 1 or 2 times, with 25% using the allowable 4 visits. This would indicate that 4 visits are enough in most cases.

RESULTS

All PCPs agreed that the MHBIS had assisted treatment and improved outcomes for pa-

tients, compared with PCP care alone. With MHBIS, patients returned less frequently, and, as described by one PCP, “they go away and ... don’t bounce back.”

Physicians reported that access to MHBIS made a positive difference in the use of psychotropic medication: 67% wrote less prescriptions, 23% wrote the same number of prescriptions, and 5% prescribed more; 85% reported that they prescribed medications more effectively (based on their perception of “more effective”). Of note, 76% of physicians reported greater patient compliance with medication regimens. One physician commented, “when MHBIS is seeing patients, issues are talked over and ... the result [is that] they are more compliant with treatment.”

Deciding factors for PCPs making a referral to MHBIS were: presentation of symptoms, patient’s level of functioning and willingness to accept help, whether the patient presented in emotional distress, and office time pressures. All PCPs reported regularly receiving positive feedback from patients.

Interestingly, 81% of physicians reported an improvement in their relationship with SMHS and 33% used SMHS for medication reviews more frequently. Furthermore, 71% of physicians reported that access to MHBIS resulted in decreased referrals to SMHS; 5% referred more, 5% the same, and 19% saw no change in referral rates. During the 6 months of the study, only 4% of patients seen by MHBIS were referred to SMHS. All PCPs reported that patients with a moderate men-

tal illness preferred referral to MHBIS rather than to SMHS. Additionally, PCPs and PNs perceived that patients were more likely to attend a referral to MHBIS than a referral to another counselor in the community (91% PCPs, 96% PNs).

The benefits of having an MHBIS presence in the PCP office as an initial point of contact were: easier access to treatment, acceptance by patients, smoother-running primary care visits, enhanced professional communication, and earlier detection and intervention of mental health disorders.

DISCUSSION

Systematic literature reviews have concluded that collaborative models of mental health delivery in primary care yield improved outcomes for patients.^{10,11} Our study results support those findings.

Our key findings are that ease of access is critical to providing effective mental health services in primary care. Furthermore, the MHBIS provides mental health care that is acceptable and valued by both PCPs and patients.

The model used by the MHBIS targets a patient population different from that served by SMHS, and is now used by most primary care providers in the South Island of New Zealand.

Generally, patients are seen in the PCP's practice rooms, providing a familiar environment, continuity of care, and a referral path more readily accepted than referral to other community services. In this way, MHBIS is seen as an extension of the care provided by PCPs and is viewed as being an integral part of the practice.

This study supports the findings of the NZ Guidelines Group,¹² an independent nonprofit organization that has provided the Ministry of Health with best-practice recom-

mendations for treating mental illness in a primary care setting. (These recommendations include self-management strategies, patient education, and structured problem solving for patients with mild-to-moderate mental illness.)

Patients working with MHBIS are supported in making lifestyle changes that enable them to take control of their health by learning how to remain well and using self-help strategies.

While this model of mental health service provision has costs that prohibit its implementation for many primary care practices internationally, our study highlights the benefits of providing mental health services in terms of access, acceptability to patients, and communication with primary care providers.

Limitations of the study

Qualitative responses in many ways allow for deeper understanding, but they are nevertheless subjective.

The focus groups occurring as part of peer group meetings between physicians and PNs were time limited. Input from the MHBIS clinicians was also limited; at the time of the study, 2 staff members were new to the service, and this study's researcher (ST) is an MHBIS clinician who did not otherwise participate. She is also known to some practices, which could have had either a positive or limiting impact on focus group feedback.

Nevertheless, our study highlights the effectiveness of MHBIS. The service is well accepted and provides good support for PCPs. As such, MHBIS fills a gap for patients who would not meet criteria for admission to SMHS and allows for early identification and treatment within primary care. **JFP**

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