Malatest International

Final evaluation report:

Implementation of the Integrated Primary Mental Health and Addiction services

Ministry of Health

To the end of March 2022

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Acknowledgments

The evaluation of Integrated Primary Mental Health and Addiction Service (IPMHA) was funded by the Ministry of Health as part of a continuous learning process about implementing IPMHA services in Aotearoa New Zealand.

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The Malatest International team

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Acronyms and abbreviations

CSW	Cultural support worker
DHB	District Health Board
FTE	Full-time equivalent. There are 10 FTEs in a full-time position.
GP	General practitioner
HC	Health Coach
HIP	Health Improvement Practitioner
IPMHA	Integrated primary mental health and addictions services
LTC	Long-term conditions
NGO	Non-government organisation
PHO	Primary Health Organisation
PMS	Patient management system
SLT	Senior leadership team
SW	Support worker

Executive summary

Integrated Primary Mental Health and Addiction Services (IPMHA)

Budget 2019 invested in increasing access to, and choice of, mental health and addiction services (the *Access and Choice* Initiative). The Ministry of Health (MOH) Integrated Primary Mental Health and Addiction Service (IPMHA) is one element of this investment.

IPMHA services are a fundamental shift in approach to enable people to identify what they need and develop and manage their response to improve their wellbeing. Introducing IPMHA services into general practices is a system level change that introduces new roles and new ways of practising and brings together service components that have not previously been combined.

The Ministry of Health (MOH) has commissioned an evaluation of the IPMHA service to examine the implementation, delivery, impact and effectiveness of the initiative. The evaluation includes 11 districts (15 DHBs[1]).

This report is the final IPMHA evaluation report. It synthesises information from the interim evaluation reports and case studies and IPMHA data provided by the districts to MOH to the end of March 2022. The data focus is on 1 April 2021 to 31 March 2022.

District contexts influence implementation

The priority populations for the implementation of IPMHA services are Māori, Pacific Peoples, young people (including practices based within tertiary education providers) and people living in rural settings. Differences in the community demographics, the types of primary care and NGO services, the size and nature of general practices and the relationships between providers influence delivery of the IPMHA service model.

In almost all districts, there are more medium and large practices in the IPMHA roll-out to date and fewer smaller practices. Implementation in medium and large practices has enabled reach to a greater proportion of the population. However, extension of IPMHA services to smaller practices has implications as the IPMHA roles will be part-time, space may be more challenging and implementation will be relatively more resource intensive per enrolled patient.

[1] The Auckland Collaborative comprises Auckland, Waitematā and Counties Manukau DHBs. The Wellington Collaborative comprises Capital and Coast, Hutt and Wairarapa DHBs.

The size of the general practice determines the allocation of HIP and HC,SW FTE available to support patients/whānau as funding is based on 1 HIP:10,000 enrolled population and 1-1.5 HC/SW/SW per 10,000 population. Practice sizes of less than 10,000 enrolled population are therefore funded for less than one HIP FTE.

Implemented HIP and HC ratios were broadly consistent with the funded ratios. The ratio of HIP FTE to enrolled patients in the IPMHA general practices (excluding MidCentral) was on average 1: 12,062. The funded ratio of 1-1.5 HC/SW/SW per 10,000 population is district-wide and can vary between practices based on level of need. The ratio of HC, HC/SW and SW roles combined (excluding MidCentral) was on average 1: 8,498. These ratios are consistent with the MOH funding criteria and in all districts (except Lakes) the HC, HC/SW and SW ratio is higher than the HIP ratio.

In smaller practices a minimum FTE is recommended by the IPMHA trainers and district teams. Allowing districts flexibility to apply the HIP ratio at district level may be required in the next phase of roll-out to respond to the increasing numbers of small practices and to focus support on populations with high needs. In rural localities where clustering of practices is not practical due to distance and travel time, increased ratios may also need to be considered.

IPMHA roll-out was staggered in general practices across the districts

Early implementation prioritised implementing IPMHA in general practices with the largest proportions of the priority groups.

The main facilitator for implementation has been recognition of the need for additional support for patient wellbeing.

The main challenges to implementation have related to understanding of the IPMHA model, perceptions of its relevance to te ao Māori and Aotearoa New Zealand, workforce recruitment and training, and relationships in districts between DHBs, PHOs, general practices and NGO services. COVID has also been a barrier to primary care practice recruitment and service delivery.

IPMHA is not yet established as a business-as-usual service in most districts. Even where IPMHA is established in general practices, interviewed stakeholders emphasised the need for ongoing IPMHA leadership to avoid drift away from the IPMHA service model.

Patients/whānau reached by IPMHA

The evaluation focus is on the 84,270 patients/whānau seen between 1 April 2021 and 31 March 2022 and 236,292 IPMHA sessions they completed.

In the 12 months between 1 April 2021 and 31 March 2022, IPMHA supported 3.7% of the population enrolled in practices delivering IPMHA. The actual reach is greater as whānau may also be supported but not recorded and there are gaps in data from community-based HC/SWs.

The MOH aim for *Access and Choice* is that these services will reach an additional 6.5% of the population. Based on administrative data, with the addition of more practices in 22/23 reaching 6.5% of the population seems achievable in practices participating in IPMHA.

IPMHA is reaching the priority population groups:

- In most districts IPMHA supports younger and older age groups: 19% of those supported are aged 15-24; 62% are aged 25-64 and 17% are 65 and older.
- In most districts, IPMHA has been implemented in practices with higher proportions of enrolled populations with high needs (41% of IPMHA enrolled patients/whānau are defined as high needs compared to 31% of all enrolled patients/whānau).
- In all districts with robust data, the reach to Māori (4.1%) was higher than for 'other' ethnic groups (3.7%). Reach to Pacific was highest in Waitematā, Canterbury and Southern districts.
- On average, across all districts, females (64%) were more likely to use IPMHA services than males (36%).

The elements of IPMHA important to patients/whānau included the way IPMHA practitioners interacted with them, holistic support, the tools they learnt and the confidence they built as a result. The accessibility of IPMHA services were important including that the service is free and waiting times are short. For Māori and Pacific, support from Māori or Pacific practitioners made a positive difference.

The IPMHA workforce

IPMHA services have developed a new workforce that has improved the wellbeing of patients and whānau. IPMHA services are provided by three core roles: a health improvement practitioner (HIP), a health coach (HC) in the general practice and a support worker (SW) in the community. The HC and SW roles were combined into a dual role that provides both functions in seven of the 11 districts included in the evaluation and three regions had both HCs and merged HC/SWs. In three districts the merged HC/SW role was employed by NGOs and had an increased community rather than general practice focus. There is limited data available to examine the differences this role makes for patients/whānau.

The HIPs are a registered workforce and need to maintain their registration requirements as well as HIP accreditation. There are progression opportunities for HIPs to become trainers and lead HIPs in their districts.

The HC role and support for development of the role is less established because of the different employment contexts. Differences in HC training and employment contribute to differences in the IPMHA model that is delivered in different districts.

The focus of MOH funded training on the core HIP and HC roles has left gaps in training, some of which can be provided by districts. The major training gaps are about how the roles work together and training modules for managers, implementers and NGOs.

Patient/whānau pathways

The first point of contact for patients/whānau was most often the HIP (62%). The most common process was for the GP or practice nurse to refer patients/whānau to the HIP. In some practices patients/whānau could be referred through the reception staff, nursing staff or self-refer. Some patients/whānau were referred by staff directly to the HC and 21% of patients/whānau had first contact with the HC and 11% with a HC/SW in a general practice.

The first contact was face to face for 59% and by phone for 33%. During COVID-19 restrictions some HIPs and HCs were asked to work remotely and this increased the percentage of first contacts that were by phone.

Many patients/whānau were seen on the same day – 61% with the HIP, 63% with the HC and 70% with a merged HC/SW based in a general practice [2]. Social support through SW and NGO social services were an important connection enabled by the IPMHA model.

The most common presenting issue differed by IPMHA role and aligned with expectations in the IPMHA model. The most common presenting issue for HIPs was related to taha hinengaro (mental and emotional wellbeing). HCs saw similar percentages of people for issues related to taha tinana (long-term condition management and health and lifestyle). The differences between HCs and merged HC/SW in general practices relates to differences between districts in roles as Auckland HC training is focused on taha tinana.

Many patients/whānau had one session with an IPMHA practitioner: 67% of those who received HIP support had one session; 61% of those receiving HC support and

[2] The data need to be interpreted in the context of part-time roles which limit the feasibility of same day contact.

66% of those receiving support from a HC/SW. SW are intended to support patients/whānau in the community but SW data are limited.

IPMHA is making positive differences for patients/whānau and general practice teams

General practice-based support for wellbeing is effective. Where HIP and/or HC roles are well integrated into general practices, they are making a positive difference by reducing pressure and workloads and improving the quality of care for patients/whānau. This difference is evident even in areas that have less alignment between their implementation of the roles and the IPMHA model.

Patients/whānau described feeling supported, feeling better, having tools to cope with their issues and reduction in their mental health issues including alcohol and drug problems.

IPMHA practitioners and other members of general practice teams described more effective use of medication, moving general practice from managing medical conditions to helping people become healthier and reducing the need for referrals to specialist support.

Recommendations

Implementation

IPMHA is a large new initiative and was implemented on a tight timeline. In many districts, those tasked with implementation understood the intent to have new roles in general practice supporting wellbeing but did not have a clear understanding of the detail of the model.

- An ongoing strong implementation focus is needed to roll-out IPMHA to the new practices, NGO partners and to maintain fidelity to the model. Further funding of implementation leadership roles at an appropriate level is essential for continued roll-out and model fidelity until IPMHA services become business-as-usual.
- There are fixed costs associated with implementation overheads regardless of district size. Reviewing fixed and variable costs and considering allocation of implementation overheads will help support smaller districts. In the districts, the implementation teams may be employed by a large PHO but leave the smaller PHOs and NGO organisations with limited support. Ensure districts make implementation support accessible to all participating organisations and practitioners.

- There is a gap between general practices and NGO providers in many districts. Strong leadership and active facilitation are necessary to close the gap. Ensuring implementation resources are available for NGO partners is also important.
- Review ratios of HIPs and HC to enrolled populations to consider whether a minimum FTE is required in small practices where roles cannot be easily clustered.

Design

Adaptation of the model to different settings was expected and encouraged. Adaptations have included additional time for whakawhanaungatanga and introductions, adapting IPMHA tools to align with tikanga and going out to patients/whānau, variations in warm handover processes, and different strategies to reach people who were not frequent general practice attendees.

The ongoing impact of confusion about the model at the start of implementation is seen in uncertainty about the extent the model can be adapted. Uncertainty is compounded by differences in the advice from the HIP trainers and ongoing differences between the two HC training providers.

Increased clarity is needed in districts about what adaptations of IPMHA will be effective without compromising model fidelity, achievement of goals and patient/whānau and practitioner safety. More data are required to improve understandings of the strengths and challenges of different adaptations and impacts on access and equity. Current data that would inform variations to the model such as the merged HC/SW role are incomplete in some districts and there is not a consistent way to quantitatively record outcomes. Options include:

- Discussing how to enable data from NGO based roles such as the NGO employed merged HC/SW roles and the SWs.
- Workshopping with district leads including Māori organisations to discuss adaptations and the strengths and challenges associated with each. A workshop would allow districts to share experiences and ideas.
- Communication with districts about the targeted *Access and Choice* initiatives and how these initiatives reach not enrolled populations and how to integrate them with IPMHA services so not enrolled people could be connected to these services.
- Developing resources for NGO providers and while maintaining an implementation focus on general practice also including implementation support for NGOs and the IPMHA practitioners they employ.

Workforce

A new workforce has been developed and it needs to be recognised.

The HC roles were often more difficult to establish in general practices than the HIP roles. HCs are not required to have a health professional background and must overcome lack of understanding of what they offer to patients.

- Develop online training modules for district leads to complement the existing resources for implementing IPMHA in general practices.
- Filling training gaps by adding training about the model and how the roles fit together and providing expectations to districts about the training gaps they need to fill.
- Considering additions to the HIP and HC tools and resources such as purpose-built resources for virtual delivery.
- Considering what refresher training might be required to maintain model fidelity for HIP practice for HIPs and HCs trained as part of the earlier cohorts.
- Reviewing the trainer workforce – regional trainers were described as an advantage and interviews with trainers suggested the need to review and define the part-time trainer role.
- Continue to progress work to define workforce roles and credentials required to establish HIPs and HCs as a recognised IPMHA workforce.

Continuous improvement

- Strengthen data collection processes for NGO employed roles (as outlined above).
- Provide access to monitoring dashboards for district teams. Even though there are data challenges, providing data back to stakeholders is a very effective way of improving data quality. It is important to understand the data in the context of different district general practices and communities.
- Develop with IPMHA practitioners a simple outcome measure that will inform continuous improvement at practitioner and national level.

1. Integrated primary mental health and addiction services

IPMHA are the general practice-based component of the *Access and Choice* programme. Location in a general practice enables a large proportion of people to be reached. MOH considered general practices to be the ideal place to uncover mental health or addiction issues, even before people are aware they exist, including issues that present as physical concerns rather than social or emotional concerns.

There are no eligibility criteria: anyone of any age whose thoughts, feelings, actions or social circumstances are adversely affecting their wellbeing can use the services. This includes people with more severe mental health and addiction issues who may identify specific things they want to change that are adversely affecting their wellbeing[3].

IPMHA services are provided by three core roles: a health improvement practitioner (HIP), a health coach (HC) in the general practice and a support worker (SW) in the community. The HC and SW roles can be combined into a dual role that provides both functions. The SW role connects people to resources within local communities to address social or cultural issues.

The HIP and HC/SW provide evidence-based behavioural interventions to patients and whānau. They extend reach in other ways, e.g. through offering group based programmes for common issues and using pathways to optimise general practice team contribution to mental wellbeing.

Team based delivery maximises access to effective care by leveraging the expertise of the general practice team, enhancing their responses to issues adversely affecting wellbeing, including mental health, alcohol or other drug issues, and improving continuity and eliminating duplication.

Services are free, so the only payment required is if the person sees their GP first. People can come back into the service if future issues arise without seeing their GP.

1.1. Background

The integrated primary mental health and addiction service (IPMHA) is one element of the Budget 19 funded programme to increase access to, and choice of, primary mental health and addiction services (*Access and Choice* programme). IPMHA aims

[3]However, these roles do not provide specialist mental health advice to the GP nor do they provide case management: like other members of the general practice team – they may provide support to a person / whānau pending access to specialist services.

to support general practice enrolled populations. Other elements of the investment targeting Māori, Pacific Peoples and youth are not delivered within general practices.

The overall purpose of *Access and Choice* is to improve population mental wellbeing by greatly increasing access to effective support for people to address any thoughts, feelings, actions or social circumstances that are adversely affecting mental wellbeing, including mental health or addiction issues.

The *Access and Choice* funding is approximately 18% of total mental health and addiction community funding. If MOH used this funding to fund additional specialist-style services (referral based, one-hour appointments) the additional funding would be expected to reach approximately a further 1% of the population (to bring the total access from around 4% to around 5%). The aim for *Access and Choice* is that these services will reach an additional 6.5% of the population.

Locating services within general practice is designed to maximise the access to effective services for the available funding. IPMHA services aim to enable the general practice team to reach *all* of the "mild to moderate" need among people enrolled in participating practices[4], especially the priority populations.

The wider *Access and Choice* programme recognises that not all people will choose to receive mental health and wellbeing supports through their general practice and that there are people not enrolled with general practice. Therefore, targeted services are also being rolled-out for priority populations (Māori, Pacific Peoples and young people) in other settings.

The aims of the IPMHA service are to:

- Increase access and equity of access
- Increase choice in addressing people's holistic concerns
- Reduce wait times for mental health and addictions support
- Improve population health and equity outcomes.

An additional intention of the service is to contribute to building a general practice team that is confident and capable to support the wellbeing of people with mental health and addiction issues in their enrolled populations.

More detail about the programme is provided in Appendix One.

[4] Improved equity of access and outcome were also IPMHA aims, to be achieved within the IPMHA programme by rolling out this approach in practices with high Māori, Pacific and youth populations first and by enabling flexibility so that more health coaching and cultural and social supports could be available in practices with the highest needs.

1.2. The IPMHA roles

A team-based approach to IPMHA is unique to New Zealand. Team based delivery aims to maximise access to effective care by leveraging the expertise of the general practice team, enhancing their responses to issues adversely affecting wellbeing, including mental health, alcohol or other drug issues, and improving continuity and eliminating duplication.

Patients/whānau are supported by IPMHA roles:

- A health improvement practitioner (HIP) placed in the general practice. HIPs are experienced and registered health practitioners[5]. They come from a broad range of backgrounds including social work, occupational therapy, general and mental health nursing and psychology. HIPs are trained to provide rapid access to evidence-based brief interventions to help people make lifestyle changes to enhance their health and wellbeing. They provide assessment and brief intervention therapy accessible to all enrolled patients.
- A health coach (HC) also placed in a general practice. HCs are trained support, peer or cultural workers who support patients/whānau to manage their health through a range of personalised interventions. HCs are not required to be a registered health practitioner. In some parts of the country the HC and SW roles are combined and vary in the extent they are in a general practice or work in the community.
- A support worker (SW) who complements the practice-based roles. SWs are embedded in their communities. Their local knowledge and connections help them engage with patients/whānau and connect or accompany them to cultural and social supports within their local community. SWs are not based in general practices but may spend some time there.

Working with the HIP and/or HC and SW as well as the general practice team provides whānau/patients with wrap-around care that aims to teach them skills to help support their mental health and help to support them with the practical aspects of having high anxiety or low moods such as not having a job or not being able to ride a bus.

1.3. The IPMHA service model

Underpinning the IPMHA model are evidence-based brief behavioural interventions delivered at the moment of need to primary care patients of any age. The HIP and HC work as a part of the practice team to provide immediate support and brief

[5] This includes a registration under the Health Practitioners Competency Assurance Act (HPCA), dapaanz or the Social Work Registration Authority (SWRB).

intervention focused on strengthening self-management strategies. Their notes are written directly into the practice-based PMS and 'warm handovers' ensure that the practice team members can make an introduction when the need arises and are kept updated with patient information.

Warm handovers and same day appointments help increase the number of people who follow through in a referral. Warm handovers are easier if IPMHA staff are located centrally. Same day appointments and personal introductions increase the number of people who follow through on a referral by approximately 50%.

Briefer and/or fewer sessions (on average) means more people can be seen each day, and a higher reach achieved than with a more traditional one-hour session or fixed (higher) number of visits, whilst also allowing flexibility to provide more intensive supports for those who need it over a sustained period. Dealing with one issue at a time and returning when ready to deal with the next issue means more people can get help to address current issues, learning new skills as they go. Whilst this model is based on brief interventions there is no limit to the number of times a patient/whānau can be seen and some people may require support over a period of months.

Additionally, the HIP also supports the practice team through psycho-education, consultation and identifying patient pathways and assisting with clinics to increase access to behavioural support.

2. This evaluation report

This evaluation report is the final report for the IPMHA evaluation. It synthesises information from earlier reports and adds new information about the outcomes achieved by IPMHA.

The evaluation includes the first 11 districts where IPMHA was implemented (15 DHBs including the Auckland and Wellington Collaboratives) and data from all districts to the end of March 2022.

MOH has commissioned an evaluation of IPMHA to examine the implementation, delivery, impact and effectiveness of the initiative. The evaluation includes the first 11 districts (15 DHBs[6]) to implement the programme.

The evaluation focus is the general practice based IPMHA service model. The purpose of the evaluation is to examine:

- Implementation and the key factors that are associated with implementation support.
- Delivery: Variations in how IPMHA is delivered and key factors that are associated with achievement of intended outcomes in general, and for different priority population groups.
- Impact: The impact of the service model and delivery mechanisms across wellbeing and recovery outcomes for both service providers and service users.
- Effectiveness: Whether IPMHA provides value for money and the lessons learned that can inform the implementation of IPMHA Services on a broader scale.

2.1. The theoretical foundation for the evaluation

Evaluative judgement has been formed by considering IPMHA activities, outputs and measurable changes against a theoretical foundation comprising a logic model and evaluation framework.

The logic model outlines the activities and outputs that were co-designed with MOH for IPMHA to achieve positive mental health and wellbeing impacts (Appendix Two). An evaluation framework was developed to identify the indicators and measures that inform evaluative conclusions.

[6] The Auckland Collaborative comprises Auckland, Waitematā and Counties Manukau DHBs. The Wellington Collaborative comprises Capital and Coast, Hutt and Wairarapa DHBs.

2.2. Information for this report

Information sources for this report are detailed in Appendix Three. Qualitative information was sourced from:

- Interviews in late 2020 with the key stakeholders in each district.
- A series of detailed case studies completed during 2021 and early 2022, of 26 general practices to provide in-depth understanding of different service models, different general practice and primary care settings, and the strengths and challenges of each. The case studies included interviews with the general practice teams, HIPs, HCs, HC/SW, SWs and other key stakeholders. Staff some in practices also completed a brief survey about the difference the roles had made.
- Interviews with patients/whānau about their experiences and the support they received.
- A final series of interviews in March and April 2022 with representatives of the DHBs, PHOs, NGOs and implementation teams in each district.

Quantitative analyses were primarily from data provided by each district to MOH.

- Data were analysed to the end of December 2021 for the final case study report and from 1 April 2021 to 31 March 2022 for the final evaluation report. This time period was selected to allow IPMHA to be established.
- Most analysis focused on patients/whānau and episodes of care with at least one session of support by IPMHA in DHBs between 1 April 2021 and 31 March 2022. Analysis also included any encounters this group of patients/whānau had prior to 1 April 2021 or after 31 March 2022.

Although the data provided to MOH are valuable in understanding IPMHA roll-out, data are missing from some roles in some districts limiting interpretation.

Table 1. IPMHA roles and recorded activities data (Source: MOH data; Information about roles from interviews in districts)

Districts	HIP	HC	HC/SW in GP	HC/SW in NGO	SW	Comments
Auckland Collaborative	39,494	35,443	NA	NA	1,265	Most SW data are from Waitematā
Canterbury	19,280	NA	13,905	NA	938	
Hawkes Bay	5,312	3,435	NA	NA	Missing	
Lakes	2,834	NA	NA	770	0	Data from Lakes seem limited compared to FTEs
MidCentral	5,435	NA	NA	1,476	0	Limited HC/SW data Some are located in general practices
Northland	7,688	NA	10,924	NA	NA	
Southern	14,605	9,710	NA	NA	2,684	
Taranaki	4,069	NA	NA	396	NA	Limited HC/SW data
Waikato	5,320	NA	NA	7,686	568	
Wellington Collaborative	18,056	6,665	NA	NA	7,015	
Whanganui	5,112	NA	5,018	NA	NA	
Total	**127,205**	**552,53**	**29,847**	**10,328**	**12,470**	

Dark grey cells show roles are not applicable in the districts; Orange cells appear to have missing or limited data based on FTEs

2.3. Strengths and limitations of the evaluation

A strength of the evaluation is the mixed methods approach underpinning triangulation of information from different sources and ongoing input from MOH about the IPMHA service design and aims.

Evaluation findings must be considered in the context of:

- Districts being at different stages of roll-out.
- Variable quality of administrative data content. Although administrative data have improved since the interim evaluation (see more detail in Appendix 3):
    - Data are missing for some districts and some NGO providers submit data separately.
    - In MidCentral referrals come to a central point and are not recorded against the practice where patients/whānau are enrolled, preventing

analysis like IPMHA practice size and IPMHA practice enrolled population.

- Outcomes tools (Duke and Hua Oranga) are used as tools to assess need. Pre- and post-measures are available only for patients/whānau seen more than once. As they are primarily used as assessment tools and not outcome measures, they may not reflect the differences made by IPMHA support.
- Data collected do not represent all the activities of IPMHA – for example support for general practice teams is not collected.
- Comparisons between IPMHA data and enrolled patient data are estimates. Information about the proportion of the enrolled population reached by IPMHA is based on facilities coded in the IPMHA dataset and enrolled population for enrolling general practice organisations (sometimes containing multiple facilities in different DHBs).

3. Implementation

Evaluation question: The degree to which implementation has successfully stood up and supported the model across the participating practices and key factors that are associated with implementation support.

IPMHA services are a fundamental shift in approach to enable people to identify what they need and develop and manage their response to improve their wellbeing. Introducing IPMHA services into general practices is a system level change that introduces new roles and new ways of practising.

> *… it's major change management and behaviour change at the GP and nurse level … you've got to keep supporting, keeping it back on track and winning their hearts and minds again. (HIP trainer)*

> *I think one strength of the model is that it is general practice based … You have much more holistic understanding across all the disciplines that are working there. General practice isn't just doctors and nurses anymore. (PHO Staff)*

While some districts had been part of Te Tumu Waiora pilot, for many districts and general practices IPMHA services were new. A new workforce had to be recruited and trained and new partnerships formed between general practices and NGO providers, including Iwi health providers, to deliver IPMHA services.

3.1. Phased roll-out of IPMHA services in districts

Implementation of IPMHA services for each district began with a MOH RFP and procurement process. The RFP outlined the core evidence-based elements of IPMHA. MOH required collaborative responses from each district that included Iwi and Māori providers.

The amount of funding available per annum at the end of the roll-out was allocated to districts based on the component of the MOH population-based funding formula[7] specifically related to mental health and addictions[1]. Budget 19 funding per annum increased incrementally over a five-year period and implementation in districts was phased based on available funding each year and on the district roll-out sequence which was determined during assessment of the RFP responses.

The roll-out of IPMHA to general practices across the districts has been staggered. Early implementation prioritised implementing IPMHA in general practices with the largest proportions of the priority groups: Māori, Pacific, young people and those in

[7] https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards/accountability-and-funding/population-based-funding-formula.

rural localities. Implementation was delayed in many districts in the first financial year due to challenges that included IPMHA staff recruitment and training, and practice onboarding. The impacts of COVID-19 further delayed implementation and created competition for workforce with COVID-19 public health programmes. Additional funding was provided by MOH in subsequent financial years with more practices scheduled to be funded for inclusion in the 2022/23 financial year.

The staggered roll-out of IPMHA is illustrated in Figure 1. The first districts to reach 100 patient/whānau encounters with the IPMHA teams were districts included in the Te Tumu Waiora pilot.

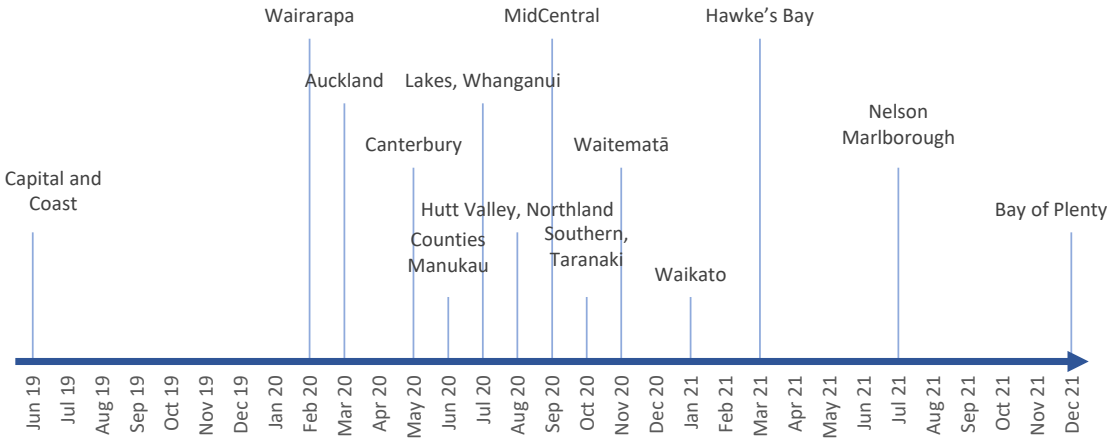

Figure 1. The month each DHB reached their first 100 encounters (MOH data)

3.2. District contexts

IPMHA services are general practice based. Within and between districts there are differences in the community demographics, the types of primary care and NGO services and the size and nature of general practices. These differences influence the workforce FTEs and the partnerships between general practices and other services that are part of the IPMHA model. For example, Māori communities are proportionately larger in Northland, Whanganui, Lakes and Hawke's Bay districts. In parts of Auckland, there are large Pacific communities and Pacific providers. In districts with high proportions of Māori there are more Kaupapa Māori providers.

The average rate of enrolment in a general practice is 94%, with variation between districts from 92% to 97% (Table 2). However, Māori and young people have lower rates of enrolment than other groups and affluent areas have the highest rates[8].

[8] Maite Irurzun-Lopez M., Jeffreys M., Cumming J. (2021). The enrolment gap: who is not enrolling with primary health organisations in Aotearoa New Zealand and what are the implications? An exploration of 2015-2019 administrative data. Int J for Equity in Health 20:93.

Table 2. Summary of population demographics in DHB districts[9] comparing total DHB populations and ethnicity percentages alongside the overall proportion of the population enrolled in PHOs.

District	Total DHB Popn	% in the DHB population			Overall % enrolled[10]
		Māori	Pacific Peoples	Youth (0-19)	
Auckland Collaborative	**1,739,800**	**11%**	**13%**	**25%**	**94%**
Auckland	499,100	8%	10%	21%	92%
Waitamatā	639,400	10%	7%	25%	95%
Counties Manukau	601,300	16%	21%	28%	94%
Canterbury	586,400	9%	3%	25%	96%
Hawke's Bay	181,400	27%	4%	27%	92%
Lakes	118,400	36%	2%	27%	92%
MidCentral	189,100	21%	3%	26%	92%
Northland	197,900	35%	2%	27%	96%
Southern	351,400	11%	1%	24%	92%
Taranaki	126,600	20%	1%	27%	94%
Waikato	445,200	23%	3%	27%	94%
Wellington Collaborative	**537,000**	**14%**	**7%**	**25%**	**93%**
Capital and Coast	326,800	12%	7%	24%	92%
Hutt Valley	160,300	18%	8%	26%	94%
Wairarapa	49,900	18%	2%	25%	97%
Whanganui	69,100	28%	3%	26%	94%
Total	**4,542,300**	**16%**	**7%**	**26%**	**94%**

As a general practice-based service IPMHA therefore has the potential to reach most of the population in each district. Other Access and Choice initiatives are intended to reach people not enrolled in general practices and specific communities such as young people, Māori and Pacific Peoples.

[9] Stats NZ (2021). *Subnational population estimates (DHB, DHB constituency), by age and sex, at 30 June 2021. Available at:* https://nzdotstat.stats.govt.nz/wbos/Index.aspx?DataSetCode=TABLECODE7509

[10] MOH (2021). *PHO enrolments – number enrolled by DHB of domicile. Available at:* https://www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations/enrollment-general-practice-and-primary-health-organisation

Although IPMHA services are intended to reach anyone in need of wellbeing support, the proportion of priority populations enrolled with general practices was used by the districts as the criteria for the selection of general practices for early implementation.

3.3. Progress towards implementation

Based on the literature[11], past evaluations of system level changes and the logic model developed for the IPMHA evaluation (Appendix Two) we summarised the key elements of system level changes to provide a framework to learn from the implementation process. Progress against these key elements and the facilitators and challenges to implementation are summarised in Figure 2.

The main facilitator for implementation has been recognition of the need for additional support for patient wellbeing.

[11] Halse J et al (2018) Creating new roles in healthcare: lessons from the literature. *Nursing Times* [online]; 114: 5, 34-37. Robust workforce planning. A literature review of 420 articles. Lynne S Nemeth et al (2008) Implementing change in primary care practices using electronic medical records: a conceptual framework; Implement Sci 3:3.

Figure 2. Progress towards the key elements of implementation

3.4. Implementation funding

IPMHA funding to the districts includes funding for implementation overheads including implementation leadership. Funding for core training is provided nationally. The key elements of implementation outlined in Figure 2 need to be in place for a new service regardless of the size of the district or the number of roles funded, and the costs of many are fixed.

In the early implementation phases of a new service, leadership and management time to communicate the vision of the service and build relationships between stakeholders may be as time intensive in small districts as in larger districts. In districts where there are multiple provider organisations (PHOs and NGOs) involved in implementation, relationship building and alignment to the IPMHA model is complex. In some of the smaller districts, especially those with HC/SW merged roles employed by NGOs, relationship building is ongoing and in one district the DHB has funded a facilitation role (additional to IPMHA implementation funding).

Quality assurance through lead HIP and HC roles has mainly been funded through the larger PHOs who employ the most HIPs and HCs. However, this can be difficult for smaller PHOs who need to rely on the larger PHOs to share that support. Effective working relationships between organisations are required.

We also heard that having a locally based trainer is an advantage but requires funding to enable districts to have these roles. Some of the complementary training that was described as an advantage and activities such as developing onboarding practices is relatively more 'expensive' per general practice to resource in smaller districts than larger ones. Shared resources developed by MOH have been helpful in enabling smaller districts.

Allocation of implementation funding needs to be considered by MOH in the context of key elements of implementation where economies of scale are not necessarily applicable. Examination of different ways to allocate implementation funding between and within districts is an important consideration for the last stages of implementation and in considering overheads required for ongoing support of IPMHA.

3.5. Workforce and workforce development

3.5.1. Training

MOH funded core HIP and HC training. Te Pou[12] as a national workforce centre for mental health, addiction and disability in New Zealand was commissioned by MOH to provide the core HIP and HC training programmes. Training details are summarised in Appendix Five.

Feedback about HIP training content was generally positive and aligned with Te Pou evaluation of HIP training[13]. The training content was defined and consistent. However, interviews with HIPs and other stakeholders found variation between trainers in the advice they provide about what are acceptable adaptations to the IPMHA model. This variation contributed to some inconsistency in delivery and uncertainty about what adaptations are acceptable and likely to be effective.

> *Variation is in what trainers are comfortable letting slide and what they're not in terms of variance in implementation. (HIP Trainer)*

Recruitment challenges also contributed to variation in the HIP workforce.

> *Some [districts] are really, really consistently strong in their recruiting for HIPs, and some other districts are really struggling with finding the right experience or the right match. (HIP trainer)*

As part of the case studies and the final evaluation, interviewed HIPs and HIP trainers discussed the potential to strengthen HIP training and model fidelity.

- Regional trainers were described as an advantage because they understood local contexts and were available to support and mentor local teams. Interviewed HIPs appreciated an ongoing relationship with a trainer as someone they could call to ask for advice. In districts with a lead HIP, the leads were also sometimes trainers and could take that role.

  … the trainer, I'm probably on the phone to her a couple of times a week. She's been absolutely superb, we just talk things through, just that excitement about the model and making sure it works. (HIP)

- Refresher courses, especially for HIPs trained in the first phases of implementation. Refresher training would provide HIPs with opportunities to compare experiences between districts and for trainers to discuss the extent adaptations maintain fidelity to the model.
- COVID and the need for virtual consultations identified the opportunity to develop HIP training to include purpose-built resources for virtual delivery.

[12] https://www.tepou.co.nz/
[13] https://www.tepou.co.nz/resources/hip-training-evaluation-jan-to-jun-2021

Virtual delivery is also important to reach patients/whānau in small general practices in isolated locations.

HC training is delivered by two training providers: Tāmaki Health and Health Literacy NZ. District stakeholders now have more understanding about the training differences and which training is the best fit for IPMHA services in their district and whether their HC roles are merged HC/SW roles and based in general practices or community settings. The differences in HC training contribute to differences in the IPMHA model that is delivered in different districts.

Tāmaki Health now mostly train HCs in the Auckland and Canterbury districts. Their focus is on the San Francisco model and general practice embedded roles to support patients/whānau with long-term chronic conditions. Health Literacy NZ mostly train HCs in other parts of the country and have a stronger focus on holistic support for patients/whānau with mental health conditions and an embedded cultural component.

Some aspects of training and preparation for IPMHA roles such as such as cultural competency training and understandings of Aotearoa New Zealand primary health care would be part of recruitment expectations for a mental health and addictions workforce. However, some HC and HC/SWs are recruited from outside the health sector and some HIPs have no or limited primary care experience. While trainers have responded to early feedback about gaps in cultural competency training, interviews with practitioners in many districts identified the need for additional pre-training for those outside the health sector (Figure 3).

IPMHA implementation would be facilitated if there was national access to consistent training about how the roles worked together.

> *… we used to have GPs and practice managers attend training … that's excluded from the Te Pou training. I think that's sad because it is primary care behavioural health, but the big part of that is integrated ways of working … I did my training alongside three GPs … And not only did they learn what this was all about, but we were learning so much from them. It gave me such an insight to the pressure that these doctors held … (HIP trainer)*

As IPMHA is focused on a general practice-based service the training has also focused on IPMHA roles embedded in general practices. However, in several districts the HC/SWs are employed by NGOs and work in the community. NGO roles in IPMHA and general practice interfaces with social services would be a valuable addition to training.

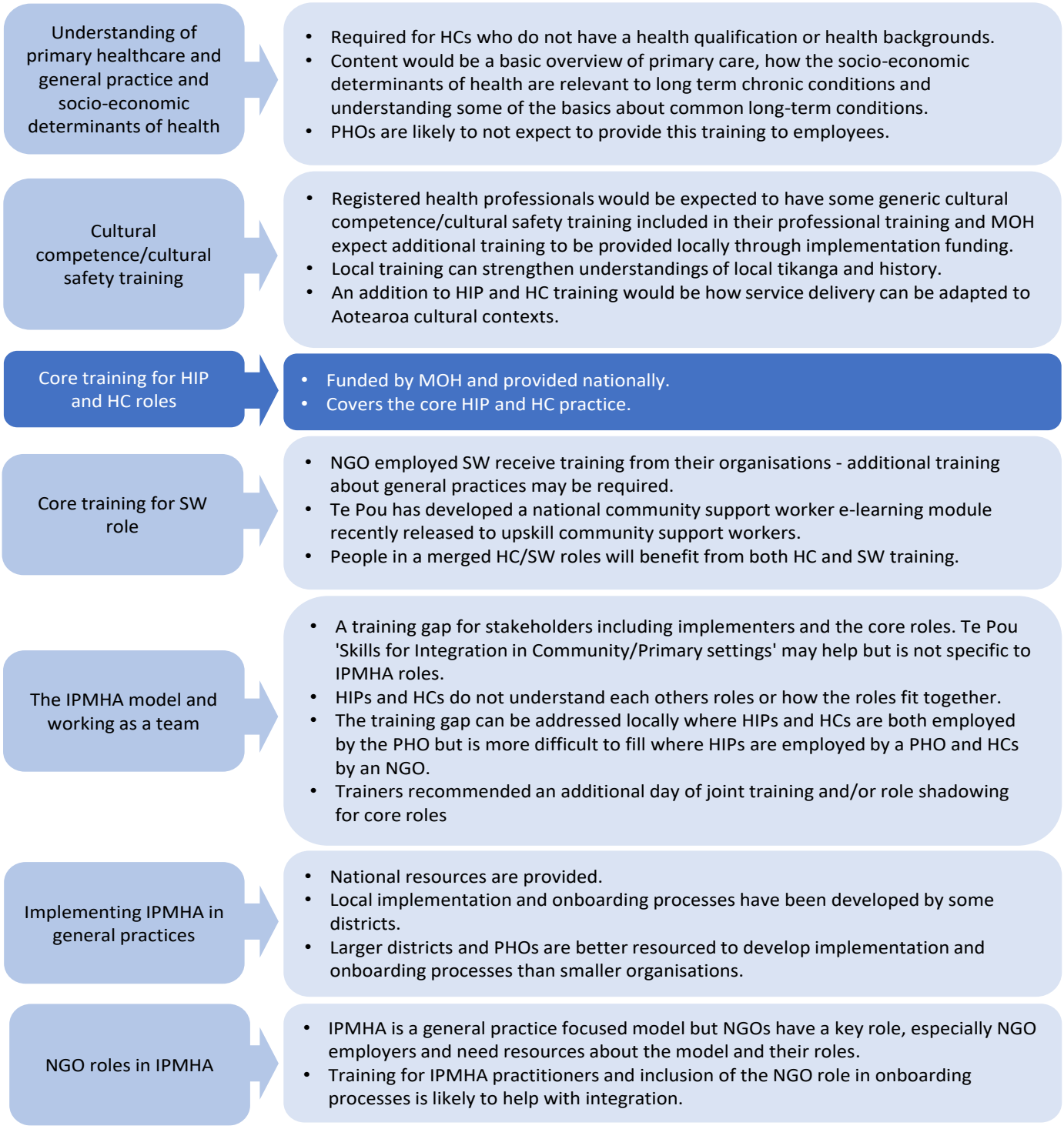

Figure 3. Training requirements identified through the evaluation

3.5.2. Employment

There are mixed employment models for the HIPs, HC and SW. Most HIPs are employed by PHOs and most SW by NGOs. HC and merged HC/SWs are employed by PHOs and NGOs and in one district by a general practice. As implementation has extended, in a few districts roles are employed by other types of organisations.

IPMHA implementation funding includes funding for clinical leadership roles in addition to other implementation support – commonly lead HIP or HC roles. Lead HIPs and lead HCs were employed by a PHO. The leads have an important role in onboarding general practices and maintaining practitioner fidelity to the IPMHA model. In most districts they facilitated regular peer meetings of HIPs and HCs, either separately or together. Peer review meetings were also essential in districts where HIPs and/or HC, HC/SW were employed by general practices to support role clarity and fidelity.

Relationships were still forming in most districts where the HC and HC/SW are employed by NGOs and there was still a separation between NGOs and general practices and between the HIP and HC roles who did not work together as a team. Joint meetings between HIPs and HC/SW employed by NGOs were not in place as regular scheduled meetings.

In most districts, the lead HIPs and HCs were employed by the largest PHO employer. The evaluation did not specifically explore allocation of implementation overhead funding. However, proportionate allocation by FTE would make it difficult for smaller PHOs and individual NGOs to recruit to these roles.

Table 3. The strengths and challenges of different employment models

Employer	Implications
PHO employees	HIPs were commonly PHO employees and, in some districts, HC and HC/SWs were also employed by PHOs. PHOs provided training and support and employer responsibilities (health and safety, HR support). PHO employment provided consistent employment arrangements and helped with building the HIP and HC as a team, but it was not as easy to integrate into the general practice as practice employed roles.
General practice employees	General practice employing HIPs and HCs helped IPMHA to be successfully integrated into the general practice and the two roles to be part of the team. This model was present in only two districts. The practice manager has responsibility for health and safety and integrating the role into the general practice team.

	Works best when both the HIP and the HC are employed by the general practice and there is professional development and IPMHA team building provided in the locality by the PHO or DHB.
Iwi or NGO employees	Mainly applied to HCs and HC/SW roles with only a few HIPs employed in community organisations. Time was required to build trust with general practices to allow a person with non-clinical qualifications to come into the practice and access patient records. Once established, new relationships between NGOs and general practices have the potential to lead to stronger support for patients/whānau. Different organisations have varying kaupapa and paradigms which can lead to inconsistency in employment and fidelity to the IPMHA model. The HC and HC/SW may be the only IPMHA staff employed by a specific organisation. We heard from many that their managers did not understand IPMHA or their roles, they were required to complete IPMHA and their organisation's training and many felt they were not well supported in their HC roles. *… they end up with the health coach training, and then the NGO training and still being in that position of like, nobody's actually telling them what the role is in the practice, and they're not integrated into the practices. (Trainer)* Employment across different organisations created a risk that people would be insufficiently supported. *The DHB is contracting providers, employers, … their employer responsibilities are just not being maintained. So, nobody's supporting [the HCs] and nobody's bringing them together… the providers then decide what the coach role should be when they've got no idea what the role should be, … they're not seeing any responsibility for the safety and practice. (Trainer)*
Other employees	Other employers such as refugee centres were in place in a few sites for merged HC/SW roles. The same challenges and need for links to a GP or nurse practitioner who can take clinical responsibility is required for these organisations.

3.5.3. Workforce development

IPMHA has created new workforce roles. The HIPs are a registered workforce and need to maintain their registration requirements as well as HIP accreditation. There are progression opportunities for HIPs to become trainers and lead HIPs in their districts.

We're not in a recognised registered workforce just yet. … we're still relying heavily on the guidelines and professional ethical guidelines from our professional bodies rather than having our own. I feel like that should be a natural progression now … (HIP Trainer)

However, we heard from people in combined practising HIP and trainer roles that the workloads and expectations were high. One noted that salary recognition did not follow the increased responsibilities.

> *… I don't get paid any extra to be a trainer. In fact, it eats into my personal life. It makes me tired, … And I'm dealing with everyone else's problems. … some trainers do get paid more for being a trainer. It does have to kind of be incentivised and recognized and it's not consistent at this stage. So more and more people might be reluctant to move into the trainer role, … so I do really worry about the future of the workforce, development side of things. (HIP trainer)*

The HC role and support for development of the role is less established because of the different employment contexts. We heard about the need for support for HCs from both trainers. Some may become lead HCs in their district. We also heard that the HC training provides a good foundation for HCs to move into other better paid roles.

> *From my point of view there needs to be training of health coach supervisors and I feel in the longer term it might be heath coaches who go up a ladder. In the short term it should be someone who has had psychological supervision training because some health coaches are not able to contain a conversation. They are getting retraumatised by what they are hearing and seeing. Even if you are staying on the model a lot of the people who are referred to the health coach are very unwell. (Trainer)*

3.6. Factors associated with effective integration of IPMHA into general practices

Effective integration into the general practice team is influenced by:

- System level integration.

  > *… the system level separations between the organisations flows down through to the roles. (HC Trainer)*

- An effective onboarding process that prepares general practices for the new IPMHA roles by providing them with a good understanding of what the roles are, how they work within the practice and the potential for the roles to make a difference for the practice and the patients/whānau. Roles such as the lead HIP and HC were important in assisting the practitioners and practices. A few districts had additional roles such as a clinical director and/or a lead GP and described these roles as facilitating implementation in general practices.
- The general practice characteristics that influence their willingness to welcome new roles. The most important factor was the extent the practice functioned as a team and their willingness to include the IPMHA practitioners as part of their team. Practice managers had a key role in including the HIPs and HCs as part of the team. Across all case studies,

organised and high functioning practices embraced and utilised the new roles.

- Strong practice governance and leadership facilitated integration of IPMHA into each practice. Some general practices had included specific IPMHA governance roles or included IPMHA as a standing item on practice leadership meetings.
- The fit of the IPMHA model with the organisation values, especially in Kaupapa Māori practices. Flexibility to adapt the model and the extent the practice/organisation teams considered IPMHA aligned with their values was very important in integrating IPMHA. Practices with a wellness focus and existing roles focused on wellbeing seemed to have the infrastructure and attitudes already in place to facilitate integration of the IPMHA roles.
- Active communication of their roles by the HIP and HC facilitated by participation in practice huddles and discussions, helping the team to function, and demonstrating the differences they make for patients/whānau. Previous experience in primary care or locality knowledge helped IPMHA staff embed themselves into the role quickly. Effective communication between the IPMHA team and the clinical team about patients/whānau and how they were being supported was important to 'close the loop' and contributed to building awareness of the roles and how they supported patients/whānau.

  It's a big ask to not only learn their own job and figure that all out, and for a health coach that's often the first time they've ever had a patient consult type thing, but also to be constantly advocating for this significant change within the clinic. It requires quite a bit of tenacity and grit and 'Tiggers' and just that intrinsic desire to help people at that level is just a key baseline. (Trainer)

- HIPs and HCs adapting the way IPMHA was operationalized in a practice to meet the needs of the practice and the way the practice usually worked.
- Active promotion of the service to build patient/whānau understandings as well as enhancing practice staff understandings. Examples included information in newsletters and information displayed in the practice waiting room. Some patients/whānau wished the service was better advertised so that they would have known about it sooner.
- Adequate resourcing of the roles and onboarding process. The HIP and HC having rooms or spaces where they can see patients/whānau.

Practices differed in the extent they saw the values offered by the roles as compensating for the costs of rooms, practice management system fees etc. Many saw the roles as a good addition to their team but not necessarily in an economic sense. As the value of IPMHA is increasingly being recognised by general practices, the DHBs and PHOs have more leverage to ensure there is adequate resourcing for the HIPs and HCs.

DHBs need to say what practices need to have in place - If you can't provide these things, then we can't give you a health coach, because it won't work … some are doing it individually or in some are trying to do it at a cluster level, and then some aren't doing it at all. (Trainer)

3.7. IPMHA is not yet established as a business-as-usual service in most districts

In the final interviews, interviewed stakeholders rated the extent **currently funded** IPMHA services were implemented in their localities (excluding the next roll-out) as between 3 and 5 on a 5-point scale where 5 was fully implemented. The districts involved in the pilot rated implementation more highly. Reasons for not rating implementation as a 5 were consistent across districts and included lack of integration of the HC or HC/SW role with the HIP role and/or in general practice settings.

… when you're talking about system change, you need some more leadership still happening at the higher levels. And that's probably the problem. I know, particularly with the Māori providers, the DHBs have sort of taken a step back … when it comes to an integration with primary care, nobody's doing it. Nobody's leading it ... (HC Trainer)

Other reasons included COVID impacts and delays to engaging and on-boarding new practices, training and embedding HIPs and HCs in practices (virtually) during and after lockdowns.

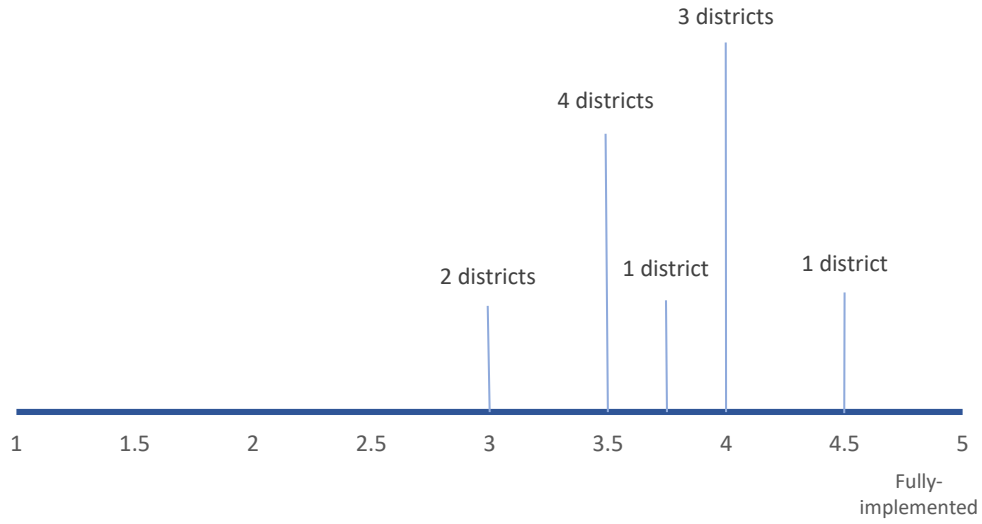

Figure 4. The extent stakeholders considered currently funded IPMHA services were implemented in their localities

4. Reach of IPMHA services

4.1. The numbers of patients/whānau supported by IPMHA services

The numbers of patients/whānau supported by IPMHA and the number of IPMHA support activities have increased over time, reflecting the progressive roll-out (Figure 5). The evaluation focus is on the 84,270 patients/whānau seen between 1 April 2021 and 31 March 2022 and 236,292 IPMHA sessions they completed. Data for the Bay of Plenty, Nelson Marlborough and South Canterbury DHBs have been excluded from the report as they are not included in the evaluation.

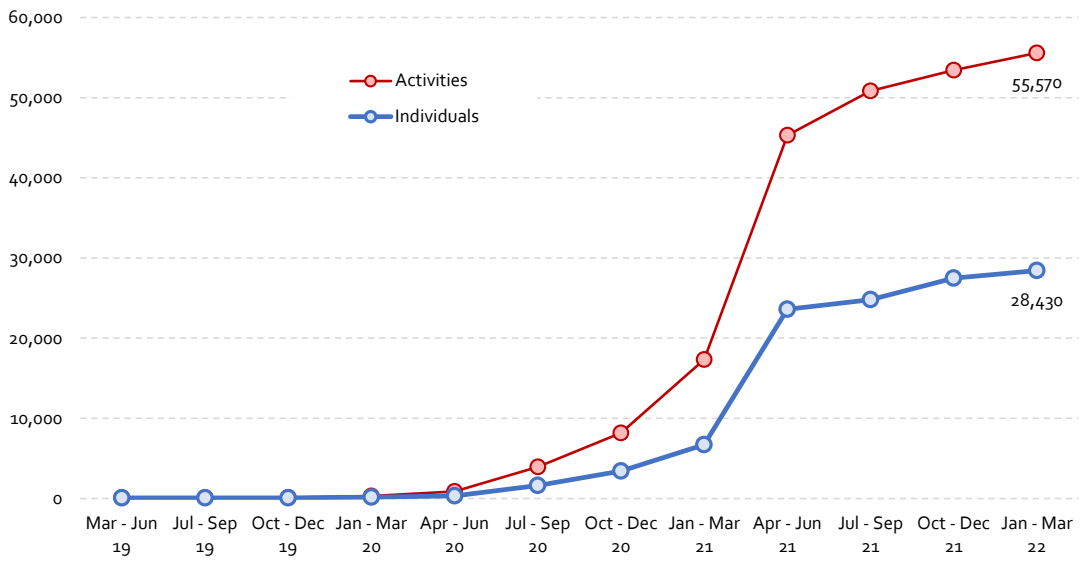

Figure 5. Number of individuals with at least one activity and total activities in each quarter (MOH data).

Based on IPMHA administrative data, in the 12 months between 1 April 2021 and 31 March 2022, an average of 3.7% of IPMHA practice enrolled populations have been supported by IPMHA services (Table 4). As whānau may also be supported but not recorded and there are gaps in data from community-based HC/SWs the proportion reached is greater (Section 2.2).

IPMHA is still being rolled-out. The MOH aim for *Access and Choice* is that these services will reach an additional 6.5% of the population. Based on administrative data, reaching 6.5% of the IPMHA enrolled population seems achievable in some districts.

Table 4. The percentage of the enrolled population at IPMHA practices receiving IPMHA services between 1 April 2021 and 31 March 2022 (Source: IPMHA dataset, MOH PHO enrolment figures for April 2022 and Statistics NZ estimated DHB populations 2021)

District	DHB total enrolled population	Total IPMHA facility enrolled population	Total # receiving IPMHA services	% of DHB population receiving IPMHA	% of IPMHA enrolled receiving IPMHA services
Auckland Collaborative	**1,632,103**	**682,105**	**26,087**	**1.5%**	**3.8%**
Auckland	460,781	208,050	9,152	1.8%	4.4%
Waitematā	605,041	42,163	2,871	0.4%	6.8%
Counties Manukau	566,281	431,893	14,064	2.3%	3.3%
Canterbury	562,078	240,709	13,414	2.3%	5.6%
Hawke's Bay	168,169	112,379	3,904	2.2%	3.5%
Lakes*	109,881	114,531	1,851	1.6%	1.6%
MidCentral[14]*	174,772	.	3,905	2.1%	-
Northland	189,568	155,376	6,857	3.5%	4.4%
Southern	325,916	188,193	10,788	3.1%	5.7%
Taranaki*	118,645	61,584	1,929	1.5%	3.1%
Waikato	418,529	260,178	3,608	0.8%	1.4%
Wellington Collaborative	**501,095**	**391,566**	**9,611**	**1.8%**	**2.5%**
Capital and Coast	302,278	245,881	5,872	1.8%	2.4%
Hutt Valley	150,446	100,340	2,623	1.6%	2.6%
Wairarapa	48,371	45,345	1,116	2.2%	2.5%
Whanganui	65,539	56,296	2,345	3.4%	4.2%
TOTAL	**4,266,295**	**2,262,916**	**84,299**	**1.9%**	**3.7%**

**Data are missing for districts shaded orange*

Variation in reach is complex and may also be influenced by time since implementation and participation in the pilot, the number of sessions per individual within an episode of care and number of episodes of care per individual (Table 5). In districts with a high percentage of rural population, reach particularly for HC and HC/SW is also influenced by travelling time.

> *…to save the kaimahi driving out to [the GP clinic] and sitting there all day because no one has turned up, or they only have a couple of appointments, [GPs] will send the referral into the provider and then the kaimahi will ring them and have a kōrero on the phone…They*

[14] MidCentral IPMHA data not available by practice

seem to be able to work with more people doing it that way rather than sitting in a general practice all day. (DHB staff).

Table 5. Table showing additional measures of reach by DHB (Source: MOH IPMHA dataset)

District	Total encounters per individual		Total episodes of care per individual for those with more than one encounter		
	% with two or more encounters	% with three or more encounters	% with one episode	% with two episodes	% with three or more episodes
Auckland Collaborative	**54%**	**33%**	**77%**	**18%**	**6%**
Auckland	53%	33%	78%	17%	5%
Waitematā	58%	34%	70%	21%	10%
Counties Manukau	53%	32%	77%	17%	5%
Canterbury	48%	26%	78%	15%	7%
Hawke's Bay	48%	26%	74%	17%	9%
Lakes*	38%	17%	93%	6%	1%
MidCentral[15]*	41%	20%	86%	12%	2%
Northland	46%	27%	73%	18%	9%
Southern	52%	28%	71%	18%	11%
Taranaki*	42%	21%	87%	9%	3%
Waikato	49%	33%	70%	20%	10%
Wellington Collaborative	**52%**	**31%**	**76%**	**18%**	**7%**
Capital and Coast	50%	29%	79%	16%	5%
Hutt Valley	57%	34%	69%	20%	10%
Wairarapa	58%	34%	76%	20%	4%
Whanganui	61%	40%	68%	23%	9%
TOTAL	**50%**	**29%**	**76%**	**17%**	**7%**

**Data are missing for districts shaded orange*

[15] MidCentral IPMHA data not available by practice

4.2. Reach of IPMHA services by general practice

Relative to the percentage of enrolled population at different practice sizes, the large practices (10,000+ enrolled population) had a greater share of patients/whānau with the potential to receive IPMHA support overall (45%) and in most districts (Table 6).

Table 6. Percentage of people enrolled in IPMHA general practices of different sizes and compared to the percentage of people enrolled in IPMHA in practices of different sizes. (Source MOH: IPMHA data)

District	All General Practices Proportion of people enrolled in different sized practices			IPMHA practices Proportion of people enrolled in different sized practices		
	5,000 or fewer	5,001 to 9,999	10,000 or more	5,000 or fewer	5,001 to 9,999	10,000 or more
Auckland Collaborative	**40%**	**40%**	**20%**	**12%**	**29%**	**60%**
Auckland	49%	37%	14%	13%	29%	58%
Waitematā	29%	49%	22%	0%	31%	69%
Counties Manukau	42%	33%	25%	12%	29%	60%
Canterbury	38%	49%	13%	19%	54%	28%
Hawke's Bay	19%	55%	26%	8%	34%	58%
Lakes	29%	34%	37%	27%	28%	45%
MidCentral*	52%	26%	22%	-	-	-
Northland	63%	31%	6%	26%	41%	33%
Southern	52%	32%	16%	25%	39%	37%
Taranaki	45%	36%	19%	32%	31%	37%
Waikato	33%	39%	28%	19%	38%	43%
Wellington Collaborative	**34%**	**45%**	**22%**	**14%**	**45%**	**41%**
Capital and Coast	31%	62%	8%	8%	53%	39%
Hutt Valley	38%	18%	44%	20%	39%	41%
Wairarapa	37%	15%	49%	34%	15%	51%
Whanganui	43%	36%	21%	21%	57%	22%
Total	**40%**	**41%**	**19%**	**17%**	**38%**	**45%**

**Data are missing for districts shaded orange*

4.3. Patient/whānau profiles

4.3.1. Age

IPMHA data show the services have reached both older and younger client groups. Overall, the age profile aligned with that of general practice enrolled patients but in many districts and overall, the percentage of IPMHA clients aged 15-24 years was higher than their percentage of the enrolled population (Table 7).

HIPs and HCs spoke of the unique needs of young people and children they supported but said that largely the model did not need to change to support them. Some areas wanted this model to be available in other settings such as schools and maraes – not just general practices. Interviewed IPMHA staff were not aware of other Access and Choice initiatives in these settings.

Table 7. Age of IPMHA patients/whānau by district compared to age in years of all patients/whānau enrolled in IPMHA practices. The 1-14 age group is excluded from both and 160 individuals with age recorded as 0 have been excluded (Source: MOH IPMHA data)

District	IPMHA clinic – enrolled patients/whānau age profile			IPMHA patient/whānau age profile		
	15-24 (%)	25-64 (%)	65+ (%)	15-24 (%)	25-64 (%)	65+ (%)
Auckland Collaborative	**18%**	**69%**	**13%**	**17%**	**69%**	**14%**
Auckland	19%	66%	14%	19%	68%	13%
Waitematā	15%	70%	15%	13%	69%	19%
Counties Manukau	18%	69%	13%	17%	71%	13%
Canterbury	14%	66%	20%	17%	65%	18%
Hawke's Bay	15%	62%	23%	21%	66%	14%
Lakes*	14%	63%	22%	18%	68%	15%
MidCentral*	-	-	-	26%	61%	13%
Northland	13%	59%	27%	13%	57%	30%
Southern	14%	64%	22%	17%	64%	20%
Taranaki*	15%	62%	23%	18%	64%	17%
Waikato	17%	65%	18%	21%	64%	15%
Wellington Collaborative	17%	66%	18%	**25%**	**62%**	**13%**
Capital and Coast	18%	66%	16%	30%	57%	13%
Hutt Valley	15%	67%	18%	18%	69%	14%
Wairarapa	13%	59%	28%	19%	64%	17%
Whanganui	14%	60%	26%	18%	65%	17%
Overall	**16%**	**65%**	**19%**	**19%**	**65%**	**17%**

**Data are missing for districts shaded orange*

4.3.2. Equity

MOH aimed to prioritise support for some populations groups including Māori and Pacific Peoples by prioritising the initial roll-out of the IPMHA initiative to practices with higher proportions of Māori and Pacific enrolled patients. In most districts, IPMHA has been implemented in practices with higher proportions of enrolled populations with high needs[16] (Table 8). The percentage of the IPMHA enrolled population at high needs practices was highest in Counties Manukau, Northland, Whanganui, Lakes and the Waikato.

Table 8. Reach of IPMHA services to high-need populations. (Source: IPMHA dataset, MOH PHO enrolment figures for April 2022 and Statistics NZ estimated DHB populations 2021)

District	Total DHB enrolled population	% of enrolled population with high needs	Total IPMHA facility enrolled population	% IPMHA enrolled at a practice with high needs
Auckland Collaborative	**1,632,103**	**32%**	**592,811**	**50%**
Auckland	460,781	28%	202,056	48%
Waitematā	605,041	20%	42,163	15%
Counties Manukau	566,281	49%	348,592	55%
Canterbury	562,078	18%	240,709	19%
Hawke's Bay	168,169	41%	101,389	43%
Lakes	109,881	51%	109,033	50%
MidCentral	174,772	38%	-	-
Northland	189,568	51%	147,269	53%
Southern	325,916	20%	188,193	20%
Taranaki	118,645	28%	61,584	35%
Waikato	418,529	38%	181,991	50%
Wellington Collaborative	**501,095**	**28%**	**348,316**	**36%**
Capital and Coast	302,278	24%	206,919	33%
Hutt Valley	150,446	35%	96,052	43%
Wairarapa	48,371	33%	45,345	34%
Whanganui	65,539	50%	56,296	51%
TOTAL	**4,266,295**	**31%**	**2,027,591**	**41%**

[16]Defined by MOH as Māori, Pacific or New Zealand Deprivation Index quintile 5 https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/very-low-cost-access-scheme

The reach of IPMHA to Māori and Pacific Peoples was examined by considering the percentage of IPMHA practice enrolled people reached by IPMHA services. In all districts with robust data, the reach to Māori was higher than for 'other' ethnic groups. Reach to Pacific was highest in Waitematā, Canterbury and Southern districts.

One interviewed provider commented that it takes time for trust in a new service to be built with Māori.

> *[IPMHA clinic] runs really well for us and we see up to eight to 10 people, but the percentage of our Māori people is still little. I am not too sure why, whether it's because they are whakamā, but the majority are still non-Māori. (Provider staff).*

Table 9. Ethnicity of the enrolled population of IPMHA clinics and the proportions reached by IPMHA (the proportion of IPMHA practice enrolled populations of each ethnic group receiving IPMHA support) (Source: MOH IPMHA data)

District	Enrolled population of IPMHA patients/whānau			Percentage of IPMHA practice enrolled patients/whānau from each ethnic group reached by IPMHA		
	Māori	Pacific	All others	Māori	Pacific	All others
Auckland Collaborative	**99,255**	**179,930**	**400,260**	**4.6%**	**3.1%**	**4.0%**
Auckland	33,189	45,297	129,058	5.1%	4.1%	4.3%
Waitematā	2,736	2,315	37,086	9.3%	7.9%	6.6%
Counties Manukau	63,330	132,318	234,116	4.1%	2.7%	3.3%
Canterbury	23,068	7,188	209,026	7.1%	5.7%	5.4%
Hawke's Bay	31,337	3,573	77,094	4.2%	3.5%	3.2%
Lakes*	39,706	2,900	71,223	1.6%	1.1%	1.7%
MidCentral*	-	-	-	-	-	-
Northland	56,072	3,027	95,762	4.6%	3.6%	4.3%
Southern	19,211	5,006	163,234	7.0%	5.4%	5.6%
Taranaki*	14,243	827	46,242	3.5%	1.9%	3.0%
Waikato	79,623	13,921	165,037	2.6%	0.8%	0.9%
Wellington Collaborative	**65,206**	**38,678**	**285,508**	**2.8%**	**2.5%**	**2.4%**
Capital and Coast	35,865	26,938	181,232	2.6%	2.6%	2.3%
Hutt Valley	20,904	10,731	68,518	3.1%	2.3%	2.5%
Wairarapa	8,437	1,009	35,758	3.0%	2.4%	2.3%
Whanganui	15,802	1,524	38,908	4.8%	2.9%	4.0%
TOTAL	**443,523**	**256,574**	**1,552,294**	**4.1%**	**3.1%**	**3.7%**

**Data are missing for districts shaded orange*

4.3.3. Sex

Enrolment rates in IPMHA general practices are approximately the same for females and males. On average, across all districts, females (64%) were more likely to use IPMHA services than males (36%) (Table 10). However, we heard from practices that the IPMHA focus on wellbeing was effective in reaching males

The differences in IPMHA reach align with differences in primary care attendance by males and females (and opportunities to be referred to IPMHA services):

- Across all age groups, women are more likely than men to visit a GP[17] over a 12 month period, even after excluding gynaecological and obstetric conditions.
- Compared to women, men are less likely to seek help for mental health issues despite having a disproportionately higher suicide rate[18].

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[17] Jatanra S and Crampton P. (2009). Gender differences in general practice utilisation in New Zealand. Journal of Primary Health Care 1(4):261-9

[18] Sagar-Ouriaghli I, Godfrey E, Bridge L, Meade L, Brown JSL. Improving Mental Health Service Utilization Among Men: A Systematic Review and Synthesis of Behavior Change Techniques Within Interventions Targeting Help-Seeking. Am J Mens Health. 2019 May-Jun;13(3)

Table 10. Sex of IPMHA patients/whānau per district (Source: MOH IPMHA data)

	IPMHA practice enrolled population		IPMHA patients/whānau	
	Female (%)	**Male (%)**	**Female (%)**	**Male (%)**
Auckland Collaborative	**51%**	**49%**	**61%**	**39%**
Auckland	52%	48%	61%	39%
Waitematā	53%	47%	64%	36%
Counties Manukau	50%	50%	60%	40%
Canterbury	52%	48%	66%	34%
Hawke's Bay	53%	47%	66%	34%
Lakes*	52%	48%	68%	32%
MidCentral*	0%	0%	67%	33%
Northland	52%	48%	64%	36%
Southern	51%	49%	63%	37%
Taranaki*	52%	48%	67%	33%
Waikato	51%	49%	63%	37%
Wellington Collaborative	**52%**	**48%**	**66%**	**34%**
Capital and Coast	52%	48%	66%	34%
Hutt Valley	51%	49%	64%	36%
Wairarapa	52%	48%	69%	31%
Whanganui	52%	48%	64%	36%
TOTAL	**51%**	**49%**	**64%**	**36%**

**Data are missing for districts shaded orange*

5. Delivery of IPMHA services

Evaluation question: Variations in the model and its delivery on the ground and key factors that are associated with achievement of intended outcomes in general, and for different priority population groups.

5.1. Variation in the core IPMHA roles

The way the core IPMHA roles have been implemented, the interfaces between the roles and the extent they work as a team influences the IPMHA service delivery model. The intended functions of the roles and the way the roles deliver IPMHA services are summarised in Figure 6.

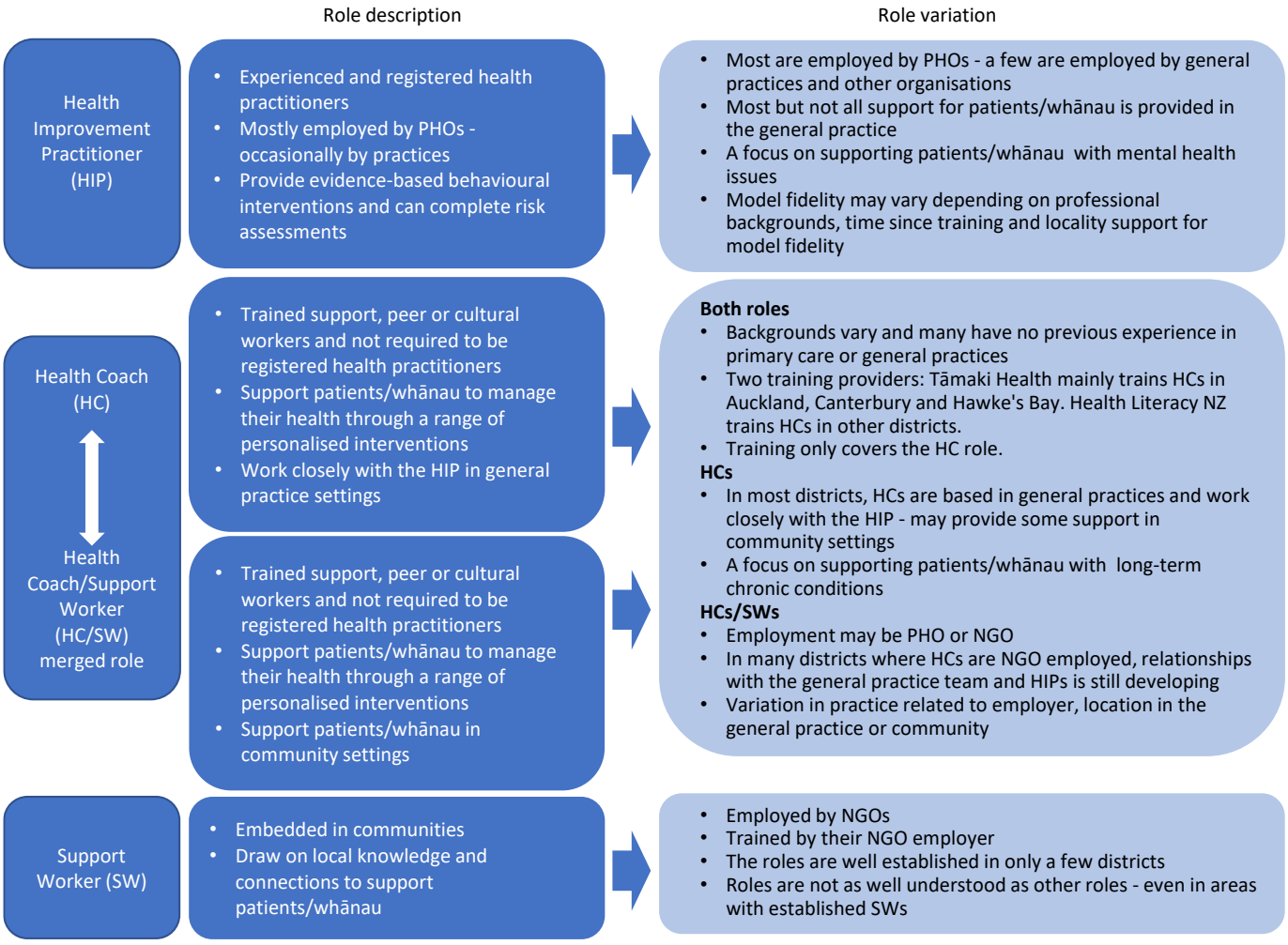


Figure 6. The IPMHA role descriptions and role variations

The HIP role is more clearly defined than the HC role. In most districts the HIPs have a trainer or lead HIP who provides mentoring and aims to ensure fidelity to the model and HIP practice. HIPs meet and discuss practice and challenges.

The HIPs and HCs spoke about the balance between adhering to the model and their reporting expectations and adapting the model to meet the general practice environment and needs of the communities they are serving.

> *… to get immersed in a clinic, you have to be helpful for the people presenting… I had to be pretty flexible on how I approach that. (HIP)*

However, some variation in HIP practice was described and observed during the case study visits resulting from:

- Pressure from the general practice team for HIPs to have a triage role and assist with patients/whānau with complex mental health issues.

  [Some managers] are turning the HIP role into triage roles and they can really see how unsafe that is and it's inconsistent with the training and what that means for them. (Trainer)

- Drift in practice over time with HIPs falling back on their professional practice which could be reflected in lower numbers of patients/whānau supported and longer consultations.

There are differences between districts in the ways the HC role has been implemented that relate to different training programmes, different employment contexts and different local needs. In some districts the merged role is placed in a general practice and in others employed by an NGO provider and primarily based in the community (Table 11).

In one district the HIPs and HCs work in the clinics and the community. GP referrals are still required. GPs will send a referral through to the HIP, the HIP will complete an initial phone consult and arrange to meet with whānau. Providers consider this is an effective 'warm handover'. HIPs and HCs are based off-site and keep their own patient notes with a feedback loop to GPs offered via email.

> *"Although physically the room was in a slightly different space, it was still general practice wrap around" (PHO staff).*

There are also differences between practices within districts, so the table below provides a general overview only.

Table 11. An overview of IPMHA roles based on FTEs current at the time of interviews (not funded FTEs) (Source: Interviews with implementation teams)

	HIP FTE	HC FTE	HC/SW merged and in general practice	HC and merged HC/SW not in general practice	SW
Auckland Collaborative	50.4	43.2			55.4
Canterbury	20.8		27.5		
Hawke's Bay	10	11.4		2	4.5
Lakes	10.9 (includes 1 at NGO)			8.6	
MidCentral	11.4			10.7 +3FTE at NGO)	
Northland	13		17		
Southern	19.2	15.6	2.5		7.6
Taranaki	6.4			9	
Waikato	18.9			29.1	
Wellington Collaborative	23.9	8	7.55		12.4
Whanganui	7 (0.34 NHC)		7 (0.34 NHC)		

**Data are missing for districts shaded orange*

5.2. HIP and HC ratios were broadly consistent with the funded ratios.

MOH services are funded at a ratio of 1 HIP per 10,000 population in all practices which aims to maximise reach. The ratios of both roles to enrolled populations described in Table 12 are based on FTEs filled at the time of the evaluation and may not reflect funded ratios.

Interviewed stakeholders described adhering to the 1:10,000 HIP ratio for each general practice with the exceptions of MidCentral, Taranaki and Whanganui districts that applied the same ratio but at district level. The ratio of HIP FTE to enrolled patients in the IPMHA general practices (excluding MidCentral) was on average 1: 12,062.

The funded ratio of 1-1.5 HC/SW per 10,000 population is district-wide and can vary between practices based on level of need. The ratio of HC, HC/SW and SW roles combined (excluding MidCentral) was on average 1: 8,498. These ratios are consistent with the MOH funding criteria and all districts (except Lakes) the HC, HC/SW and SW ratio is higher than the HIP ratio.

Application of the ratio at district level enabled implementation teams to allocate resources based on need and practical considerations, such as avoiding multiple very part-time roles and providing greater resource to practices in communities with complex needs or to practices that used the resources more effectively.

Table 12. The HIP and HC/SW/SW ratios per enrolled population. Ratios were provided by interviewed stakeholders and reflect the filled roles at the time of interviews which may differ from funded roles. Note total FTE and ratio figures exclude MidCentral because no practice level information was available.

DHB	Total people enrolled at IPMHA facilities	FTE HIP	Ratio HIP/IPMHA enrolled popn	FTE HC & HC/SW &SW FTE	Ratio HC & HC/SW & SW to IPMHA enrolled popn
Auckland Collaborative	682,105	50.4	13,534	98	6,932
Canterbury	240,709	20.8	11,573	28	8,753
Hawke's Bay	112,379	10	11,238	15	7,492
Lakes*	114,531	10.9	10,507	9	13,318
MidCentral*	.	11.4	-	13.7	-
Northland	155,376	13	11,952	17	9,140
Southern	188,193	19.2	9,802	26	7,351
Taranaki*	61,584	6.4	9,623	9	6,843
Waikato	260,178	25.7	10,124	29	8,941
Wellington Collaborative	391,566	23.9	16,383	28	13,788
Whanganui	56,296	7.3	7,670	7	7,712
TOTAL (excluding MidCentral)	**2,262,917**	**187.6**	**12,062**	**266**	**8,498**

**Data are missing for districts shaded orange*

5.3. Practice size

The size of the general practice influences the FTE of HIPs, HCs and SWs available to support patients/whānau. As the HIP roles have a fixed ratio at general practice level of 1 HIP:10,000 enrolled population, practices with less than 10,000 enrolled population are therefore funded for a proportion of a HIP FTE[19].

Practice size influenced delivery of IPMHA services because it influenced the ratio of the core IPMHA roles to the enrolled population. In all districts, enrolled populations

[19] MOH have agreed to exceptions to the ratio for some isolated small practices such as Great Barrier Island, on a case by case basis.

of 5,000 or fewer are the most common practice size (Table 13). The highest percentage of small practices was found in Northland, Southern, Auckland and MidCentral districts. The percentage of general practices with 10,000 or more enrolled population is highest in Hutt Valley and Lakes districts.

Table 13. The size of general practices in districts and general practices where IPMHA has been implemented (Source: MOH enrolled population data by practice)

District	All General Practices Proportion of different sized practices in each district			IPMHA practices Proportion of different sized IPMHA practices in each district		
	5,000 or fewer	5,001 to 9,999	10,000 or more	5,000 or fewer	5,001 to 9,999	10,000 or more
Auckland Collaborative	**68%**	**26%**	**7%**	**32%**	**35%**	**33%**
Auckland	76%	20%	4%	35%	31%	35%
Waitematā	55%	37%	9%	0%	50%	50%
Counties Manukau	69%	22%	9%	33%	35%	31%
Canterbury	62%	33%	5%	36%	50%	14%
Hawke's Bay	47%	43%	10%	27%	45%	27%
Lakes*	53%	32%	16%	50%	28%	22%
MidCentral*	76%	18%	6%	-	-	-
Northland	84%	14%	2%	54%	32%	14%
Southern	77%	19%	5%	48%	35%	16%
Taranaki*	70%	23%	7%	55%	27%	18%
Waikato	63%	27%	10%	47%	36%	17%
Wellington Collaborative	**59%**	**34%**	**7%**	**31%**	**48%**	**21%**
Capital and Coast	55%	42%	3%	21%	59%	21%
Hutt Valley	65%	17%	17%	38%	38%	23%
Wairarapa	71%	14%	14%	67%	17%	17%
Whanganui	69%	23%	8%	40%	50%	10%
Total	**68%**	**26%**	**6%**	**40%**	**39%**	**22%**

**Data are missing for districts shaded orange*

In a large practice, with a substantial FTE of HIP and HC, teamwork is enabled, the roles are in the practice and can work together to integrate support for patients/whānau. Their presence in the practice raises awareness of IPMHA services.

Pragmatic adaptations to IPMHA service delivery are required to respond to the part-time workforce in smaller practices. In response a merged HC/SW role has

developed in some locations to consolidate the FTE that are available and to work in both the practice as a HC and the community as a SW.

Where the HIP and the HC or HC/SW are both part-time, the options for practices are to have both staff there together for part of each week or to have the HIP and HC/SW in the practice on different days.

> *…Where you have the HIP for half a day and different days and it isn't really the model. What might work better in the smaller areas is if a health coach spends one whole day in a clinic and the next week a whole day in a different clinic. (Trainer)*

Both approaches have implications for the IPMHA service delivery model:

- It is more difficult to work as a team and there is a risk of the HIP and HC working independently

  The health coach is not an independent role … A HIP might see someone who has a mental health issue, then the HIP gives directions to the health coach on how to support this person in the next two weeks. And they do that with the health coach hat on and not trying to do therapy with them. That is part of the role being a supporter and help to navigate. (Trainer)

- It is more difficult to embed the roles into the general practices

  If you're employed less, how do you have time? But it's really hard to participate in the whole workings of the practice. When you're not there. (HIP)

- Warm handovers need to be adapted.

The other implication of part-time roles is recruiting staff to the FTE available. While some staff may want part-time work, others need to work across more than one practice to gain full-time employment. In some very small rural and isolated practices it is not feasible to provide IPMHA support because the enrolled patient numbers are small and travel distance is too great to make sharing roles between practices an option.

In Whanganui, the three National Hauora Coalition practices are starting to implement IPMHA. In total there is a 0.34 FTE for a HIP and 0.34 FTE for a HC/SW. Currently only one practice is participating but if three wanted to there would be approximately half a day a week for each role in each practice.

Interviewed stakeholders considered there was a minimum feasible FTE of 0.4 to 0.6 FTE (two to three days) to support IPMHA model delivery through enabling cross-over between HIPs and HC/SW, awareness and familiarity with the IPMHA team amongst the general practice staff and time for meetings and training.

> *Two practices. Yes. It's okay. But three practices … the [HC] is going to need support, particularly if the practices won't work together and allow them to work with patients for any practice at any time. (HC trainer)*

Examples of ways IPMHA service delivery has been adapted for small practices

- Patient management software was also used to send a message or 'task' to the HIP or HC with the patient/whānau contact details so they could contact them directly.
- Telehealth services. Instead of seeing patients/whānau in person, HIPs would call or video-conference them, particularly for brief check-in visits.
- Clustering practices that are closely located geographically with HIPs and HC/SW shared between practices e.g. in Lakes DHB where three closely located urban practices share a HIP.

5.4. Adaptations to the IPMHA delivery model

The MOH intention for IPMHA is that IPMHA services can adapt to meet the health needs of their local community[20]. Fidelity to the model and IPMHA service delivery were facilitated by:

- Managers and implementation lead with a solid understanding of IPMHA who worked together to establish IPMHA services in their district
- Access to training support on an ongoing basis
- High levels of general practice enrolment and few barriers to general practice attendance
- Practice sizes and FTE that enabled the HIP and HC or HC/SW to work as a team in a general practice setting.

How IPMHA services were delivered in the districts was influenced by the practice size, how the HC role was implemented, the HC training and whether the role was in a general practice or in the community, and whether there was a SW role or a merged HC/SW role.

5.4.1. Reaching priority populations

Analysis of MOH data has demonstrated reach of IPMHA services to the priority populations. At least equal and often greater percentages of Māori, Pacific Peoples are reached compared to the proportions enrolled in general practices (Section 4.3)

Interviewed patients/whānau from the priority groups were positive about the support they received.

[20] https://www.health.govt.nz/our-work/mental-health-and-addiction/primary-and-community-wellbeing/integrated-primary-mental-health-and-addiction-service

Look where I am now, I couldn't be more happier where I am. Here's me thinking... that I'm too old to get in the industry [I have always wanted to work in], but I'm in there thanks [to the HIP]. She got me in there. (Patient/whānau)

Another tip she gave me was that sometimes we need to change how we think. I found that once again it might sound simple to you, but at the time I couldn't see wood for the trees. Just thinking about that can change your whole world. (Patient/whānau)

She was only there to help, not to push me to do things. Not that I didn't want to do [things] but to look at them in a different way… I like the assistance she gives me. It's not wishy-washy, it's practical. I want practical. (Patient/whānau)

I love her, I've recommended her to other people… my friend's wife was having a few issues so I said to him, no shame, no shame [in seeing her]. (Patient/whānau)

Ways of working within the IPMHA model to reach Māori and Pacific patients/whānau were frequently described and included:

- Focusing FTEs on practices with higher levels of need and/or higher utilization of the roles.

  For example, [practice] are small … but we've got a full time HIP there because they're really busy… In [practice] they just don't really have the … I'm pretty flexible. I stick to the ratio when I'm starting a practice and then adapt it based on need and use. (Lead HIP)

- Recruiting Māori and Pacific HIPs and HC/SW. Māori and Pacific practitioners brought cultural understandings to the roles.

  [The HIP] is Māori and [The HC] is a young male. [The HC] has connected with younger male patients, who can be hard to connect with… One doctor said they've had Māori patients who are very happy to hear that they can talk to a Māori person. They have made a difference for [patients] to feel more comfortable. (Practice Manager)

  All my previous [counsellors] have been Pākehā right up to clinical psychologists… I'm having a hard time as it is and I don't know what [they] are saying. But it wasn't like that with her. (Patient/whānau)

- HC/SW merged roles and SW roles in the community were described as important to complement initial practice visits. HCs and SWs would visit people in their homes who that lived rurally and found it difficult to come into town.

  … So definitely some positives in maybe having the model split in practice and out in the community. Especially having marae clinics and just being adaptable and versatile of where we can meet as opposed to HIPs that are almost stuck in general practices. (HC).

  I think it was something like employment support or support with the benefit … And the support worker went to the person's place ... The woman at the clinic presents very well … that GP has known her for years. The support worker finds that there's two adult children, … drinking and beating each other up every couple of days, holes

in the walls, holes in the roof, just chaos, and with the person's consent is able to feedback to the GP. This GP was like, '… I had no idea that home environment was like that' ... (NGO manager)

- Allowing additional time for whakawhanaungatanga in initial meetings with HIPs and HCs in general practices.

  Sometimes, if we're doing an initial session and it's with a whānau, I don't know if this is just [district] one but we have got whanaungatanga as a session and we can do another session after that. So our first session can be an hour, with half an hour allocated for whanaungatanga and half an hour allocated to the initial session. (HIP)

- Supporting whānau alongside the patient. In one practice a HIP described moving away from an individualised, Western approach and working with whānau as well as her patients, keeping whānau informed (with patient permission) and helping whānau be involved in supporting their family member.

  She is very ethical in her practice - checks with me when necessary - and ensures we are all aware of what each is contributing. (Whānau)

Kaupapa Māori providers have incorporated their understanding of the IPMHA and the learnings taken from their training, and are applying these to meet the needs of the communities they support by:

- Implementing the model within appropriate Kaupapa Māori frameworks that have cultural values at their centre and enabled tikanga.
- Recruiting staff reflective of their community and that knew the local community, were culturally competent and provided a greater understanding of the lived realities of whānau within each community they served.
- Practice informed by cultural values, knowledge and mātauranga Māori.

  Our health coaches are staff that sit within the practice, receiving those warm handovers and building those relationships with our health improvement practitioners and the practice staff and then our Kaupapa Māori staff are the ones that are sitting in the space of delivery. But our health coaches also come into that space with our group sessions so that they know if they wanted that support as well, then it is accessible.

- Flexibility of who can use the service to improve equity. In some places this means having people who whakapapa to an Iwi that owns a Kaupapa Māori Health Centre being able to go to there even if they are not enrolled and allowing whānau to use the service.

The main adaptation outside the model has been moving away from general practice-based services to reach not enrolled populations. Stakeholders in districts with higher proportions of Māori and rural populations described barriers to accessing general practice services such as costs, transport, travel times and waiting

times for appointments. Access barriers, the focus on the priority populations for early implementation, and lack of awareness of community-based Access and Choice initiatives underpinned some approaches to implementing IPMHA that moved outside the general practice based IPMHA model to connecting with patients/whānau in communities.

IPMHA practitioners in merged HC/SW roles employed by NGOs were practising in the community. Some were working closely with a general practice but quantitative data about reach are limited. Where possible IPMHA roles enrolled patients/whānau they supported with a general practice but this was not possible in some localities. Alternative pathways to access HIP and HC support included piloting HIP and HC support in schools, and community contexts such as marae.

> *We've had to adapt the model to meet the needs within the rural region that we live in…. I stand by what we're doing, because we've got such a huge non-enrolled population, they're struggling with GPs, and, and they are our priority population. … I think we are unique in that we were trying to do something different, but it's only because we know our communities. (DHB stakeholder)*

> *But that is the constraint of a very bricks and mortar GP centric approach. It diminishes the ability to fully enable that, so we are quite purposeful in our desire to see it more relationship-based, community-lead. (NGO provider)*

Where the person supported was enrolled with the general practice, the GP retained responsibility of care. However, HC/SWs employed by NGOs sometimes worked with people who were either not enrolled or the HC/SW was not communicating with the GP.

> *Nobody's checking patient safety in terms of, is it a good idea if I take them out for a 5k walk? … Is it a good idea if we think they should go on low carbs? (Trainer). Safety is an important factor when considering whether adaptations to IPMHA delivery are acceptable. Safety requires a GP to be available to hold clinical responsibility. (Trainer)*

5.5. Patient/whānau pathways

Patient/whānau pathways varied depending on the way the HC and merged HC/SW roles had been implemented in each district. Merged HC/SWs employed by NGOs and SWs who saw people in the community and connected them to the practices did not report into the MOH database as consistently as HIPs and HCs based in general practices, so we know less about these roles (See Section 2.2). Differences in the comprehensiveness of data need to be considered in interpreting the tables in this section.

5.5.1. First contact point

The first point of contact for patients/whānau was most often the HIP (62%). The most common process was for the GP or practice nurse to refer patients/whānau to

the HIP, although in some practices patients/whānau could be referred through the reception staff, nursing staff or self-refer.

Some patients/whānau were referred by staff directly to the HC and 21% of patients/whānau had first contact with the HC and 11% with a HC/SW in a general practice (Table 14).

Table 14. Proportion of all encounters and first encounters by role and DHB (Source: MOH IPMHA data)

District	Percentage of all encounters				Percentage of first encounters			
	HIP	HC	HC/SW (GP)	HC/SW (NGO)	HIP	HC	HC/SW (GP)	HC/SW (NGO)
Auckland Collaborative	**52%**	**46%**	**-**	**-**	**59%**	**41%**	-	-
Auckland	45%	55%	-	-	57%	43%	-	-
Waitematā	52%	35%	-	-	54%	44%	-	-
Counties Manukau	57%	43%	-	-	61%	39%	-	-
Canterbury	55%	-	40%	-	62%	-	35%	-
Hawke's Bay	60%	39%	-	-	68%	31%	-	-
Lakes*	79%	-	-	21%	90%	-	-	10%
MidCentral*	78%	-	-	21%	94%	-	-	5%
Northland	41%	-	59%	-	48%	-	52%	
Southern	54%	36%	-	-	54%	36%	-	-
Taranaki*	91%	-	-	9%	96%	-	-	4%
Waikato	39%	-	-	56%	53%	-	-	45%
Wellington Collaborative	**57%**	**21%**	**-**	**-**	**75%**	**18%**	-	-
Capital and Coast	60%	11%	-	-	80%	11%	-	-
Hutt Valley	50%	37%	-	-	65%	31%	-	-
Wairarapa	57%	29%	-	-	84%	13%	-	-
Whanganui	50%	-	50%	-	62%	-	38%	-
Total	**54%**	**23%**	**13%**	**4%**	**62%**	**21%**	**11%**	**3%**

**Data are missing for districts shaded orange*

5.5.2. Type of first contact

The first contact was face to face for 59% and by phone for 33%. During COVID-19 restrictions some HIPs and HCs were asked to work remotely and this increased the percentage of first contacts that were by phone (Section 5.6).

Table 15. Mode of contact for first contacts recorded by each role. Other includes missing, text, missing, email and video (Source: MOH IPMHA data).

Roles	Number	Face to face	Phone	Other
HIP	72,366	64%	28%	8%
HC	24,493	49%	47%	5%
SW	2,844	55%	36%	9%
HC/SW - GP based	12,849	57%	39%	4%
HC/SW - NGO based	2,913	55%	31%	14%*
Total	**116,170**	**59%**	**33%**	**7%**

** Includes invalid data*

5.5.3. Same day first contact

The aims of warm handovers are to decrease wait time and increase the number of people who follow through on a referral. The 'warm handover' where the GP or practice nurse takes the patient/whānau and introduces them to the HIP or HC is integral to the model.

The HIPs and HCs we interviewed described aiming to keep a proportion (ideally 50%) of their appointment slots available for warm handovers. Many patients/whānau were seen on the same day – 61% with the HIP, 63% with the HC and 70% with a merged HC/SW based in a general practice[21] (Table 16).

A lower percentage of SW (32%) reported same day first contact, reflecting referrals from the HIP and HC to the SW and the need to connect with patients/whānau in the community.

[21] Patients/whānau may have returned with a new issue which is counted as a new first encounter. Also people may see multiple staff and each will count their first session as a first encounter.

Table 16. Proportion of first encounters in episodes of care seen on the same day as they were referred (Source: MOH IPMHA data). First encounters were defined in the data provided by MOH and are greater than the number of individuals.

Role	Percentage of first contacts seen same day
HIP	61%
HC	63%
HC/SW - GP based	70%
HC/SW - NGO based	61%
SW	32%
Total	**61%**

There was variation between districts in the percentages of patients/whānau seen by IPMHA roles on the same day they were referred (Table 17). Highest rates of same day consultations with the HIP were seen in Southern, Canterbury and Hutt Valley districts.

The data need to be interpreted in the context of part-time roles which limit the feasibility of same day contact. The 'warm handover' has been adapted to fit part-time roles and the different ways practices operate:

- Where the HIP/HC are part-time and/or shared between practices a warm handover can only occur if the HIP/HC is onsite
- In the large practices where communication was usually electronic and/or distance to where the HIPs were located
- In a few practice settings where interrupting the HIP/HC was not considered appropriate.
- Alternatives described to us included 'virtual' warm handovers with introductions by email and/or text and/or scheduling an appointment time when the HIP/HC was available.

Table 17. District variation in the proportion of first encounters in episodes of care seen on the same day as they were referred (Source: MOH IPMHA data). First encounters were defined in the data provided by MOH and are greater than the number of individuals.

	HIP	HC	HC/SW (GP based)	HC/SW (NGO)	SW
Auckland Collaborative	59%	62%			41%
Auckland	60%	67%			87%
Waitematā	50%	52%			34%
Counties Manukau	61%	61%			
Canterbury	70%		58%		41%
Hawke's Bay	55%	71%			
Lakes*	41%			22%	
MidCentral*	39%			25%	
Northland	63%		83%		
Southern	77%	69%			35%
Taranaki*	37%			56%	
Waikato	58%			67%	89%
Wellington Collaborative	60%	48%			13%
Capital and Coast	55%	31%			12%
Hutt Valley	71%	61%			24%
Wairarapa	61%	23%			10%
Whanganui	51%		74%		

**Data are missing for districts shaded orange*

5.5.4. Presenting issues

The most common presenting issue differed by IPMHA role and aligned with expectations in the IPMHA model. The most common presenting issue for HIPs was related to taha hinengaro (mental and emotional wellbeing). HCs saw similar percentages of people for issues related to taha tinana (long-term condition management and health and lifestyle). The differences between HCs and merged HC/SW in general practices relates to differences between districts in roles with Auckland Collaborative HC training focused on taha tinana.

Table 18. The first main presenting issues for patients/whānau. Small numbers of patients/whānau supported with issues related to taha wairua are excluded. (Source: MOH IPMHA data)

	Taha Hinengaro - Mental and emotional wellbeing	Taha Tinana - Long term condition management	Taha Tinana - Health and lifestyle	Taha Tinana - Physical wellbeing - other	Taha Whānau	Other
HIP	66%	5%	10%	3%	12%	4%
HC	11%	31%	36%	6%	7%	8%
HC/SW - GP based	24%	15%	24%	11%	19%	8%
HC/SW - NGO *	53%	5%	8%	9%	18%	7%
SW	24%	5%	14%	8%	42%	7%
Overall	**49%**	**11%**	**17%**	**5%**	**13%**	**5%**

**Data are limited*

Patients/whānau with complex presenting issues and in mental health crisis were described by HIPs and HCs in many interviews. Supporting patients/whānau in crisis challenged many in the workforce. HIPs provided support to 'hold' people until they could be seen by specialist services. They supported them to understand what was underpinning the crisis and to develop wellbeing plans. However, we also frequently heard that patients/whānau were being referred to HIPs with severe mental health conditions where there was no-one to refer patients/whānau to without an extended wait time.

> *When secondary services are indicated the HIP can just be there to talk, to contain, to de-escalate. There's always something that the HIP can help with in that moment however small it may be. And even when people are in crisis, they still need a wellbeing plan … there's something fundamental there that a HIP can contribute to … (HIP trainer)*

The presenting issues were compared between DHBs (Table 19). In all DHBs, issues relating to taha hinengaro were most common. In the Auckland Collaborative and in particular in Counties Manukau DHB, long-term conditions were common presenting issues. Issues relating to taha whānau were a common presenting issue in Northland, Taranaki and Waikato DHBs.

Table 19. The prevalence of first main presenting issues by district (Source: MOH IPMHA data)

	Taha Hinengaro	Taha Tinana - Long-term conditions	Taha Tinana - Health and Lifestyle	Taha Tinana - Physical Wellbeing - other	Taha Whānau
Auckland Collaborative	41%	21%	19%	6%	9%
Auckland	45%	12%	21%	9%	9%
Waitematā	35%	23%	21%	5%	10%
Counties Manukau	41%	25%	17%	4%	9%
Canterbury	49%	10%	19%	4%	11%
Hawke's Bay	53%	10%	18%	4%	13%
Lakes*	60%	4%	16%	1%	15%
MidCentral*	83%	3%	4%	1%	8%
Northland	43%	8%	11%	11%	25%
Southern	40%	5%	27%	0%	11%
Taranaki*	49%	5%	21%	5%	18%
Waikato	58%	5%	7%	6%	18%
Wellington Collaborative	56%	7%	18%	3%	11%
Capital and Coast	59%	6%	12%	3%	15%
Hutt Valley	50%	10%	30%	2%	7%
Wairarapa	62%	3%	8%	3%	11%
Whanganui	66%	4%	10%	5%	12%
TOTAL	**49%**	**11%**	**17%**	**5%**	**13%**

**Data are missing for districts shaded orange*
The percentages of patients/whānau presenting with issues related to taha wairua across DHBs are not included in this table as it only contained 527 (0.6%) patients/whanau.

issues related to taha hinengaro were the most common first presenting issue for all age groups, although the percentage supported for issues related to taha hinengaro decreased with increasing age (Table 20). Taha tinana - long-term condition management was more prevalent in the older age group.

Issues relating to taha hinengaro were the most common presenting issue for Māori. For Pacific Peoples, issues related to taha hinengaro and taha tinana were the main support needs.

Table 20. First main presenting issue by age group and ethnicity for episodes of care. (Source: MOH IPMHA data)

First main presenting issue	Age			Ethnicity		
	15 - 24	25 - 64	65+	Māori	Pacific	Other ethnicity
Taha Hinengaro - Mental and Emotional Wellbeing	67%	49%	35%	46%	30%	47%
Taha Tinana - Long term condition management	3%	13%	19%	9%	30%	12%
Taha Tinana - Health and Lifestyle	13%	18%	18%	16%	20%	18%
Taha Tinana - Physical Wellbeing - other	3%	5%	6%	6%	6%	5%
Taha Whānau	9%	10%	16%	17%	10%	12%
Taha Wairua	1%	0%	1%	1%	<1%	1%
Other	5%	4%	6%	5%	4%	5%

5.5.5. Number of sessions

The IPMHA model is designed for the HIP to provide a focused brief intervention. HIPs ask their patients/whānau whether they need to come back and – where there is a likelihood that another visit will be helpful – will schedule follow-up appointments.

Many patients/whānau had one session with an IPMHA practitioner: 67% of those who received HIP support had one session; 61% of those receiving HC support and 66% of those receiving support from a HC/SW. SW data were limited.

It's brief intervention, but they're there for the long journey. (Trainer)

The ratio of one HIP, I think should be weighted more heavily to that community side of follow-up because of that more intensive longer support. Our capacity fills up quicker because we're seeing people more often. (NGO)

Table 21. The proportion of patients/whānau with different numbers of support sessions by IPMHA practitioner role (Source: MOH IPMHA data)[22]

Number of sessions	Sessions with HIP (%)	Sessions with HC (%)	Sessions with HC/SW (%)	Sessions with SW (%)
Total 1+ session episodes	73,981	38,332	4,163	3,590
1 session	67%	61%	66%	52%
2 sessions	18%	17%	15%	16%
3 sessions	7%	8%	6%	8%
4 sessions	3%	4%	3%	5%
5+ sessions	5%	10%	8%	19%

Episodes where taha tinana - physical wellbeing - other were identified as the first main presenting issue were more likely to have only one session.

Table 22. Number of sessions for each first presenting issue (Source: MOH IPMHA data)

Presenting issue	1	2	3	4	5+
Taha Hinengaro - Mental and Emotional Wellbeing	62%	19%	8%	4%	7%
Taha Tinana - Long term condition management	61%	19%	8%	4%	7%
Taha Tinana - Health and Lifestyle	61%	18%	8%	4%	9%
Taha Tinana - Physical Wellbeing - other	79%	13%	4%	2%	3%
Taha Whānau	64%	17%	7%	4%	8%
Taha Wairua	68%	18%	6%	4%	5%
Other	67%	14%	6%	4%	10%
Overall	**63%**	**18%**	**8%**	**4%**	**8%**

5.5.6. Group sessions

Most sessions were with individuals (85%) but some sessions were held with:

- Family/whānau (4.3%)
- Groups/classes (2%)
- Couples (2%).

[22] Patients/whānau with no sessions with a practitioner type were excluded from analysis as they would most likely have only seen practitioners in other roles.

Examples of group sessions included a support group for people recently bereaved and walking groups.

5.6. COVID-19 impacts

COVID-19 impacted the roll-out of IPMHA services, particularly in Auckland where the longest periods of lockdown were experienced. In Auckland, the HIPs, HCs and SW were part of the first line of defence for the country. IPMHA teams contributed to the COVID response and vaccination drives. Some assisted or were redeployed to COVID testing and vaccinations and supporting the wellbeing of patients/whānau struggling with COVID. The support they provided to the general practice teams helped strengthen their place in the team. There was little respite for workforce between the 2020 and 2021 lockdowns and the emergence of Omicron in the community.

> *But the key thing that we kind of pivoted was around that Omicron surge moment when primary care was in crisis. We made a call to really reach out to them and say, 'Hey, we can really, really help share the load here'. March, in particular, we did about 320 consults with COVID positive patients. (HIP)*

Some general practices asked IPMHA staff to work remotely during the COVID-19 lockdowns and even when staff were in the practices contact with patients/whānau was remote. The lockdowns moved IPMHA support to virtual delivery and in some areas virtual delivery continues to be the main way patients/whānau and IPMHA teams interact (Figure 7).

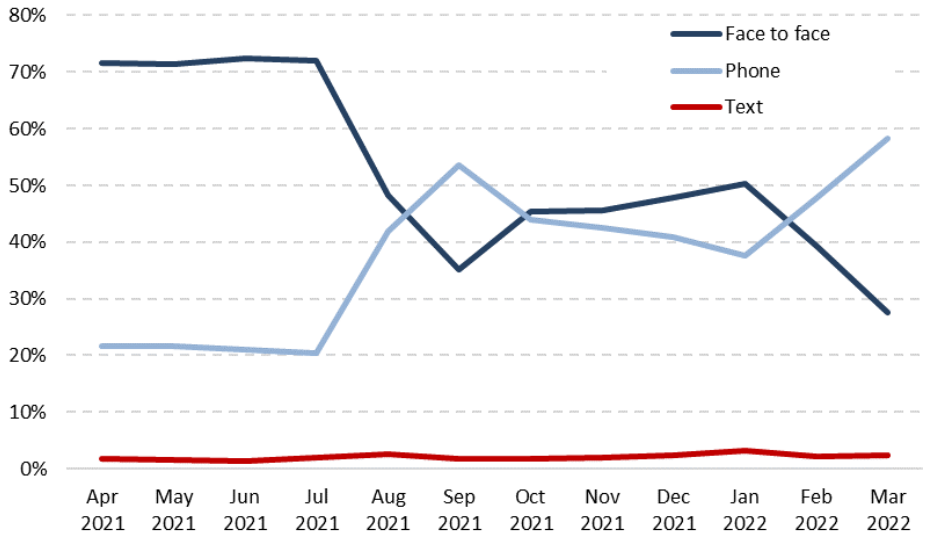


Figure 7. Proportion of contacts of different types in each month

General feedback was that patients/whānau valued phone/online delivery throughout lockdown as the support helped them to maintain wellbeing and progress made pre-lockdown. HIPs and HCs thought virtual delivery worked best

when they were supporting patients/whānau they had already met in person. IPMHA staff and patients/whānau commented that a virtual first meeting made whakawhanaungatanga and relationship building more difficult.

> *Most of the appointments were over the phone. I think that would have been the only thing just to further that connection and that sense of care. There's something about sitting across from the person that you're speaking with and being able to really connect. (Patient/whānau)*

> *Challenging and just because you don't realize how much you get from sitting with somebody face to face. You're kind of having to really listen into the tone of their voice, what they're saying. It was much harder working in that way. But equally so, a little bit easier, because you just pick up the phone, ring your patients. Easier to touch base with follow-ups. It was more so the newer people that were a little bit more difficult to engage over that kind of way. (HIP)*

Working remotely was more difficult for newly trained HIPs and HCs.

> *So you've learned all the stuff and you've been given all this encouragement, but then you can't actually physically be in the clinic, and you can't start seeing patients and you can't have these conversations and build relationships with your practice. (Trainer)*

Trainers also described a reduction in mentoring because of virtual delivery.

> *HIPs are generally more prepared to start and practice than they were under the old programme. But what's missing is the mentoring that used to take part under the original programme. (Trainer)*

5.7. Elements of IPMHA important to whānau

Basing HIPs and HCs in general practice removed the stigma of seeking help for *mental health* challenges and is normalising mental health and wellbeing support within primary care settings. A HIP described IPMHA as *opening the door to a community of support*.

We interviewed a sample of patients/whānau who were attending the case study general practices on the days we were present. Those we interviewed were all positive about the benefits of their experiences. Interviewed patients/whānau were asked what they liked about IPMHA and what was important to them. They described the staff and the way the services were delivered as well as the benefits for them.

- The people. Patients/whānau described liking the IPMHA staff and feeling comfortable with them and being able to talk with them. For some Māori patients/whānau, having a Māori practitioner to talk with was very important.
- The way patients/whānau were supported. Support included practitioners with the time to listen, holistic support, and cultural support.

- The coping techniques and tools.
- Holistic support that included help to navigate the health system and help with basic needs.
- Free service. That the service had no fee was cited as very important by every case study practice as well as by many interviewed patients/whānau.
- Immediacy and accessibility. Support from someone within their general practice was more trusted than a referral to someone they didn't know.

6. The impact of IPMHA services

Evaluation question: The impact of the service model and delivery mechanisms across wellbeing and recovery outcomes for both service providers and service users.

The impact of IPMHA services was explored using qualitative and to a limited extent quantitative data from pre- and post- patient/whānau assessments.

6.1. Patient/whānau feedback

As part of the case studies, we interviewed 39 patients/whānau. In their feedback and feedback from the IPMHA practitioners the positive changes described as result of IPMHA included:

- Positive life changes

  A long time I had a dream and it was to change careers. [HC] goes 'well what do you think about changing careers?' I go, 'I've been thinking about it but it was down to my age'. She goes, 'no you're never too old to try your passion.' So I took her advice and I went around to every [specific business type], put my name out there, told them I'd love to work as part of the [business] because it's something I've always wanted to do all my life. I'm actually there now. … I love it. (Patient/whānau)

- Decreases in AOD

  But the best thing for me was I didn't revert back to my old drug taking ways… cannabis was a big thing, too. Yeah, in all honesty, I did that when my grandad passed away. But I thought it was better than touching any other stupider drugs. But then I got to the point where that wasn't even doing anything. So I just eliminated that. So I'm on top of a quite a lot of it now aye. (Patient/whānau)

- Regaining a sense of purpose in life

  One of the things I'm grieving is I used to cycle a lot, race and I'd be on the bike five days a week, but I have hurt my back and this is the grieving. [The HIP] said, to try and get back on your bike but don't think competitively just think recreationally. That was one of the biggest things suggested to help me, among other bits and pieces. (Patient/whānau)

- Supporting wider whānau

  She has saved whānau going to jail, advocating for the family and being there and getting a lot of break throughs in the system. (Practice manager)

- Employment

  So [name], she's one of our newest and youngest health coaches and she's really good at personalising health plans. She will include yoga and meditation exercises that you can do at home. Just really simple stuff. She'll include a journal so they can

journal stuff. She has had some really good outcomes. One lady ended going and getting a job and [before IPMHA] she lacked motivation, but she's found work. (Kaupapa Māori NGO)

- Reduced stress and anxiety

  For example, we had a hui with a [workplace]… At the hui a young boy and his mum walk in. They were meant to go to somewhere else but they accidently came here. We started talking to them and then we offered our service to help him. His mum was having issues too with stress etc and the son was smoking every day…We've been working with the mum and son to help them get to this place. This shows how having the community and different supports around you can nurture the whānau to make good changes and choices. (Kaupapa Māori NGO)

- Improved wairua

  And one of the Māori HIPs said like we're seeing a lot more people, because of wairua. There's sort of loss of spirituality, loss of connection, as a result of unemployment or social deprivation or relocation or disconnect. And so for them, thinking about the impact of all of those determinants on the wairua of the people they were seeing was a component of the work that they did. (DHB staff)

6.2. Pre- and post-assessments

Duke and Hua Oranga were introduced as potential ways to measure outcomes. The Strengths and Difficulties (SDQ) tool is also available for IPMHA practitioners to use with children and young people but is infrequently used: Pre- and post-assessments were available for 448 people aged under 25.

Duke and Hua Oranga are being used as assessment tools at the start of a session. When people had two or more scores recorded, matched pre-post scores were used to provide quantitative estimates of outcomes. However, there is no effective way in place to assess outcomes for an individual receiving one session of support.

The Duke measures four domains of physical, mental, social, and general health. For the data comparisons for this report, the individual scores in the domains of physical, mental and general were averaged. The scores are out of a possible total of 100. Averages for all patients/whānau in the district were calculated.

Low Duke scores may indicate more complex support needs. When the first recorded Duke scores were considered for all patients/whānau:

- The lowest overall mean scores for general health were in the Hutt Valley, Wairarapa and Waikato.
- Auckland had low scores for physical, mental and social health.

Table 23. Duke scores at first assessment with an IPMHA practitioner (Source: MOH IPMHA data). General health is a mean of the other three components.

	Duke - General Health	Duke - Physical Health	Duke - Mental Health	Duke - Social Health
Auckland Collaborative	59	40	42	47
Auckland [23]	55	-	-	-
Waitematā	67	64	64	71
Counties Manukau	60	53	59	65
Canterbury	52	41	48	58
Hawke's Bay	53	48	51	60
Lakes	52	47	48	59
MidCentral	59	54	51	66
Northland	54	48	53	60
Southern	55	51	52	61
Taranaki	53	44	45	55
Waikato	49	48	47	52
Wellington Collaborative	54	55	45	63
Capital and Coast	55	56	46	64
Hutt Valley	41	31	40	52
Wairarapa	49	50	44	53
Whanganui	55	50	52	61
Overall	55	44	47	54

Pre- and post-intervention comparisons of Duke mostly demonstrated positive changes between the first and last assessments (Table 24). Noting data limitations, the increased scores suggest an increase in wellbeing for patients/whānau in the domains assessed.

[23] Auckland data for the different domains was not available

Table 24. Preliminary data for patient/whānau mean Duke scores matched-comparisons between the first and final HIP/HC session (Source: MOH IPMHA data)

	Number	Mean first score	Mean last score	Difference	% of people with decreased score	% of people with increased score
Auckland Collaborative	3,112	57	65	8	24%	64%
Auckland	1,120	55	61	6	27%	63%
Waitematā	199	60	68	8	22%	63%
Counties Manukau	1,793	58	66	8	23%	65%
Canterbury	1,713	50	57	7	22%	61%
Hawke's Bay	564	56	63	7	22%	61%
Lakes	174	48	60	12	17%	76%
MidCentral*	17	56	62	6	29%	47%
Northland	448	51	60	9	24%	67%
Southern	1,583	54	61	7	17%	68%
Taranaki	253	48	57	9	18%	72%
Waikato	185	50	54	4	28%	46%
Wellington Collaborative	347	52	58	6	29%	61%
Capital and Coast	316	53	59	6	31%	60%
Hutt Valley*	23	43	52	9	22%	70%
Wairarapa*	8	32	39	7	0%	88%
Whanganui	577	54	65	11	16%	73%
Overall	**8,973**	**54**	**61**	7	**22%**	**64%**

**Data are based on very small numbers*

Hua Oranga scores patients/whānau on a scale of one to five for each item in the domains of taha wairua (spiritual health), taha tinana (physical health), taha whānau (family health) and taha hinengaro (mental health. These scores are added to a possible total of 80 across all four domains.

Hua Oranga was used less frequently than Duke. As for Duke, pre- and post-intervention comparisons of Hua Oranga scores mostly demonstrated positive changes between the first and last assessments (Table 25). Noting data limitations, the increased scores suggest an increase in wellbeing for patients/whānau in the domains assessed.

Table 25. Preliminary data for patient/whānau mean Hua Oranga scores matched-comparisons between the first and final HIP/HC session (Source: MOH IPMHA data)

	Number	Mean first score	Mean last score	Difference	% of people with decreased score	% of people with increased score
Auckland Collaborative	225	53	57	4	29%	58%
Auckland	108	53	54	1	31%	52%
Waitematā*	31	51	58	7	16%	74%
Counties Manukau	86	54	59	5	31%	59%
Canterbury	1,625	54	58	4	24%	63%
Hawke's Bay	305	55	60	5	23%	62%
Lakes*	8	50	59	9	25%	63%
MidCentral	35	51	55	4	20%	74%
Northland	175	54	61	7	19%	77%
Taranaki	38	52	60	8	16%	76%
Waikato	245	45	49	4	28%	52%
Wellington Collaborative	452	52	59	7	20%	74%
Capital and Coast	91	50	56	6	24%	73%
Hutt Valley	359	52	59	7	18%	74%
Wairarapa*	2	66	62	- 4	50%	50%
Whanganui	322	58	61	3	29%	64%
Overall	**3,430**	**53**	**58**	5	**24%**	**64%**

**Data are based on very small numbers*

The mean changes between pre- and post- assessments with either Duke or Hua Oranga were comparable between ethnic groups.

Table 26. Differences in pre-intervention outcome measures for patients/whānau from different ethnic groups (Source: MOH IPMHA data)

	The Duke			Hua Oranga		
	Number	Mean first score	Pre-post difference	Number	Mean first score	Pre-post difference
Māori	1,283	51	7	855	55	4
Pacific	647	58	9	142	56	5
Asian	1,057	61	7	174	53	4
Pākehā/European	5,767	53	7	2,196	53	4
Other	177	57	8	50	56	8

6.3. The differences the roles have made to the practices

Interviewed practice staff described the positive differences the IPMHA practitioners are making. Descriptions of the differences included:

- Enabling the GPs and practice nurses to focus more on their clinical practice within the time they had available.

  HIP role works well within practice. Integrates and aligns with GPs and practice. (Case study practice survey respondent)

- Providing someone with expertise patients/whānau with wellbeing issues could be referred to when wellbeing support was indicated.

  The thing that has been most obvious to me is how amazing it is to have good access to services like those provided by the IPMHA team - particularly our HIP and HC who are not limited by other service involvement. (Case study practice survey respondent)

  [Before the HC] I'd go through some lifestyle stuff but it probably just wasn't being done well, whereas now… it gets done well… It's good for me to know that we can sort out the problem properly. (GP)

  I know our doctors have said they wouldn't have been without [the HIP and HC] especially through COVID times because there is a lot of anxiety and stress with our patients around COVID and being isolated and money and all those sorts of things. That in itself has been absolutely fantastic for our service. (Practice Manager)

- Understanding what underpins patient/whānau issues. The longer appointment times between patients/whānau and HIPs/HCs, allow more time to build trust. As a result, some patients/whānau are disclosing information to HIP/HC that they haven't disclosed to GP. Feeding this back to GP has improve their care.

  Patient A was a long-term patient of a doctor. They came in for a consult with the doctor who noticed something and asked if they wanted to talk to the health coach. The doctor did a quick [warm] handover, and what ended up happening was that the patient ended up disclosing something she had never disclosed to the doctor. The doctor … was able to better help that patient …. It opens up more doors that they keep shut while they are with the GP (Practice Manager).

  What I like about both the health coach and the HIP is they gave us very good feedback about their encounters. And so that helps me in the next consultation with that patient as well. … they help clarify sometimes what the problem or what the issue is with the patient and the observations in the next consultation, because then often they can come back to me with a much clearer request or question. (GP)

- Reducing prescribing of medication such as anti-depressants.

  It means we are not having to prescribe medications first off, which I think horribly ineffective for mental health issues anyway (GP)

We are getting a lot more of the doctors not prescribing as quick as they were going to, which is so good. Yes, we can do the meds but let's do something else first. That has been going really well. (HIP)

- Helping to upskill the practice team with advice about mental health support – mostly when the HIP had a mental health background.

  They have said to us, the days that you're not here, they feel lost sometimes. (HIP)

- Providing peer support to the general practice team.

  What they have also done is during COVID, they have got something in the staff room as a five minute meditation tool, a bit of art that you can do just to take your mind off. So they have actually implemented a few extra things for staff, which I think is quite cool (GP).

- Reducing workloads and burn-out and increasing job satisfaction.

  I think the HIP has been the single most important intervention in my whole time in general practice… It means that we are not struggling to deal with those things that we are poor at dealing with, that are taking up a whole lot of time and making us way behind. (GP)

  Doing a good referral, you don't do that in 15 minutes. Talking with the HIP, the HIP can then together with the GP make a call. That makes life so much easier for the GP because that means those next two or three appointments are done by the HC and the HIP and it isn't the GP that needs to do it. They just keep each other informed of what's going on. That really makes a difference. It saves some appointments but also the length of appointments is so much better for them. And I think the outcome for the patient is way better. (Practice manager)

6.4. Differences to NGOs

NGO managers commented on the differences IPMHA had made for NGOs:

- One Māori provider highlighted how IPMHA had empowered the Māori workforce by providing a toolkit for people in kaiāwhina and similar roles and enabled Māori whānau to be placed at the centre of responses.

  I also want to say that this model, what it has done for a Māori workforce is at a five {on a one to five scale] because it has enabled us to have the conversations and dive into people's wellbeing in a different way, with a good baseline of knowledge but having a toolkit then to offer a solution. Whereas traditionally, we have had these Māori kaiāwhina type roles spread around the communities, who for a good decade or two were just there to really broker a conversation and not really offer a solution but be a connector and be a navigator, so to speak. But this enables them to actually have a resource of knowledge and skills and tools to bring a solution. (NGO provider)

- Some secondary services saw IPMHA as a good way for NGOs and GPs to work together instead of being siloed. Many HC come from NGOs so their pre-existing relationships forged connections that previously didn't exist between NGO and GPs. In many districts forming these relationships is ongoing.

  It's quite hard to get into GPs. Generally, they're too busy to engage to find out what services are out there so it's really good that [HIP] links in. (Stakeholder, DHB 11)

- Increase in referrals to NGOs because of relationships the HIPs/HCs have built with them allows them to get more funding.

  Our referrals are up from 64%. (Stakeholder)

6.5. Differences to prescribing

Qualitative information suggests reduced prescribing of medication for depression and anxiety, reduced prescribing of sleeping pills and changes in referral patterns. A system could be set up at MOH to track these changes at practice/PHO and district level.

The doctors will say things like before you guys were here, we would prescribe antidepressants because we didn't know what to do and we would put a referral through to community mental health, knowing it won't be accepted but we don't know what else to do. It's been really lovely having that feedback. (HIP)

6.6. Differences made to interfaces with secondary care

GPs and the IPMHA practitioners described reductions in referrals to secondary care because of IPMHA support. They also discussed building relationships with the secondary care team who had increased confidence that referrals from IPMHA practices would be appropriate.

> *With the role of the HIP we have reduced referrals especially to mental health services. I talked to one of our mental health coordinators at our PHE, he has noticed their referrals are a lot more intense than what they normally are. We look at the really low to moderate, we stop those from escalating into services. We fulfil a big need of people who don't actually fit mental health services. (HIP)*

> *Our referrals coming from primary care probably decreased since the HIP and HCs got put in place. (Stakeholder)*

Some HIPs had secondary mental health experience and could assess people for their appropriateness for a secondary care referral, work with people who don't quite require secondary care/ won't be accepted into secondary care and give advice to GPs making referrals.

7. Effectiveness

Evaluation question: Whether IPMHA provides value for money and the lessons learned that can inform the implementation of IPMHA Services on a broader scale.

7.1. Access and equity of access

Improved equity of access and outcomes are aims to be achieved within the IPMHA programme by rolling out services in practices with high Māori and Pacific populations first and by enabling flexibility so that more health coaching and cultural and social supports could be available in practices with the highest needs.

Analysis of IPMHA data confirms the general practices included in IPMHA have higher proportions of enrolled people with high needs, Māori and Pacific Peoples than enrolled populations as a whole. Overall, 31% of the enrolled population in the IPMHA districts included in the evaluation have high needs compared to 41% in the practices with IPMHA practitioners. The percentage of the IPMHA enrolled population at high needs practices was highest in Counties Manukau, Northland, Whanganui, Lakes and the Waikato.

The reach of IPMHA has been examined by considering the percentage of IPMHA practice enrolled people reached by IPMHA services. The overall reach of IPMHA services to populations enrolled in IPMHA general practices was 3.7% across all ethnic groups and districts. In all districts with robust data, the reach to Māori (4.1%) was higher than for 'other' ethnic groups (3.7%). Reach to Pacific was highest in Waitematā, Canterbury and Southern districts.

Delivery of IPMHA services by Māori and Pacific HCs and HC/SWs was widely reported as helping engage Māori and Pacific patients/whānau. Outcomes for Māori and Pacific who were supported by IPMHA services are comparable to outcomes for other ethnic groups.

Equitable access to IPMHA services has been facilitated by free services. However, equity of access is also influenced by inequitable access to general practice care and barriers to attending general practices for some of those who are enrolled. Some patients/whānau who are enrolled in general practices face barriers such as cost, taking time off work and transport costs. Some general practices in the case studies had developed strategies to reach whānau proactively using registers such as diabetes registers and case management systems to identify people needing different types of support e.g., low frequency attenders, people with poorly controlled diabetes, other chronic conditions.

> *I think that has been one benefit of this programme, it has allowed us to reach out to either the unenrolled and get them enrolled, or the non-engaged and use our community-*

based relationships. We already know one another, these whānau allow us into their homes. (NGO)

In localities with a high proportion of Māori communities, model adaptations to include tikanga and Mātauranga Māori elements and delivery by Kaupapa Māori organisations, including community-based services were described by interviewed stakeholders as helping to reach and support Māori for whom there were barriers to general practice attendance. There is only very limited data available about numbers reached and outcomes from community-based support.

There are ongoing challenges in integrating Kaupapa Māori employed IPMHA practitioners and general practice located practitioners. Bridging the gap between general practices and Māori organisations is essential for fidelity to the IPMHA model in localities where HC/SWs are employed by NGOs and work in the community. Fidelity to the IPMHA model requires a change from traditional approaches to supporting Māori that are embedded in the kaupapa of Māori organisations. Concerns by some Māori organisations about a 'top-down' approach, the cultural appropriateness of the model, lack of clarity about the model and how it aligns with Whānau Ora are barriers to integration reported by some interviewed Kaupapa Māori providers.

The roll-out of other Access and Choice initiatives started after IPMHA because greater time was required for consultation and collaborative design. A separate evaluation of the Kaupapa Māori Access and Choice undertaken by a Kaupapa Māori evaluator is under way. That evaluation and further analysis of improved IPMHA data will help provide clarity about what strategies and model adaptations are working for Māori.

7.2. Choice in addressing people's holistic concerns

IPMHA services are providing choice for people to address their holistic concerns. The evaluation focus was on the 84,270 patients/whānau seen between 1 April 2021 and 31 March 2022 and 236,292 IPMHA sessions they completed. Roll-out is ongoing.

Across all districts and case study practices we heard from managers, IPMHA practitioners and organisation staff that IPMHA is providing patients/whānau with access to wellbeing support that they would previously not have been able to access or would have considerable wait times to access.

IPMHA services are for people enrolled in general practices and there is flexibility to provide support to enrolled patients/whānau outside the physical walls of the general practice. HC and HC/SW support is provided in both general practice and community settings. SWs complement the HIP and HC and provide support in the community.

Interviewed stakeholders suggested national promotion of IPMHA would help raise awareness and increase accessibility. Promotion is difficult when services are not available to all general practices but may become feasible after the 22/23 roll-out to additional practices. Alternatively, promotional material could be produced by districts for use by IPMHA practices.

7.3. Wait times for mental health and addictions support

IPMHA services were designed to provide same day support and same day introductions to the IPMHA practitioner. Between 1 April 2021 and 31 March 2022, many patients/whānau were seen on the same day – 61% with the HIP, 63% with the HC and 70% with a merged HC/SW based in a general practice[24].

The data need to be interpreted in the context of part-time roles which limit the feasibility of same day contact. Where the roles are part-time same day support cannot be provided on days the core roles are not present in the practice. Follow-up with these patients/whānau maybe by phone.

7.4. Population health and equity outcomes

Qualitative and limited quantitative data describe positive differences IPMHA services have made for patients/whānau across a wide range of support needs.

IPMHA services with their various adaptations were highly valued in the districts. Interviewed stakeholders in 10 of 11 districts rated the value of IPMHA services in their localities as 4 or 4.5 on a 5-point scale where 5 was the most positive score.

[24] Patients/whānau may have returned with a new issue which is counted as a new first encounter. Also people may see multiple staff and each will count their first session as a first encounter.

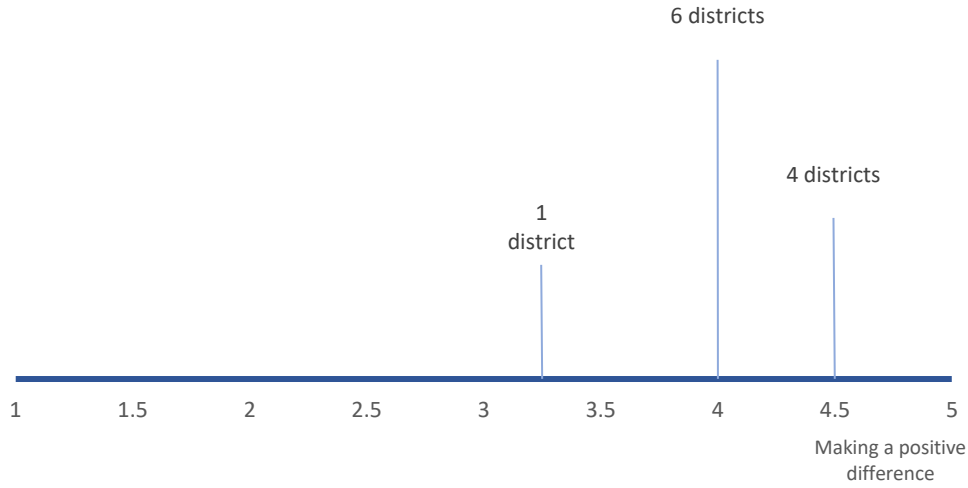


Figure 8. The extent IPMHA services are making a positive difference

Throughout the evaluation those we interviewed provided many examples of how IPMHA services had identified and supported patients/whānau to address challenges that affected the mental and physical health. Examples included:

- Providing tools and strategies to assist patients/whānau to manage wellbeing issues.

  There's been very positive responses because sometimes people just feel overwhelmed and just need a couple of sessions to work through that. And practitioners can give them some tools to manage that. Other times they need more, and then the assessment will help with the referral on. (PHO)

  In the old days we used to see the mum and the baby. And now we just see the baby at the six-week check, and so there's stuff that gets missed. But if… one of the things we do for mum on the sixth week check is offer them a HIP, then maybe they can pick up those post-natal depressions. … (GP)

  [The HIP] gave me exercises, like the grounding techniques and movement exercises that work with your nervous system. Doing those gave me a really big sense of relief, especially initially when I was definitely not feeling very good. The relief in that was so helpful. (Whānau)

  It's amazing. It sounds a bit stupid, but if we put more funding into people like her instead of into the drugs, we would mostly be a better society. Because you're actually learning techniques to help yourself and along the way we'll help our people as well. The drugs won't last, they are masking the issue. (Whānau)

  I've stopped taking all the meds… Those changes I made came from working with [the HC] as you need someone to talk to about certain things, like GPs don't like to hear you're not taking the meds at least with [the HC] I can say I'm not taking that crap anymore, then she suggested the lifestyle changes that might help. (Whānau)

- Reducing isolation.

  We also did the walking group around the lake it was the same group of ladies, I've met some amazing people through that group. (Whānau)

- Helping with whānau.

  She helped out my 10 year old, she didn't have a lot to do but we went for a few walks and made her feel like there was some one she could talk to if needed and [my daughter] will now be doing some art therapy at the same space I did. (Patient/whānau)

- Uncovering challenges patients/whānau do not share with their GP which are impacting on their mental health. For example, identifying issues such as embarrassment and lack of money to buy essentials such as incontinence pads that contributed to depression arising from isolation.

  I pulled everyone together who was going to be involved with her and we had a hui and decided that we needed to bring her in and find from her perspective what was going on. It was really clear that there was a lot of systemic racism in every system she had come in contact with. … it took three days to sort her problem out which took her six months. … all she needed was incontinence pads. She couldn't walk, she couldn't work, she couldn't see whānau …. (HIP)

- Practical support leading to improved outcomes. For example, identifying housing situations where lack of cooking facilities meant the dietary changes recommended by the GP to improve diabetes or cholesterol levels could not be made. Patients/whānau had not shared this information with their GP.

  She got me onto the community kitchen for doing some volunteer work, I mean she would just send emails and texts or photocopies of the newspaper of things that were going on in the community form the kitchen through to art at an art place, so she is constantly sending that info through to help us keep busy. I got the whole package deal, and it's important to have someone pushing that stuff in the community otherwise I wouldn't ever have done it. (Whānau)

7.5. Building the general practice team

General practice teams are the foundation for the new roles. The different general practice ownership models including GP owned, primary health organisation or PHO owned, Iwi Trust owned need to be supported because they influence attitudes to new roles within the practice and how these roles need to be implemented. While ownership models may influence the implementation of new roles and expectations of payment for overheads, the attitudes of the practice lead (GPs and/or practice managers) are important in welcoming and enabling the new IPMHA roles to be effective. Across all case studies, organised and high functioning practices embraced the new roles and utilised them.

It takes time for IPMHA practitioners to be embedded into practices. Interviewed trainers considered a minimum FTE of 0.4 to 0.6 was required to effectively embed IPMHA services in a general practice.

The HIPs and HCs have an important role in introducing themselves to the teams, being proactive in providing support and demonstrating their value. However, responsibility for integration into the team also sits with the local implementation teams. DHB, PHO and NGO managers must also work together to develop ways to embed the HC and HC/SW roles into general practices. These roles are an important part of the IPMHA model but in many districts are not fully integrated into general practices.

In general practices where IPMHA services were embedded, the general practice teams described:

- Increased ability to support patient/whānau wellbeing needs because they could refer them to IPMHA services.
- Ability to refer patients/whānau to IPMHA service reduced GP workload and stress.
- Reduction in the numbers of 'difficult' and 'disruptive' patients/whānau who were often frequent attenders because the IPMHA service helped these patients to learn how to manage their behaviour and helped identify and manage issues underpinning challenges.
- Added value of HIPs with a mental health background who could provide advice about medication and other types of care for patients/whānau with mental health issues. However, some HIPs may also be working outside the IPMHA model to provide this support.

8. Overview and recommendations

The IPMHA model (support using brief behavioural interventions) is evidence based so the evaluation focus is:

- Whether the service is implemented and delivered in Aotearoa New Zealand in a way that is consistent with the evidence-based model
- The extent to which adaptation/variation to the model achieve intended outcomes.

IPMHA services have developed a new workforce that has made a difference to patient/whānau outcomes by improving their wellbeing. Services have been rolled-out to reach all people, prioritising Māori and Pacific Peoples and those with high needs. Young people are also being reached by IPMHA services.

Roll-out of IPMHA services to date provide a solid foundation to continue to develop the services. Additional general practices will be added for the 22/23 financial year.

MOH included implementation funding in district contracts in recognition of the project management and other implementation coordination and planning needs. Districts had flexibility in how they used this funding. Some DHBs used the funding to resource central project management/implementation roles and in others PHOs were resourced to provide implementation support.

Implementation funding will be scaled down in July 2022. However, in many districts IPMHA is not a business-as-usual service. The main challenges are integrating the HIP and HC/SW roles into the general practice team, especially where roles are employed by NGO providers. The need for funding for implementation support is ongoing until IPMHA is established as a business-as-usual service in districts. Some DHBs are committed to IPMHA and will continue to fund support roles but in others where this does not happen, the IPMHA model delivered may drift away from the intended model.

In all districts except Lakes, there are more medium and large practices in the IPMHA roll-out to date and fewer smaller practices. While this will have resulted in providing access to more patients/whānau there are implications for further roll-out:

- Managing part-time roles
- Relatively greater investment of resources to enrolled population in onboarding practices than required for larger practices
- Finding spaces and concerns about overheads that may be more common in smaller practices.

The current ratios of HIP and HCs to enrolled populations seems appropriate. However, in smaller practices a minimum FTE is recommended by the IPMHA trainers and district teams. Allowing districts flexibility to apply the ratio at practice level may be required in the next phase of roll-out to respond to the increasing

numbers of small practices and populations with high needs and maintain model fidelity. In rural localities where clustering of practices is not practical due to distance and travel time, increased ratios may also need to be considered. MOH has offered facilitation support throughout implementation and has responded to feedback from districts by developing resources to support implementation (Appendix Six). Limited support has been provided by the MOH IPMHA team and this has been increased more recently with the addition of access to an experienced IPMHA project manager and HIP trainer.

In the final stakeholder interviews with district DHB and PHO leads we asked about the adequacy of the implementation support they received from MOH. Some stakeholders were very happy with a hands-off approach from MOH. District leaders who did not consider they received adequate support from MOH had wanted more information and support about the model and how to implement a new model of care and establish new workforce roles.

An MOH co-ordinated national implementation team forum provides opportunities for IPMHA project teams to discuss aspects of implementation and to learn from each other. The meetings have been well attended and MOH have been responsive to questions raised. Suggestions from interviewed stakeholders included:

- Opportunities for a forum where more experienced implementation teams including lead HIPs and HCs can problem solve
- A forum for NGOs to discuss issues.

8.1. Implementation learnings to date can inform future roll-out.

IPMHA services are a fundamental shift in approach to enable people to identify what they need and develop and manage their response to improve their wellbeing.

Implementing a new system is challenging without clarity about the vison and a shared understanding of the model. Where there are implementation time constraints a focus on bringing those tasked with implementation together to share understandings of the new service will help to make up for some lag in developing resources.

It is also important to recognise that implementing a new service in multiple different settings such as general practices takes time.

Early roll-out has focused on medium and large general practices. While this will have resulted in providing access to more patients/whānau there are implications for further roll-out that would include more smaller practices:

- Managing part-time roles
- Relative to the enrolled population numbers, more resources are needed to onboard smaller practices than required for larger practices

- Finding spaces and concerns about overheads may be more prevalent in smaller practices.

Recommendation

- An ongoing strong implementation focus is needed to roll-out IPMHA to the new practices, NGO partners and to maintain fidelity to the model. Further funding of implementation leadership roles at an appropriate level is essential for continued roll-out and model fidelity until IPMHA services become business-as-usual.
- There are fixed costs associated with implementation overheads regardless of district size. Reviewing fixed and variable costs and considering allocation of implementation overheads will help support smaller districts. In the districts, the implementation teams may be employed by a large PHO but leave the smaller PHOs and NGO organisations with limited support. Ensure districts make implementation support accessible to all participating organisations and practitioners.
- There is a gap between general practices and NGO providers in many districts. Strong leadership and active facilitation are necessary to close the gap. Ensuring implementation resources are available for NGO partners is also important.
- Review ratios of HIPs and HC to enrolled populations to consider whether a minimum FTE is required in small practices where roles cannot be easily clustered.

8.2. Design

Adaptation of the model to different settings was expected and encouraged. Adaptations now accepted as part of the IPMHA model include additional time for whakawhanaungatanga and introductions, variations in warm handover processes, and different strategies to reach people who were not frequent general practice attendees. Alignment of other adaptations such as adapting IPMHA tools to align with tikanga and community-based HIP and HC services is less clear.

The ongoing impact of confusion about the model at the start of implementation is seen in uncertainty about the extent the model can be adapted. Uncertainty is compounded by differences in the advice from the HIP trainers and ongoing differences between the two HC training providers.

Although IPMHA is general practice based, in many districts the HCs and HC/SW are employed by NGO providers. The focus of implementation has been on implementing the roles in general practices. There is a need to develop resources

about implementing the roles in NGOs, the support the organisations need, the IPMHA service model and how to work with general practices.

IPMHA was rolled-out before the *Access and Choice* services designed for Māori, Pacific and young people were communicated to districts. Lack of understanding about these additional services has contributed to push-back from providers that IPMHA is not a culturally safe service.

Recommendation

Increased clarity is needed in districts about what adaptations of IPMHA will be effective without compromising model fidelity, achievement of goals and patient/whānau and practitioner safety. More data are required to improve understandings of the strengths and challenges of different adaptations and impacts on access and equity. Current data that would inform variations to the model such as the merged HC/SW role are incomplete in some districts and there is not a consistent way to quantitatively record outcomes. Options include:

- Discussing how to enable data from NGO based roles such as the NGO employed merged HC/SW roles and the SWs.
- Workshopping with district leads including Māori organisations to discuss adaptations and the strengths and challenges associated with each. A workshop would allow districts to share experiences and ideas.
- Communication with districts about the targeted *Access and Choice* initiatives and how these initiatives reach not enrolled populations and how to integrate them with IPMHA services so not enrolled people could be connected to these services.
- Developing resources for NGO providers and while maintaining an implementation focus on general practice also including implementation support for NGOs and the IPMHA practitioners they employ.

8.3. Workforce

The roll-out of IPMHA has created new workforce roles. The roles are now established but are not yet a recognised workforce. This creates challenges for:

- HIPs who have to meet the criteria to be a HIP as well as to maintain their professional registration.
- HCs who have different backgrounds. The HC title is quite a generic title and there are different HC training programmes as well as the IPMHA HC training. Establishing HCs as recognised workforce would help to provide understanding of how their roles differ from peer support workers and other similar roles.

- Progression pathways for both roles.

Aotearoa New Zealand's approach to IPMHA emphasises the IPMHA team and not just the core roles. However, the training has been focused on the core roles and not on the team and how it functions. Expansion of elements of training will facilitate ongoing implementation and establishing IPMHA teams in districts.

Recommendation

- Develop online training modules for district leads to complement the existing resources for implementing IPMHA in general practices.
- Filling training gaps by adding training about the model and how the roles fit together and providing expectations to districts about the training gaps they need to fill.
- Considering additions to the HIP and HC tools and resources such as purpose-built resources for virtual delivery.
- Considering what refresher training might be required to maintain model fidelity for HIP practice for HIPs and HCs trained as part of the earlier cohorts.
- Reviewing the trainer workforce – regional trainers were described as an advantage and interviews with trainers suggested the need to review and define the part-time trainer role.
- Continue to progress work to define workforce roles and credentials required to establish HIPs and HCs as a recognised IPMHA workforce.

8.4. Continuous improvement

MOH commissioned process, monitoring and outcomes evaluations to inform the continuous improvement of IPMHA. MOH have responded to evaluation findings as part of a continuous learning process.

Administrative data provided to MOH by the districts has been used for monitoring. It has taken time for districts to develop systems to provide robust data to MOH, one challenge being different PMS used by different organisations. Interviewed stakeholders requested feedback such as monitoring dashboards so they could use the data they provide to inform local continuous improvement.

The use of administrative data for monitoring could be strengthened by:

- Including a robust measure of outcomes. As many sessions focus on a single issue the approach of pre- and post-measures is not useful. A session specific

measure is needed. An example could be the feedback informed treatment session rating scale[25].

- Reviewing the current dataset and considering whether additional data collection is required to respond to practitioner feedback. e.g. collecting more than one ethnic group, including gender-diverse options, and more information about the breadth of HIP support for general practices.

Recommendation

- Strengthen data collection processes for NGO employed roles (as outlined above).
- Provide access to monitoring dashboards for district teams. Even though there are data challenges, providing data back to stakeholders is a very effective way of improving data quality. It is important to understand the data in the context of different district general practices and communities.
- Develop with IPMHA practitioners a simple outcome measure that will inform continuous improvement at practitioner and national level.

[25] https://blog.betteroutcomesnow.com/ors-and-srs-rating-scales-development

9. District summaries

After the final interviews a summary was prepared for each district to summarise the IPMHA approach in that district. The summaries were sent to the districts to review for accuracy.

Auckland Wellbeing Collaborative

The Auckland Wellbeing Collaborative (the Collaborative) consists of Auckland DHB (ADHB), Waitematā DHB (WDHB), and Counties Manukau DHB (CMDHB), Tainui – Mana Whenua, Ngati Whātua, seven Primary Health Organisations (PHOs) covering 335 practices, Māori and Pacific health organisations and many Non-Government Organisations (NGOs).

Auckland has a resident population of 1.8 million[26] and an enrolled population of 1.6 million[27]. The metro-Auckland Collaborative represents the largest population group and caters to almost 40% of the total New Zealand population. Auckland has a diverse resident population including 25% of the total Māori population (200,000 people), 69% of the total Pacific population (295,000 people) and 37% of the total 13–24-year-old population (295,000 young people)[28] [29].

The IPMHA model across the district

The IPMHA model for the metro-Auckland collaborative was informed by key learnings from Kia Kaha (a pilot initiative between Tāmaki Health and Counties Manukau Health testing the Health Coach role working with people who were frequently attending Middlemore ED as a result of poorly managed medical and mental health LTCs), Awhi Ora (NGO and primary care support piloted in Auckland and Waitematā DHB districts) and the MoH funded Fit for the Future pilots (building on existing Awhi Ora and HC roles, but also adding the role, to seven ADHB practices).

Ratio used to allocate roles to general practices: 1 HIP:10,000 and 1.2 HC: 10,000 enrolled general practice population. General practice selection was based on the priority groups and willingness of the practices to participate.

Throughout 2021 and 2022, Auckland experienced extensive COVID outbreaks, clusters and extended lockdowns. Auckland primary care services bore the brunt of the Government's COVID-response, and swiftly pivoted to set up and manage testing and vaccination sites and, minimise harm for the rest of Aotearoa New Zealand. Many primary care practices prioritised and redeployed staff to COVID-response activities which impacted on the roll-out and delivery of IPMHA across the metro-Auckland district.

[26] Stats NZ (2021) Subnational population estimates (RC, SA2), by age and sex, at 30 June 1996-2020 (2020 boundaries)
[27] Stats NZ (2020). Subnational population estimates (DHB, DHB constituency), by age and sex, at 30 June 1996-2020 (2020 boundaries).
[28] Te Pou o te Whakaaro Nui (2018). DHB population profiles, 2018-2028: Statistics New Zealand projections 2017 update. Auckland: Te Pou o te Whakaaro Nui.
[29] Stats NZ (2021) Subnational population estimates (RC, SA2), by age and sex, at 30 June 1996-2020 (2020 boundaries)

The IPMHA roles

IPMHA roles/names	FTEs (MoH Contracted Level to 30th June 2021)	FTEs (actual up to mid-May 2022)	Employer
HIPs	54.6	50.4	PHOs, Primary Care Practices, Pacific Consortium and Kaupapa Māori Providers
HCs	41.8	43.2	PHOs, Primary Care Practices, Pacific Consortium and Kaupapa Māori Providers
Awhi Ora	41.8	55.4	NGOs

These roles are operating across 71 general practices settings, supporting an enrolled population of 535,000 people. The Auckland Collaborative have prioritised culturally matching the HIP and HC with the practice population profile where possible. Awhi Ora see fewer patients but spend more time with those they do see.

The metro-Auckland collaborative continues to implement the integrated model at pace with increasing scale. By 30 June 2023 it is expected that IPMHA will be operating in approximately 120 general practice settings with close to 100 HIP FTE, 84 HC FTE and 84 SW FTE.

Adaptations to the model

As the model is implemented it is continuously reviewed and appropriate adaptations made. Adaptations to strengthen the model include:

- **Within a COVID context:** HIPs and HCs provided virtual and phone services, supports and wellbeing check-ins. GPs booked appointments for referrals which were followed up immediately by HIPs and/or HCs in lieu of warm-hand overs.
- **Within an Aotearoa New Zealand context:**
  - HIPs invest time in whakawhanaungatanga and relationship building before completing assessment tools such as Hua Oranga.
  - Multiple pathways to HIP and HC support are being integrated into the model to address limited reach to priority groups within primary care settings. For example, access to HIP/HC support in a school setting, and through Awhi Ora (i.e., support for people to enrol/re-enrol in primary care to access HIP/HC services). Access via community settings remains a gap which may broaden reach to Māori and Pacific whānau and communities.
  - HIP and HC support has been supplemented by wider wellbeing and Whānau Ora services provided within some Kaupapa Māori and Pacific practices.

Metro-Auckland governance

Governance and leadership are provided by a Strategic Sponsors and Governance Group and Programme Leadership Board. All governance groups include representation from DHBs, PHOs (and Pacific primary care practices), Iwi, NGOs and clinical representatives. The different components of governance and leadership are inclusive and collaborative – supported in part by building on and

maintaining relationships established during foundational pilot programmes such as Awhi Ora and Fit for the Future.

Implementation team

The implementation team provide a central point of operational leadership and coordination. The team includes operational implementation leads, and clinical, cultural and Awhi Ora workforce leads. A Programme Director coordinates and works alongside the implementation team and acts as a conduit between the team, the programme leadership board and the strategic sponsors and governance group.

Managing changes in staff and recruiting and on-boarding new members requires committed time as the initiative continues to progress. However, established staff able to support new members helped to maintain the momentum built in engaging new practices. Project management responsibilities and work transitioned well between the outgoing and incoming project managers.

The implementation team have been critical to the development and delivery of IPMHA particularly during extensive lockdowns. Some practices considered the IPMHA model restrictive for Māori health practices and were reluctant to engage in the pilot. Members of the team created new communication tools and resources to support the recruitment and onboarding of new practices, and supported Kaupapa Māori practices to engage in training and implement/adapt IPMHA to align with the kaupapa of the practice and holistic provision of care.

The extent IPMHA is making a difference

In practices where IPMHA is embedded there are many positive changes. There is considerable qualitative evidence about the positive differences IPMHA is making for practices, staff (including working in a multi-disciplinary way) and patients (who have received immediate access to support for low-to-moderate and complex mental health needs).

Stakeholders described how the impacts of COVID and helping patients manage COVID in Auckland general practices has slowed some aspects of IPMHA support.

Challenges and risks

COVID: As above, extended outbreaks, lockdowns and redeployment of primary and secondary care staff to COVID responses delayed IPMHA delivery, training, HIP and HC preparedness, and recruitment and engagement of new practices. The metro-Auckland collaborative are committed to returning to business-as-usual as soon as possible and are aware of an extensive catch-up task ahead.

Ratio of 1 HIP:10,000 and 1.2 HC: 10,000

- Proportional HIP and HC FTE shared across multiple small practices is a challenge. Primary care use of HIPs and HCs reduces with increased proportional FTEs and does not align with the model of warm handover and immediate access to support.
- One HIP or HC FTE includes time for training, annual and sick leave and does not equate to 40 hours of service delivery. Some practices are also not able to maintain HIP services when a HIP is on leave.

- The ratio does not consider districts with higher proportions of Māori and Pacific presenting with higher and complex needs – and increased levels of intensity throughout COVID.

Workforce capacity and recruitment:

- Extremely limited mental health workforce capacity within primary and secondary care – the current workforce and pipeline for a future potential workforce requires attention. The Auckland collaborative have recently expanded HIP recruitment to counsellors (who have specific training and experience in talking therapies and other modalities similar to HIPs, and an understanding of the fast pace in which primary care operates). There are mixed views about whether training mental health nurses and navigators already based in primary care settings as HIPs and HCs would address workforce recruitment challenges or place additional pressure on an already active workforce and divert commitment to the IPMHA model and direct access to services.
- Expanding HIP qualifications to include counselling qualifications and intentional career pathways for tertiary students studying psychology widens the pool for an extremely limited workforce and for Māori and Pacific practitioners.

Training:

- HIP and HC training does not align with workforce recruitment. The Auckland Collaborative see benefits in developing a regional trainer workforce to coordinate, manage and control training schedules that align with a need to recruit new staff at pace.
- Virtual training and opportunities for in-practice integration were severely impacted by COVID
- Training is needed to broaden understandings about the support provided by Awhi Ora
- Māori and Pacific HIPs and HCs commonly use Hua Oranga as a culturally meaningful, practical and fitting tool with patients. However, not all have been trained in the use of Hua Oranga
- Māori and Pacific HIPs described integrating elements of cultural protocol into practice to adapt the model to their communities, but then being criticised by their trainers for doing this, when their practice is evaluated in phase 2 and 3 training.

Reach: IPMHA reach to target groups is primarily limited to those presenting to primary care. However, access via the community is a key component of Awhi Ora who support people to enrol/re-enrol with the GP to access support. Multiple pathways of access to HIPs and HCs are needed. The Auckland Collaborative are extending accessibility to HIPs and HCs through a school pilot, and communications tools for young people have also been developed (i.e., video explaining IPMHA service).

Funding: Funding for the implementation team decreases over the next two years, despite the team being a key enabler for the pilot and a need for ongoing oversight/management independent from general practices. Transparency of funds is required moving forward, as well as clarity about the potential impacts of shifting from DHBs to Health New Zealand. A commitment and reassurance from Health New Zealand is needed to sustain the implementation team and/or an ongoing body to oversee implementation.

Lack of crisis support: HIPs have provided mental health support rather than brief assessments to uphold the principle of immediate access to support and in response to high numbers of referrals presenting with high and complex needs.

Other district initiatives

Community-based *Access and Choice* initiatives

Access and Choice funded projects for Māori, Pacific and young people are also being rolled-out. Some Kaupapa Māori and Pacific primary care practices involved in the metro-Auckland Collaborative are contracted directly by CMDHB. Although this provides an element of autonomy for reporting, participation at all levels of governance and implementation supports an inclusive Auckland Collaborative approach and partnerships.

Canterbury DHB

Canterbury has a mix of urban and small rural communities. People in Canterbury have been affected by the earthquakes, the Mosque shootings and more recently the rural community has been affected by flooding.

The IPMHA model in the district

Canterbury DHB was part of the Te Tumu Waiora pilot. The IPMHA model used in the district aligns closely with the Te Tumu Waiora model. The HIPs are generally well embedded in Pegasus PHO general practices. The HCs are employed by NGOs reflecting the locality priority of integrated healthcare. The HC roles are less well integrated with the general practices than the HIPs.

Number of general practices: 38 practices on board and the model is being socialized at two additional practices. Full implementation will see 55-60 of a total of 110 practices providing IPMHA support to patients. General practice selection was based on the priority groups and willingness of the practices to participate.

Ratio used to allocate roles to general practices: 1 HIP:10,000 enrolled general practice population.

The IPMHA roles

IPMHA roles/ names	FTEs	Employer	Comments
HIPs	20.8	PHO	
HC/SW	27.5	PHO	There are only two merged HC/SW roles.
SW		NGOs	Eight NGOs are allocated one SW each

Adaptations to the model

The implementation team emphasise the importance of fidelity to Te Tumu Waiora. Some adaptation of parts of the model such as the warm handovers has been necessary in rural practices with shared HIP roles. Additional time for whakawhanaungatanga is incorporated as required.

The HIPs are primarily seeing people with mental health issues and not whole of health. The HCs have been trained by either Health Literacy or Tāmaki Health resulting in differences in how they view their roles. The HIPs and HC are operating more in silos than as a well integrated team. Resistance from some practices to integrate the HC role, partly related to lack of integration between general practices and NGOs, contributes to the silos.

District governance

Governance is provided by the Canterbury Clinical Network.

A focus on shared decision making and inclusion of representatives from the DHB, PHOs and NGOs, general practice, Māori representative, specialist mental health services and consumer perspectives are important elements of Canterbury health leadership. However, not all members have the same commitment to the IPMHA model. Shared decision-making in this context can lead to a more

complex process that can be frustrating for project focused implementation teams such as the Te Tumu Waiora team.

Implementation team

The implementation team includes an implementation lead, a project lead, a DHB contract lead, a HC lead and a NGO liaison lead.

A GP champion has been appointed recently to work with the general practitioners to educate about the model and provide support. The GP champion is employed by Pegasus and is not part of the project team. The GP champion also sits on the governance group.

The district has developed implementation support material for onboarding the HIPs and the general practices. It includes an information pack, socialization visit, more information and a 12-week supported onboarding process.

The extent IPMHA is making a difference

In practices where Te Tumu Waiora is embedded they are seeing positive changes. There is considerable qualitative evidence about the positive differences Te Tumu Waiora is making.

Challenges and risks

Implementation funding decreases in June. The implementation leads do not see this as a risk because processes are in place and oversight will continue to be provided by one role that sits across all primary mental health initiatives in the PHO.

The biggest risk is that people with deep knowledge of the model will leave and there are no mechanisms to pass that knowledge onto others.

Workforce turnover is another risk. Increased workforce development opportunities such as through formal credits could mitigate this risk.

Other district initiatives

Community-based *Access and Choice* initiatives

Access and Choice funded projects for young people and Pacific are just being rolled-out.

Hawke's Bay DHB

The IPMHA model in the district

Number of general practices: 8 practices across 13 sites

Selection of general practices: Expression of interest process, with a panel that decides based on equity, practice readiness etc.

Ratio used to allocate roles to general practices: 1:10,000

The IPMHA roles

IPMHA roles/ names	FTE	Employer
HIPs (Pouora)	10	Mixed – PHO and practices
HC (Poutoko)	11.4 across 15 HCs	Mixed – PHO and practices
SW (Poumahu)	4.5	NGO
HC/SW mixed	2 HC/SW	Mixed – PHO and practices

Adaptations to the model

- Flexibility with length of appointments
- Supporting rural patients with transport when needed
- During COVID Omicron wave, IPMHA service has been offered to anyone who has caught COVID, regardless of whether they were enrolled in a practice. Uptake, however, was minimal.

District governance

DHB, PHO and NGO steering group that initially assisted with IPMHA implementation was disbanded. NGO collaborative continues to oversee SWs. The PHO service lead, and the Health Services and Innovation Group Manager provides oversight over the implementation team.

Implementation team

The main implementation support is from the Health Programme Service Manager, IPMHA Service Lead and HIP Lead (currently a dual role during a maternity cover), and HC Lead.

Professional development and support for HIP/HC

- Monthly in-service meeting with guest speakers
- External webinars and smoking cessation training for HCs
- Te reo Māori classes
- Supervision for both HIPs and HCs.

Training

- Te Pou training – delays on access to training are currently creating hiring delays
- Health Literacy training for HCs – originally used Tāmaki Health but switched to Health Literacy as this training was offered online and did not require HCs to travel to Auckland.

The extent IPMHA is making a difference

- At the service level IPMHA is making a difference for patients/whānau and reducing referrals to NGOs. However, the HIP and HC team are under utilised by practices and receiving a low number of referrals.
- Evidence for the success of the service comes from monthly reports the PHO receives from their HIPs and HCs that provides examples of the support.
- The assessment tool used most often is Hua Oranga because it is most appropriate for their high Māori patient population. Some HCs who were taught to use Duke during early implementation continue to use this assessment tool.

Challenges and risks

- Lack of space in practices. Rent payment is provided by PHO but space is used for COVID isolation or there is no extra space available.
- Approximately half of the HCs – those with a nursing background – were temporarily redeployed to support COVID community testing, the positive COVID clinical team management, and covering nursing staff in practices.
- The NGO collaboration who employ and oversee the SWs are siloed from the PHO who employ and oversee the HIPs and HCs. This makes communication between the implementation team and the SWs difficult.
- There has been minimal utilisation of HCs and SWs in some practices.

Other district initiatives

Community-based *Access and Choice* initiatives: none

The PHO employs talking-based therapists. Some of these are based at or work closely with practices. This service allocated extra FTE for people who are not enrolled in practices.

Lakes DHB

The IPMHA model in the district

Four organisations deliver IPMHA: Rotorua Primary Health Services (RAPHS) in Rotorua and Pinnacle mainly in Taupō) deliver IPMHA across their districts. The two PHOs are committed to working together to provide IPMHA support. Te Arawa Whānau Ora employ HCs and Tūwharetoa employ HCs and one HIP.

FTE for project management and coordination is shared across RAPHS and Pinnacle PHOs and Lakes DHB. The DHB contracted a project manager to sit with the Rotorua model and provided 0.3 FTE for Pinnacle to support the model. RAPHS contracted their own project co-ordinator. Te Arawa Whānau Ora contracted their own HC co-ordinator.

Number of general practices: There are 19 general practices in the district. Eleven RAPHS practices have HIPs (6 HIPs) and four Pinnacle general practices (3.9 HIPs and 2 HCs). A Rotorua based HIP also provides support to two Pinnacle general practices in Rotorua. In Southern Lakes there are two large general practices and two small general practices with enrolled populations between 3 and 4,000.

One rural general practice in Mangakino is not covered by IPMHA but has a 0.4 HC FTE subcontracted through Te Arawa Whānau Ora and funded by Lakes DHB.

Ratio used to allocate roles to general practices: Stakeholders considered the ratio of 1:10,000 was appropriate. Demand varies, with some areas worked to capacity or beyond and in other areas IPMHA was not fully implemented and demand may increase.

The IPMHA roles

IPMHA roles/ names	FTEs	Employer	Comments
Southern Lakes			
HIPs	3.9 FTE across 5 people	Pinnacle	
	1 FTE	Tūwharetoa Health	
HC/SW	1.8 FTE	Tūwharetoa Health	1 FTE in Taupo and Turangi
Northern Lakes			
HIPs	6 FTE		In RAPHs practices
HC	6.8 FTE	Te Arawa Whānau Ora	In Rotorua. They support their whānau by adapting IPMHA through a te ao Māori lens.

Adaptations to the model

Interviewed stakeholders described variable fidelity to the IPMHA model.

In Southern Lakes and Northern Lakes, HIP practice is consistent with the core IPMHA model. The Tūwharetoa HIP contract allows community consultation in different locations and other adaptations such as consultation time may also vary from general practice-based roles.

The HCs are not based in general practices and accept referrals from other places with 94% of referrals not from general practices. The Tūwharetoa and Te Arawa Whānau Ora Health HC roles allow longer sessions, more flexibility and co-facilitation. Whānau they support are enrolled in a general practice or the HC assists them to enroll if possible – some general practices are not taking new enrollments.

All stakeholders identified a need for greater integration between the HCs and general practices in both Southern and Northern Lakes.

District governance

The DHB manages the contracts. The DHB and the leads from the four providers meet monthly. An increased focus is planned to bring together the four providers to agree on the IPMHA model that will deliver a consistent district-wide service.

Implementation team

In Northern Lakes in the early stages of implementation, lack of understanding of IPMHA and insufficient dedicated resource for implementation led to challenges in establishing fidelity to the model. Appointment of a HIP lead has strengthened implementation.

In Southern Lakes, there was effective socialisation of the model and the practices were early adopters. Southern Lakes has a stable workforce and has not had the recruitment issues described in many districts.

The extent IPMHA is making a difference

Interviewed stakeholders considered IPMHA was making a positive difference across Lakes. IPMHA support has opened access to mental health support earlier and provided other options to support whānau wellbeing.

Challenges and risks

- Fidelity to the model differs across the different providers in the district.
- While there is progress towards four providers working together as one team with a shared understanding of the IPMHA model there is a need to improve integration between the general practices and HCs. HCs are not integrated into practices and space is described as a challenge for some general practices. Lack of integration between HCs and general practices results in limited awareness of the HC role by GPs.

MidCentral DHB

The district varies in terms of population demographics and level of need. Horowhenua is characterised by a diverse rural population, a high proportion of Māori and a high level of need. There are GP shortages and a substantial not enrolled population.

The IPMHA model in the district

The model is Te Ara Rau *Access and Choice* and the roles are Mātanga Whai Ora (HIPs) and Kaiwhakapuaki Waiora (HCs).

Number of general practices: There are 32 general practices in the district and only four are taking new patient enrolments. If fully staffed, Mātanga Whai Ora will be in 11 general practices and four Iwi Māori providers. Mātanga Whai Ora may also receive referrals from general practices they are not located in.

Ratio used to allocate roles to general practices: The ratio has been applied at district level. The DHB considers one HIP and one HC are needed in each community as public transport between some communities and the nearest health providers is very limited. Stakeholders suggest a ratio of 1:7,000 would better meet the needs of MidCentral communities and take into account the number of general practices with small enrolled populations.

The IPMHA roles

IPMHA roles/ names	FTEs	Employer	Comments
HIPs - Mātanga Whai Ora	Funded for 14.4 – have 11.4 FTE	PHO – THINK Hauora except for 1.5 FTE sub-contracted to NGOs.	The FTE is slightly less than funded due to recruitment challenges. FTE will be up to 16.3 for each role in July 2022.
HC/SW - Kaiwhakapuaki Waiora	10.7 FTE	Iwi Māori providers	
Pasifika Health Coach (x2) and Refugee Health Coach (x1)	3 FTE	PHO – THINK Hauora	

Adaptations to the model

Stakeholders considered the model was sound and helps Mātanga Whai Ora consolidate a holistic perspective. At a district level, concerns about how to reach the not enrolled population has led to location of some Mātanga Whai Ora with Iwi providers and NGOs and referrals to a central point.

The service manager and clinical lead provide a contact point for HIPs work outside general practices and who are also linked with a GP.

Individual Mātanga Whai Ora adapt the model to meet the needs of the person they are supporting. A common adaptation is inclusion of time for whakawhanaungatanga.

District governance

A mental health and addictions operational executive provide oversight. The portfolio manager and the service manager carry operational responsibility.

The PHO employers of the Mātanga Whai Ora and Iwi and Māori employers of Kaiwhakapuaki Waiora are included in discussion but not decision-making.

Implementation team

The DHB employs a service manager who acts as a conduit between the DHB and the PHO. The service manager is a subject matter expert who is key to implementation and decision-making. The role is partly funded from IPMHA implementation funding and the DHB has funded additional FTE for this role. The DHB will continue funding the role after implementation funding ends. The PHO employs a clinical lead.

Kaupapa Māori support has been contracted to assist with implementation and to develop ways of describing IPMHA and the roles using te ao Māori concepts.

Duke and Hua Oranga are both used as assessment tools. Use of Hua Oranga has been increasing.

The extent IPMHA is making a difference

IPMHA is making a positive difference in MidCentral and stakeholders described it as improving equity of access to wellbeing support. The main elements underpinning effectiveness is that the service is free and non-judgemental and reduces stigma associated with mental health services. Stakeholders reported a reduction in referrals to secondary mental health services.

Challenges and risks

Recruitment has been an ongoing challenge, especially in Horowhenua. Salaries and the risk of loss of staff to higher paying organisations is a risk when recruitment is difficult, especially for the Kaiwhakapuaki Waiora who are paid on a non-clinical scale.

Integration between the Mātanga Whai Ora and Kaiwhakapuaki Waiora is progressing. A priority for the implementation team is to improve the interface and communication between the roles.

Implementation is some general practices is challenges by lack of space, especially for Kaiwhakapuaki Waiora who are not based in the practices all the time.

Remote and rural practices pose an implementation challenge as a minimum FTE is required for small remote practices to make the roles feasible.

The district has nurse practitioner clinics where GPs are not always on site. Reporting lines to nurse practitioners rather than GPs are being discussed.

Other district initiatives

Community-based *Access and Choice* initiatives

Not integrated with IPMHA.

Northland DHB

The IPMHA model in the district

IPMHA in Northland is called Te Tumu Waiora. The 12-month Northland Te Tumu Waiora pilot was launched in late 2018 as a joint initiative between the Northland DHB, Manaia Health PHO and Arataki Ministries[30]. Three tranches have been rolled out. Planning for the fourth and final tranch roll-out is underway, made up of mostly small remote rural practices. Te Tumu Waiora will be fully implemented across 35 practices by the end of 2023. Twenty-five of Northland's general practices has Te Tumu Waiora roles in place.

Te Tumu Waiora roles as of May 2022

IPMHA roles/ names	FTEs	Employer	Comments
HIPs	13	Mahitahi Hauora Comprehensive Care	Mahitahi subcontracts two Māori health providers, Hauora Te Hiku and Ngati Hine Health and Social Services Trust.
HC/SW flexi role	17	Arataki Ministries Te Mana Oranga Hauora Te Hiku Hokianga Health	NGO collective employs HC/ SW across the district.

Adaptations to the model

- Northland was the first district to combine the HC and SW roles. This adaptation proved successful and addressed the challenge of fragmented FTEs in practices. The merged role is now standard practice across Northland.
- Many Northland general practices have an enrolled population of less than 10,000, so GP practices are grouped in "clusters", and a HIP and HC/SW will work with one cluster (made up of multiple practices).
- Connection is critical in Northland. Therefore, additional time for whanaunatanga is incorporated into sessions as required.
- One lead HC/SW organisation works with all the NGOs who employ HC/SW in the district. This adaptation has been successful in ensuring consistent messaging.
- If the GP practice meets with patients in other settings, the HIPs and HC/SWs replicate that. For example, in Kerikeri, the HIP visits a residential home for the elderly alongside the GP. Another general practice runs a clinic at a marae once a month which the HC/SW also attends.
- Northland trialled partnering with a community youth service to place a HIP in a local secondary school. But, without GP clinical oversight in the school and the school's lack of

[30] Community-based support for people with mental illness in Northland

understanding of the difference between the HIP and a school counsellor, the role of the HIP deviated too far from the intention of Te Tumu Waiora and the HIP was withdrawn.

- Regardless of who employs the HIP or HC/SW, the Northland Implementation Team intentionally include the general practice in recruitment which helps with relationship building.
- GP practices had to adapt to COVID-19 restrictions. E.g. virtual consults rather than face-to-face and HIPs and HC/SWs working on different days to accommodate work "bubbles".

District governance

A steering group established for the Northland collaborative as part of the pilot continues to meet. The steering group has representatives from Northland DHB, PHOs, the NGO collaborative lead, a GP Practice Lead, Consumer Lead and Iwi representation.

Due to the introduction of two new PHOs in Northland, the DHB is looking to establish a new HIP clinical leadership role to provide support across all practices. Similarly, work is underway to create a new Māori HIP leadership role.

Implementation team

The implementation team has representation from the PHO, NGO collaborative, HC/SW Lead and HIP trainers. This group focuses on higher-level governance discussions.

Separate monthly HIP and HC/SW operational meetings have started to replace the operational group meetings originally established during the pilot. Stakeholders consider role-specific meetings more effective at providing peer support and continuous learning for each role.

The HIP trainers and PHO lead provide monthly peer support. A third of the HIPs identify as Māori, and recruitment processes are mindful of employing HIPs who reflect the population of their working practices.

Northland has moved away from utilising Tāmaki Health to Health Literacy New Zealand for HC/SW training as this seemed to be more aligned to the HC/ SW flex approach.

The lead HC/SW is Māori and makes herself available to discuss any questions about cultural responsiveness and te ao Māori practices. Over 50% of the current HC/SW workforce in Northland identifies as Māori. In addition, each NGO meets with their HC/SWs every three weeks for peer supervision.

The extent Te Tumu Waiora is making a difference

GP practices have spoken of how invaluable Te Tumu Waiora has been, and as word of mouth spreads in communities and whānau since the first pilot, more and more GP practices are interested in being part of it. There is also an increasing number of self and whānau referrals.

The Northland team have been developing 'pathways' including wellbeing checks for patients who are enrolled and have not been presenting at the practice for a period of two years or more. This outreach has been a useful way of letting patients know that the Te Tumu Waiora service is now available in the practice and linking patients back into the practice.

Challenges and risks

COVID-19 has caused some delays in the recruitment and onboarding of GP practices, who (rightly) prioritised their COVID-19 response. Unfortunately, it also added to GP practice stress, and it has taken time for the implementation team to re-establish contact that had dropped off due to the COVID-19 response.

Recruitment, especially in rural and remote areas, continues to be a challenge. The FTE allocation of 1:10,000 across rural and remote areas does not take into account travel time between practices. Small rural practices also struggle to have 'space' for a HIP or HC/SW, and so practices work together to support service delivery.

Employing non-registered health clinicians in the HIP role could alleviate some pressure by opening up a new pool of candidates (e.g. appropriately registered counsellors). In addition, combining the HIP/HC/SW role may allow smaller remote practices to deliver services.

Northland DHB has tried several avenues to engage young people via the IPMHA model, including trailing a HIP in a local secondary school and employing a youth worker to work alongside the HC/SW and linking them to the local school health clinic. There was limited success in both approaches due to the loss of integration within general practice. HC/SWs receive additional training (funded by NGOs) to engage with young people. There are multiple services in Northland with youth contracts, and the challenge is how best to partner with them to ensure full coverage and avoid service duplication.

There is a GP shortage in areas of Northland, and some GP practices are not taking on new patients, which has an impact on the reach of Te Tumu Waiora.

There is some concern that the implementation funding will stop at the end of 2023, regardless of whether or not IPMHA is fully implemented across the country. Interviewed stakeholders considered there is still a lot of work to be done to support the integration of the model across practices in Northland.

Southern DHB

IPMHA in Southern is called Tōku Oranga

The IPMHA model in the district

Number of general practices: IPMHA has been implemented in 33 practices – two-thirds of the population.

Selection of general practices: The priority criteria of the proportion of enrolled Māori, Pacific and youth were used to rank practices to achieve the most overall impact based on those criteria. Expression of interest rounds were also run as part of the selection process.

Ratio used to allocate roles to general practices: 1 HIP, 1 HC, 0.4 SW for every 10,000 practice population. Kaupapa Māori providers have one FTE of each role with a lower population rate.

The IPMHA roles

IPMHA roles/ names	FTEs	Employer	Comments
HIPs	19.2	PHO	There is one PHO in the district,
HC	15.6	NGOs	There are six NGO/Māori health provider employers
SW	7.6	NGOs	
HC/SW combined	2.5	NGOs	Mostly in smaller practices with small FTE allocations. The blended role is still called a HC.

Adaptations to the model

Two Kaupapa Māori providers employ the HC and SW within their Kaupapa Māori practices. The model in these providers is more community-centred. For example, the HC and SW spend more time following up with people at their houses and getting involved alongside patients/whānau in community programmes.

During COVID outbreaks, part of the HIP and HCs' roles have changed to support people through organising food parcels, dropping off medications for people self-isolating and providing phone support to people with COVID. COVID-positive patients from practices that don't have the IPMHA roles, may be referred to a HIP at another practice for support during their isolation.

HCs also support the Well South smoking cessation call centre alongside their normal caseload.

HIPs adhere to the 30 minute appointment model. For HC the focus is on the number of patients supported which they achieve through longer sessions, holding groups and phone call follow-ups.

District governance

There is a steering group that includes the service manager from the local PHO and the six NGO employers. This group meets once a month to discuss the service and implement any changes needed. The steering group provides both governance and operational overview. The DHB is not involved in delivering the service – it is primary care and community led.

Implementation team

The implementation team consists of the *Access and Choice* clinical services manager and *Access and Choice* programme project manager. They are supported by the two HIP team leaders, HC lead, and SW lead.

The extent IPMHA is making a difference

For practices, IPMHA is a popular service. There is a waitlist of practices wanting to implement IPMHA. The implementation team have also captured stories from patients of the positive impacts the service has had on their lives.

IPMHA delivery

HCs have been trained by Health Literacy New Zealand. This training is supplemented by training material created by the implementation team. People in the HC/SW blended role also complete the HC training.

Both the Duke and Hua Oranga are used as assessment tools and are chosen depending on what the HIP or HC consider most appropriate for the patient/whānau. The same tool is used across all sessions with the patient/whānau to maintain data consistency.

Challenges and risks

- In rural areas, it has been difficult to recruit people who fit the role requirements.
- Access to HIP training has been a challenge.
- Because practices have been used to working separately and remotely during COVID outbreaks, going back to the IPMHA model that includes warm handovers has been an adjustment in some areas.
- Maintaining consistency across the NGOs that employ the HCs, SWs, and the dual role is has been challenging. This is managed by having lead HCs and SWs who work across the NGOs and ongoing organisational conversations.
- There is no specific training for SWs and people in the blended role.
- Space in practices to house HIPs and HCs in offices has been a key difficulty in implementation.

Other district initiatives

Community-based *Access and Choice* initiatives: none.

Taranaki DHB

The IPMHA model in the district

Te Manawanui is the Integrated Primary Mental Health and Addictions initiative in Taranaki. In Taranaki the focus has been on a multi-organisation partnership to integrate primary mental health responses across the DHB.

Number of general practices: There are nine HIPs employed across 11 general practices. Not all practices are eligible because of low representation of the priority populations in the practice enrolled populations. Access to HIP support is also limited by the relatively high proportions of not enrolled population.

Ratio used to allocate roles to general practices: The ratio of 1:10,000 enrolled populations was applied to initially allocate HIP FTEs. Subsequently the ratio has been adapted based on the needs of the practice population, the practice size and the extent the HIP was utilized by the practice.

The kaitautoko were allocated based on Iwi boundaries to three districts. A hub and spoke model is the basis for delivery with each Iwi provider being the employer and managing kaitautoko services in their areas.

The IPMHA roles

IPMHA roles/ names	FTEs	Employer	Comments
HIPs	6.4 FTE	PHO	All HIPs are PHO employed and supported by a lead HIP also employed by the PHO.
HC/SW/ Cultural worker - kaitautoko	9.0 FTE (9.6 FTE funded)	Iwi providers	Hybrid HC/SW and cultural worker roles combined into a single Kaitautoko role. Not well integrated into general practices.

Adaptations to the model

HIP practice emphasises fidelity to the IPMHA model. However, there may be some adaptation of the HIP role to fill the gap left by lack of integration of kaitautoko with general practices. The HIPs use Duke or Hua Oranga for assessments, depending on their personal preferences.

The kaitautoko role combines the HC, SW and cultural worker roles to support whānau. The kaitautoko combined roles and employment by Iwi health providers has the potential to reach not enrolled people and/or refer people not enrolled in a general practice to other community services.

District governance

The Te Manawanui Collaborative includes Pinnacle PHO and Te Kawau Mārō (TKM) Alliance of kaupapa Māori health providers, Ngāruahine, Ngāti Ruanui, Taranaki DHB, Tui Ora and Pathways NZ.

Implementation team

The HIP implementation is dependent on a lead HIP who is also a trainer. The HIPs are well supported by the lead HIP and meet regularly as a group.

The kaitautoko are managed by the employing provider organisation and alignment of implementation of the role to the IPMHA model varies.

The extent IPMHA is making a difference

Interviewed stakeholders were positive about the benefits of Te Manawanui to Taranaki but also considered integration of the HIP and kaitautoko roles had the potential to strengthen the model and benefits.

IPMHA is providing opportunities to strengthen the Māori workforce and kaitautoko are providing positive role models and some are considering extending their training to include other health roles.

Challenges and risks

The main challenges faced in establishing IPMHA in Taranaki are:

- The need for a focused facilitator role to integrate Te Manawanui as a multi-organisation partnership and reset the delivery of IPMHA including integrating the HIP and kaitautoko roles.
- The impacts of COVID including loss of some kaitautoko as a result of the vaccine mandate for health workers and reluctance of general practices to have kaitautoko come into the practices during COVID.
- Establishing IPMHA in small practices and rural locations. One practice does not currently have a full-time general practitioner and is in a community with potential to benefit from IPMHA.

Other district initiatives

Community-based *Access and Choice* initiatives

Other *Access and Choice* initiatives are starting to be implemented. There is a risk of new initiatives creating silos and becoming barriers to a multi-organisation approach to primary mental health.

Waikato DHB

In this district, a joint application to deliver IPMHA services within the district was submitted by the DHB on behalf of the Whānau Pai Collective. The collective consists of four Kaupapa Māori NGO providers, three PHO providers and DHB representatives. HIPs and HCs are employed by the Kaupapa Māori providers. PHOs provide brokering support into GP clinics where relationships don't already exist between NGO providers and the clinics. The DHB provide project management support to the collective.

HIPs and HC/SW roles operate as a pair. Flexibility with role titles to fill the funded HC/SW non-clinical components of the IPMHA have been adopted by the Waikato providers. The providers consider the activities in the non-clinical positions meet the contractual requirements of the funded HC/SW positions.

IPMHA roll-out has happened in tranches. Due to COVID, not all clinics from tranche two have been onboarded.

The IPMHA model in the district

Number of general practices by provider

Provider	GP Clinics	Engagement
Taumarunui Community Kokiri Trust	10 (Tranche 2) 1 (Tranche 3)	8/10 (Tranche 2) 0/1 (Tranche 3)
Te Korowai Hauora o Hauraki	9 (Tranche 2) 9 (Tranche 3)	8/9 (Tranche 2) 1/9 (Tranche 3)
Te Kohao Ltd	12 (Tranche 2) 9 (Tranche 3)	8/12 (Tranche 2) 3/9 (Tranche 3)
Raukura Hauora o Tainui	12 (Tranche 2) 4 (Tranche 3)	4/12 (Tranche 2) 0/4 (Tranche 3)

Selection of General Practices – Equity weightings were applied in the selection and timing of the roll-out of services to general practices. This means practices were prioritised based on their percentage of Māori, Pacific, Youth and those whānau living within rural areas to ensure target groups (as defined by MoH) can access the service.

Allocation - MoH allocated funding based on a ratio of 1 HIP:10,000 ESU (Enrolled service user). This allocation may work for large urban populations located within close proximity to a general practice, however, the Collaborative consider it does not provide equitable coverage across smaller rurally dispersed populations such as those that exist within significant parts of the Waikato. This impacts both the level of resource available to rural practices and the provider's ability to recruit e.g. some practices may be allocated a 0.33FTE based on it's population, with a HIP needing to provide services across a number of general practices to cater to the 10,000 ESU despite travel not being factored into the minimum number of patients/whānau needing to be seen by each HIP – 8/10 ESU per day.

The IPMHA roles

FTE allocation across providers

IPMHA roles/ names	FTEs	Employer
HIPs	18.9 FTE employed across the district as at 31 March 2022	5 – Taumaranui Community Kōkiri Trust 4.9 – Te Korowai Hauora o Hauraki 6 – Te Kohao Ltd 3 – Raukura Hauora o Tainui
HC/SW	29.1 FTE employed across the district as at 31 March 2022.	8 – Taumaranui Community Kōkiri Trust 9.6 – Te Korowai Hauora o Hauraki 10.5 – Te Kohao Ltd 1 – Raukura Hauora o Tainui

** Note that this is not the full extent of FTEs funded, as these are staged over three years to June 2023.*

Adaptations to the model

Consultation timeframe extension

- Extending timeframe of sessions to enable whakawhanaungatanga to take place in a meaningful way. A prescribed timeframe is not placed on these initial visits.

Practising offsite

- HIPs and HCs are not always present in the GP clinics. The model has been adapted to reduce travel time and therefore increase time spent with whānau. GPs will send a referral through to the HIP. The HIP will complete an initial phone consult and arrange to meet with whānau. Providers and clinics consider this a warm handover.
- To enable access to rural communities moving away from the GP clinic model was necessary. GP clinics did not always have available space, and some GP clinics did not want external providers accessing their patient management systems. The decision was made, by providers and clinics initially, and then supported by the wider collaborative, to continue to offer the service to the community. GP referrals were still required; however HIPs and HCs were based off-site and kept their own patient notes with a feedback loop to GPs offered via email.

District governance

Since the beginning, a collaborative of Kaupapa Māori services, PHOs, NGO providers and the DHB have worked together to provide regular and on-going governance and oversight of Whānau Pai - IPMHA.

Implementation team

Each Kaupapa Māori provider leads implementation to provide services into allocated general practices within their rohe, with support from PHOs and DHB as required.

Training – Te Pou provided HIP training. Mahi ā-Atua is used for culturally informed care training. Mahi ā-Atua training was approved by MOH but was required over and above HIP training. Health Literacy NZ was the provider used for HC training.

The extent IPMHA is making a difference

Service integration is making a difference for whānau. Where roles are based within clinics, relationships and understanding of IPMHA strengthen service integration across GP clinic services. NGO providers offer access to other community services and this provides additional support options for whānau.

The Waikato DHB acknowledges that improvements in the reporting system are required and is working in collaboration with its Whānau Pai partners and MOH to ensure mechanisms that support timely and robust performance reporting are being implemented. Current reporting is output based and manually entered. There would be real benefit in being able to report on outcome measures, as these would better indicate the difference being made through IPMHA as they are whānau driven.

Outcome Rating Score and Service Rating Score are tools used as part of feedback informed treatment. This is not required for contract reporting but is part of one provider's service model.

Other providers use Duke. This tool is mainly used by HIPs. HC are using Whānau Ora assessment tools.

Challenges and risks

Reaching the priority groups

- In this district, 20-25% of the Māori population are not enrolled with GPs. To enable access to IPMHA services, HIPs and HCs/SWs support whānau to enrol so they can receive the appropriate supports.

COVID

- As seen nationally in reponse to COVID, GP Clinics, Kaupapa Māori providers, PHOs, NGOs and the DHB focus moved to respond to Covid. This naturally delayed on boarding clinics, training of HIPs and HCs/SWs, and face to face engagement with whānau.

Staffing

- Recruitment and retention of staff has been an ongoing issue. Staff shortages arising from inability to recruit and delays in training staff after recruitment have contributed to some clinics not receiving the resource allocation they were expecting.
- HIP and HC/SW fit within clinics is important to building relationships with clinical staff, How these roles are welcomed and received by clinical staff/general practices is key in the successful implementation of the new roles.
- Having four different Kaupapa Māori providers has enabled better locally based options to support Māori whānau to engage in mental health and addiction supports earlier and closer to home. The different approaches by each provider, however, have been challenging for some GP services who are accustomed to the standardised implementation approach delivered by PHOs.

- Staff shortages also limit the extent staff are available to cover HIPs when they are unavailable or sick. There is an increased risk of staff burn out with no relief being available for them.

Understanding of IPMHA service.

- Reluctance of GP clinics to receive IPMHA services was due to a lack of understanding of the service. This was reinforced by referrals that didn't always meet the IPMHA criteria. There is an opportunity to strengthen communication about the service at all levels.

Different PMS Systems.

- HIPs are required to be trained in different PMS systems dependant on which clinics they are placed in. Some providers also have their own PMS. Sharing protocols have been a barrier for some GP clinics who did not want external contractors accessing their PMS system. The inability of different systems to talk to one another has been a barrier from a provider perspective. Data not sitting in one place, or able to be extracted easily, means outcome and output measures could be missed. Data are merged manually for reporting.

Other district initiatives

Community-based *Access and Choice* and other initiatives

National Hauora Coalition – Mahi ā-Atua, delivers services focused on the Matamata, Waharoa, Taumarunui, Te Kuiti, Hamilton and Tokoroa areas of the Waikato DHB area.

- Kaupapa Māori primary mental health and addiction services Kaupapa Māori services are available for people of all ages. They are whānau centred, delivered for Māori by Māori and incorporate Te Reo, tikanga and Mātauranga Māori within their services. This provider began offering services as 9 December 2021.

Emerge Aotearoa – Ease Up! Delivers services in the South Waikato area of Waikato DHB.

Pathways Health Ltd – Whetū Mārewa (Youth Service – Greater Hamilton area). Currently servicing Hamilton and looking to expand into Hauraki.

- Youth services are aimed at 12 to 24-year-olds in places that are acceptable for and accessible to young people. These two providers began offering services as of 9 December 2021.

K'aute Pasifika Trust – Pacific primary mental health and addiction services

- Pacific services are available for all ages and targeted to areas with the largest Pacific populations. The services is Pacific-led and incorporate Pacific values, beliefs and practices, language, and models of care. This initiative expands on the existing service provided by K'aute Pasifika Trust.

Wellington DHBs (Capital and Coast, Hutt Valley, Wairarapa)

IPMHA in Wellington is called Access and Choice.

The IPMHA model in the district

Number of general practices: IPMHA has been implemented in 48 practices across the Greater Wellington Region.

Selection of general practices: The decision sat at a governance level. Practices were prioritised based on the number of a Māori, Pacific and 12–25-year-olds, consideration was also given to practices with a high rural population. Ratio used to allocate roles to general practices: For a population of 10,000, practices are allocated 1 FTE HIP, 0.5 FTE HC and 0.5 FTE SW. If practices are using the HC/SW dual role, the FTE is combined to make 1 FTE.

The IPMHA roles

IPMHA roles/ names	FTEs	Employer	Comments
HIPs	25.8	PHOs	Te Awakairangi Health Network employ HIPs and HCs in the Hutt Valley and Tū Ora Compass Health employ HIPs and HCs in Wellington, Porirua, Kāpiti Coast and Wairarapa. Ora Toa employ HIPs in Wellington and Porirua and Cosine employs HIPs in Wellington and the Hutt Valley. One practice employs a HIP directly.
HC	6.6	PHOs	Whether practices have a HC and SW or a HC/SW dual role is up to each practice. There is a mix of individual and dual roles across the region. One practice employs a HC.
SW	4.5	NGOs	Undergoes HC training but continues to be called a community support worker and work in the community.
HC/SW	18.35	NGOs	The combined role is in Wellington, Porirua, Kāpiti and Wairarapa but not in the Hutt Valley.

Adaptations to the model

The importance of whakawhanaungatanga with Māori and Pacific patients was noted and the flexibility for first sessions to be extended to enable rapport to be built between the roles and patients/whānau.

There is one HIP in the Wellington Collaborative who is currently not based in a practice and is instead temporarily part of the COVID Manaaki response team. The HIP provides virtual consults to people testing positive with COVID and isolating at home.

District governance

The Greater Wellington Wellbeing Collaborative (GWWC) oversees the district governance, which has approximately 20 representatives of different IPMHA providers including PHO, NGO, and DHB representatives. The collective meets on a bi-monthly schedule, made up of the following organisations:

- Pathways
- Te Paepae Arahi
- Te Waka Whaiora
- Te Hauora Runanga o Wairarapa
- Vaka Tautua
- Emerge Aotearoa
- PACT Group
- Te Awakairangi Health Network
- Ora Toa Health Services
- Tū Ora Compass Health
- Cosine Primary Care Network
- Te Whatu Ora Capital and Coast District (previously CCDHB)
- Te Whatu Ora Wairarapa District (previously WaiDHB).

Implementation team

The main implementation support is from the project manager for Access and Choice, the cultural lead for Māori, cultural lead for Pacific, NGO project lead, and the project data analyst. There are clinical leads at three of the Wellington PHOs implementing IPMHA. These roles work with the implementation team. Included on the implementation team is a project analyst who creates a data dashboard which demonstrates the reach of IPMHA and informs the service's implementation and delivery.

The responsibility of health and safety, development and training are held by the organisations the HIPs, HCs, SWs and HC/SWs are employed by. These health and safety requirements include:

- HIPs have monthly clinical supervision with a supervisor and monthly peer supervision groups.
- Cultural supervision is provided by the Māori lead and individual organisations to the workforce.
- There are peer meetings with other HCs and HIPs they work with
- Regular training opportunities through the collaborative and their own organisation

- SWs and people in the dual role are required to complete a NZQA Level four or above health/wellbeing qualification
- Service Level Agreements between the practice and employer are implemented during practice onboarding to align with these requirements

Training: Health Literacy is used for HCs, SWs and people in the dual role. Regional trainings and sessions are provided for HC line managers and team leads to gain an in-depth understanding of the HC role.

The extent IPMHA is making a difference

In some cases, practices where IPMHA roles have been implemented, the number of referrals to the primary mental health services have reduced. Assessment tools: Both Duke and Hua Oranga are used. Hua Oranga is encouraged more by the implementation team as it is an Aotearoa New Zealand developed tool. All HIPs, HCs, SWs, and HC/SWs are trained in Hua Oranga. Only HIPs are trained in using Duke.

Challenges and risks

- Difficulty accessing timely training has caused difficulty in recruiting workforce, particularly when recruiting to replace a HIP.
- Space has been an issue with some practices. Remote and hybrid models during the COVID outbreak have helped with this issue as kaimahi can work from home.

Other district initiatives

The three new community-based Access and Choice initiatives (Kaupapa Māori services, Pacific services, Youth services) have begun to be rolled out with different timelines. The governance collective anticipate that these initiatives will interact with IPMHA once they are further into their roll-out, but the specific ways they will work together has not yet been outlined.

Whanganui DHB

The IPMHA model in the district

Number of general practices: There are 11 Whanganui Regional Health Network (WRHN) practices and three National Hauora Coalition (NHC) practices (10% of the enrolled population). IPMHA is in place in nine of the 11 WRHN general practices. NHC did not take part in the first roll-out of IPMHA. The roles are now being introduced in the NHC practices and are in place in one of the three NHC sites.

Ratio used to allocate roles to general practices: Allocation is based on 1:10,000 at district level. Practices with higher proportions of enrolled population with high needs have a slightly higher allocation ratio.

The HCs are technically a merged HC/SW role but referred to as HCs for simplicity.

The IPMHA roles

IPMHA roles/ names	FTEs	Employer	Comments
WRHN HIPs	7 FTE	Practices	A pragmatic approach was taken to employment. At the request of the practices, the roles are employed by the practices. An exception is three smaller practices located in the same street that share a HIP and HC. In these practices the HIP and HC are employed by the WRHN. In one practice, implementation has been delayed by COVID as the practice did not want new people in the practice during the outbreak.
WRHN HCs/SWs	7 FTE	Practices	
NHC HIPs/HC	0.34 FTE HIP 0.34 HC/SW	National Hauora Coalition	Recent addition of a small number of FTEs of both roles to work across three sites. Implementation is in place in one site with an enrolled population of 2,500. Discussions are ongoing in others with COVID related delays to implementation.

Adaptations to the model

Most support is delivered by HIPs and HCs adhering to the IPMHA model. The merged HC/SW roles mean the HCs can also work in the community. One practice has adapted the HIP role to align it with the tikanga of the organisation and to include time for whakawhanaungatanga while still working to the general principles of the model.

Practice employment of HIPs and HCs is working well and likely to be sustainable.

District governance

At district level, IPMHA sits under the mental health and addictions SLA. The SLA includes representation from the DHB, Iwi providers, PHO and NGO. The WRHN project manager reports IPMHA data to the SLA and joins meetings.

IPMHA also sits under the governance structures of each of the two PHOs.

Implementation team

The project manager employed by the WRHN has provided most of the implementation support and considered this appropriate given the small size of the district. IPMHA is well established in the WRHN practices and the project manager considered the model will be self-sustaining as she moves to a new role in the district.

While project management is separate across the two PHOs, there is cross-communication and sharing of support. For example, all HIPs and HCs working in the Whanganui district were invited to a one-day Hapai Te Hoe workshop that provides whakawhanaungatanga, local history and cultural orientation and team building on the awa. The NHC HIP was able to shadow a WRHN HIP.

The NHC HIP and HC can attend an internal weekly peer review session virtually with the NHC team based in Auckland. The NHC Senior Health Psychologist also meets with the NHC HIP and HC fortnightly for check-ins. However, there are challenges supporting HIPs and HC who work a small number of FTEs as regular meetings can eat into the FTEs and finding days for team meetings is challenging when staff work on different days.

The extent IPMHA is making a difference

The interviewed stakeholders considered IPMHA was making a very positive difference to wellbeing and resilience in the district. However, interviewed stakeholders were not clear whether IPMHA was reducing demand on specialist services.

Integration to the general practice team was key to successful implementation. In this district implementation was achieved through employment of the HIPs and HC by the general practices.

The HIPs and HC have helped with the COVID responses and in practices where the role is newly established, this has helped build trust and inclusion of the HIPs and HCs into the practice teams.

Challenges and risks

A focus on COVID responses has delayed implementation in the last few general practices. Some teams are working remotely and adjusting IPMHA support to remote working.

The project manager is leaving to a new role in the district. A lead HIP will be employed (0.2FTE). The high level of implementation, ongoing support from the project manager if required, the appointment of a lead HIP and the practice employment model are expected to minimise any risks arising from the project manager leaving.

Alignment of recruitment with training is challenging in a smaller district where recruitment can be difficult.

Other district initiatives

Community-based *Access and Choice* initiatives

There is increasing need for support for youth wellbeing. Te Oranganui and Pathways (support for young people) hold other *Access and Choice* contracts.

Appendix One: More detail about IPMHA services – provided by MOH

Why locate services in general practice?

In May 2022, 4.8 million New Zealanders were enrolled with a PHO and an estimated 80% of the population accessed their general practice each year. Given that such a large percentage of the population accesses general practice every year, this provides the ideal setting to recognise and respond to mental health or alcohol and other drug-related need early, as part of routine healthcare.

Mental wellbeing and physical wellbeing issues are not separate: issues related to mental wellbeing, alcohol or other drug use and social circumstances can present as physical symptoms. Even when they do not, many people would not seek out mental health or addiction services for support, though they do regularly attend their GP for their physical health care. For these reasons, general practice is ideally placed to check in on mental health or alcohol and other drug issues when seeing people for other reasons, uncovering issues early before people would have gone for help.

Further, the general practice team can draw on the HIP and HC skills in behavioural health to assist patients to change behaviours contributing to physical ill health to improve holistic wellbeing, particularly for those with long term conditions who commonly experience mental health issues.

Many people use general practice for health issues making it the ideal place to uncover mental health or addiction issues, even before people are aware they exist, including issues that present as physical concerns rather than social or emotional concerns. The IPMHA skills also enable them to support people to improve their physical wellbeing, especially those with long term conditions.

Why team-based?

Mental health and wellbeing is already a significant part of the work of the general practice team. Adding HIPs to the team enhances the existing expertise through both direct service provision and by HIPs acting as educators / resources for the wider team, extending reach over and above the volumes reached by HIPs and HC/SWs.

HIPs and HC/SWs have complementary skills which enables greater choice and flexibility in the range of supports and services offered. With IPMHA in place, the general practice team is well placed to respond to any issue adversely affecting people's wellbeing, including adverse social circumstances, drawing on the community knowledge and connections of the support worker role.

Being part of the general practice team enables the development of close, trusting working relationships which do not result from traditional "shifted outpatient" or consultation liaison services.

This team-based approach significantly enhances the continuity and effectiveness of care for people. It means follow-up can – when appropriate - be a part of routine general practice care where someone is already seeing their GP or practice team member for other issues. This eliminates duplication, delivering better experience and maximising reach.

Team based delivery maximises access to effective care by leveraging the expertise of the general practice team, enhancing their responses to issues adversely affecting wellbeing, including mental health, alcohol or other drug issues, and improving continuity and eliminating duplication.

Why the 1:10,000 population for HIPs and flexibility for HC/SW?

The IPMHA model is unique internationally in that it brings together three separate roles to support the enrolled general practice population, with 2 – 2.5 FTE available per 10,000 population on average across practices (1 FTE per 4 – 5,000 population). This compares favourably with HIP ratios in the US of 1 FTE per 4 – 7,000 population (where these exist).

We considered that it was likely that the increased level of need in high needs practice would relate predominantly to addressing the social determinants of health and wellbeing and so allowed for health coach and support worker roles to vary between practices, enabling higher levels of this kind of support in higher needs practices.

The ratio of 1:10,000 enrolled population for HIPs is fixed across all practices, so as to maximise the reach of the model.

The team-based approach is unique to New Zealand. Together, the ratios for this team-based approach compare favourably to those for HIPs alone in other countries. The ratio of 1 HIP per 10,000 population in all practices aims to maximise reach while the ratio of 1-1.5 HC/SW per 10,000 population is district-wide and can vary between practices based on level of need.

Why same day appointments and personal introductions?

International and local experience is that 30 – 40% of people who are referred elsewhere for mental health care do not attend their first appointment. This drop-off can largely be eliminated by offering same day appointments and making personal introductions. Every second appointment for HIPs and HC/SWs in the practice is kept free to accommodate this and sessions can be briefly interrupted for introductions. Most people will happily accept a pause in their consultation for the HIP or HC/SW to step out and meet a new client because commonly this will have been how they were first introduced, and they can empathise with the next client[31].

Same day appointments and personal introductions increase the number of people who actually follow through on a referral by approximately 50%.

Why not identify and try to solve all the issues a person is facing?

Focusing on resolving the current and most pressing issues and not having to tackle everything at once maximises the number of people that can receive help and is the preferred approach for many people. This is very much aligned with a general practice model, which aims to rapidly resolve issues that arise and refer on people with more complex health issues who require more intensive investigation or intervention. The door is always open to return and deal with the next issue when the time is right.

[31] On some occasions because of session content it is not appropriate to interrupt – this is at the discretion of the practitioner.

Dealing with one issue at a time and returning when ready to deal with the next issue means more people can get help to address current issues, learning new skills as they go.

Why on average shorter sessions and fewer of them?

The average length of a HIP or HC session is 30 minutes, while social and cultural support sessions will often take a little longer. Evidence shows that the approach taken by HIPs is as effective as the traditional one-hour session and enables them to see twice as many people. This session length is not fixed. Follow-up visits will often be briefer, say 15 minutes, while there will be some initial visits that take a little longer.

Traditional brief therapies prescribe a set number of sessions and many use the first session for assessment purposes. The IPMHA model is designed to be flexibly tailored to the needs of each person/whānau. There is evidence that approximately 30% of people referred for traditional therapies do not return after their first visit. The IPMHA HIPs and HC/SWs aim to develop a plan to address the presenting issue in the first session, so people who do not choose to return still receive some help.

For HIPs, approximately half of the people who are seen do find one session is enough to enable them to put in place the changes they need to address their concerns, knowing they can come back at any time in the future should they need to. Of the remainder the majority find their needs have been met within 2-4 visits, however there is no limit to the number of times a person can be seen. This provides the flexibility to offer support for those who need it over a longer period.

Briefer and/or fewer sessions (on average) means more people can be seen each day, and a higher reach than could be achieved with a more traditional one-hour session or fixed (higher) number of visits, whilst also allowing flexibility to provide more intensive supports for those who need it over a sustained period of time.

Why locate HIPs and HC/SWs in the heart of the busy practice?

The more the HIP and HC/SW are visible, clearly communicate their roles, participate in practice huddles and discussions and roll up their sleeves to help the team to function, the more likely other team members are to think about social / emotional wellbeing and identify issues IPMHA may be able to help with. Warm handovers are also easier if IPMHA staff are located centrally. The HIP and HC/SW within the practice are able to connect people to SWs located within the community.

What other aspects of the model enhance access?

Services are free, so the only payment required is if the person sees their GP first. People can come back into the service if future issues arise without seeing their GP and thereby incurring cost.

There are no eligibility criteria: anyone of any age whose thoughts, feelings, actions or social circumstances are adversely affecting their wellbeing can use the services. This includes people with

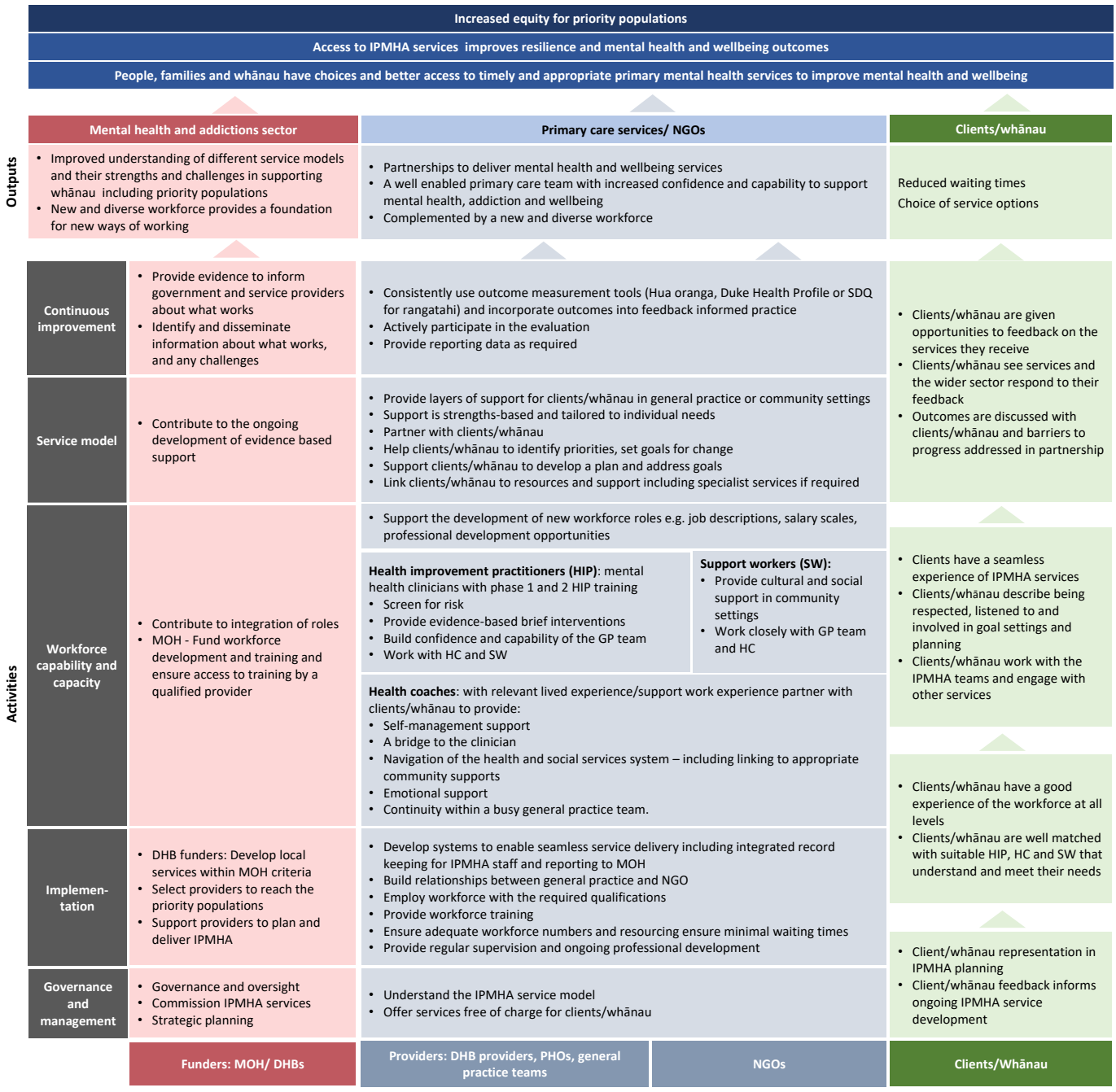
more severe mental health and addiction issues who may identify specific things they want to change that are adversely affecting their wellbeing[32]*.*

The HIP and HC/SW extend reach in other ways, e.g. through offering group based programmes for common issues and using pathways to optimise general practice team contribution to mental wellbeing e.g. routine pathways for all mothers with new babies.

[32] However, these roles do not provide specialist mental health advice to the GP nor do they provide case management: like other members of the general practice team – they may provide support to a person / whānau pending access to specialist services.

Appendix Two: Evaluation logic model

IPMHA evaluation logic model



Appendix Three: Information sources for the evaluation

Districts	Final interviews completed
Auckland Collaborative	Implementation team x 6 Governance: • Programme Leadership Board x 3 • Strategic Sponsors Group x 3 • PHOs x 5 • NGOs x 1 • ! Pacific provider There are two Pacific provider interviews outstanding - one primary care practices and one Pacific NGO. We will continue to attempt to schedule for one more week.
Canterbury	Implementation team x2 DHB GP lead PHO CEO
Hawke's Bay	PHO manager Service and HIP lead HC lead
Lakes	DHB x 2 Lead HIP NGO provider and lead HC (scheduled)
MidCentral	Implementation lead Clinical lead DHB NGO manager
Northland	Implementation team group meeting PHO manager
Southern	Implementation team group meeting
Taranaki	Implementation team – lead HIP PHO project manager DHB NGO Collaborative (scheduled)
Waikato	DHB Staff x1 PHOs x2 Kaupapa Māori Providers x3
Wellington Collaborative	Former project manager Group interviews with governance team, Māori governance team, implementation team
Whanganui	Project manager NHC lead DHB
Other	Te Pou trainer HC trainers – Tamaki and Health Literacy NZ Group interview with the FreshMinds team

Case studies: general practice settings and interviews completed

General practice setting[33]	Practice personnel	IPMHA team	Other organisations	Patients/ whānau
Large primary healthcare centres (x5)	GPs: 11 Nurse: 25 Practice manager: 9 Administrator: 1 Clinical lead: 2	HIP: 6 HC: 5 SW/Awhi Ora: 5	Community organisations: 4	Patients/whānau interviews: 11 Written feedback: 2
Kaupapa Māori organisations (x7)	GPs: 6 Nurses: 5 Practice manager: 4 Administrator: 1 Clinical lead: 1 Other staff: 1	HIP: 7 HC: 6 SW/Awhi Ora: 2	Secondary services: 3	Patients/whānau: 4
Small GP owned practices in rural or semi-rural settings (x3)	GPs: 4 Nurses: 3 Practice manager: 2 Administrator: 1 Clinical lead: 1 Other staff: 1	HIP: 3 HC: 1		Patients/whānau: 7
Urban practices (x10)	GPs: 12 Nurses: 16 Practice manager: 5 Administrator: 4 Clinical lead: 1	HIP: 13 HC: 9 SW/Awhi Ora: 4	Secondary services: 1	Patients/whānau: 15
Large pacific health provider (x1)	GP: 1 Administrator: 1	HIP: 1		
Total practices (x26)	GPs: 34 Nurses: 49 Practice manager: 20 Administrator: 8 Clinical lead:5 Other staff: 2	HIP: 30 HC: 21 SW/Awhi Ora: 11	Secondary services: 4 Community organisations: 4	Patients/whānau: 39

[33] Districts have not been included to provide the general practices with anonymity.

Appendix Four: IPMHA administrative data and assumptions

The dataset

The dataset includes:

- Consumer information: Age, ethnicity, gender, location
- Encounter (contacts) information: DHB, facility, worker type, encounter mode, final or follow-up encounter, patient feedback
- Needs and outcomes: Presenting issue, assessment tool data (Hua Oranga, Duke).

The total IPMHA dataset (all DHB, all time) included 292,187 **contacts** comprising:

- 169,711 sessions between 1 April 2021 and 31 March 2022 (the 21/22 financial year)
- 51,479 sessions for episodes of care that started and finished pre-21/22 FY
- 70,748 sessions for episodes of care that started pre 1 April 2021 and extended into the 21/22 FY
- 35 sessions for episodes of care that started on or after 1 April 2022.

The information included in this report is based on:

- Analysis of reach and comparison with registered populations are based on **patients/whānau** who had any contacts in the 21/22 FY. This excludes the 51,479 contacts with people with no contacts in the 21/22 FY (all of their contacts were before 1 April 2021 or after 31 March 2022. We know the data for this earlier time period was incomplete and varied between districts.
- Analyses of services delivered including presenting issues, assessments, are based on all contacts for episodes of care that included at least one session in the 21/22 FY (even if the first contact was pre 1 April 2021 or the last contact was after 31 March 2022).
- Outcomes assessment – based on first and last assessments for all episodes of care that included at least one session in the 21/22 FY (even if the first contact was pre 1 April 2021 or the last contact was after 31 March 2022).

We have used primary care enrolment data in two ways:

- DHB total enrolment: The figures for enrolled populations for each DHB are taken from the Ministry of Health published figures (see https://www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations/enrollment-general-practice-and-primary-health-organisation).
- IPMHA practice enrolment: Figures calculated from the enrolment counts for practices identified as the location of delivery for at least one IPMHA activity. These figures were drawn from data provided by the Ministry of Health and matched to the IPMHA dataset. See below for more information on the matching process.

Data limitations

Information about the proportion of the enrolled population reached by IPMHA is based on:

- Facilities coded in the IPMHA dataset (F-codes for facilities – physical sites or locations)
- Enrolled population data is based on the G-code or the organisation code which can cover multiple facilities.

Linking the facilities in the IPMHA dataset with the organisation codes to estimate population coverage is complicated by:

- Where an organisation contains multiple facilities, it is not possible to identify how much of the enrolled population belongs to each facility. To manage this uncertainty, we split the enrolled population across all facilities from that organisation who were the setting for IPMHA delivery. For example, if three facilities from one organisation were locations for IPMHA delivery, the total enrolled population for the organisation recorded was divided evenly across those organisations.
- Some facilities may be within a given DHB but grouped under an organisation based in another DHB.
- The organisation codes are updated immediately for patients who transfer to another facility but the facility may not be updated until the next consultation.
- Some clinics such as nurse practitioner clinics may not have their own facility codes.
- MidCentral DHB IPMHA facilities are not individually identified (all listed as unknown) so enrolled population for IPMHA facilities and the number of IPMHA facilities were not available.

We have reported enrolled populations based on organisation codes and the location of those organisations. Populations of IPMHA practices are based on the enrolled populations of all organisations with one or more facility delivering IPMHA.

First contacts are defined by the practitioner recording data. We used the practitioner definition of a first contact. However, there were some people seen who did not have a first contact recorded. In these cases, we assumed the earliest dated encounter was the first contact.

Appendix Five: Overview of training

HIP training

HIP training was reviewed and revised in January 2021 following a review of the content and new learning plans.

The learning outcomes are:

- Consistently practices within the primary care behaviour health model.
- Uses behavioural health techniques and tools to explore diverse people's health situations and progress them towards improved health and hauora.
- Works collaboratively to offer and promote integrated care within a primary care context.

HIP training now comprises a four-day face-to-face training (or eight half days virtual training); a pre-practicum (one day shadowing a HIP and one day with a HIP trainer specialised in establishing relationships with the primary care team), a practicum (one day of observed practice at three and six months and attendance at regular webinars and ongoing coaching)[34].

Health Coach training

The HC training programmes are delivered by two training providers: Tāmaki Health and Health Literacy NZ. Differences between the two trainers were identified as a challenge in the first phase of the evaluation. In response learning outcomes were developed by Te Pou and provided to the two trainers. The learning outcomes[35] are:

- Work in partnership with people from diverse backgrounds and health contexts to improve their emotional and physical wellbeing
- Work collaboratively within the primary care team
- Connect people with services and resources to support their emotional and physical wellbeing
- Maintain wellbeing and safety.

Tāmaki Health training comprises five days face-to-face training, onsite training in the practice 2-4 weeks after the initial training and six fortnightly webinars, virtual mentoring and one day onsite training 3-6 months after the initial training.

[34] https://www.tepou.co.nz/initiatives/integrated-primary-mental-health-and-addiction/health-improvement-practitioners-in-new-zealand

[35] https://www.tepou.co.nz/initiatives/integrated-primary-mental-health-and-addiction/health-coaching

Health Literacy NZ training comprises a planning meeting with providers, an 18-hour workshop delivered online in two-hour modules over one week or face-to-face in a two day workshop, ongoing support and mentoring for 10 weeks, and a final eight hour workshop delivered online in four 2-hour sessions over two days or one day face-to-face.

Appendix Six: Ministry of Health description of activities undertaken to support IPMHA service implementation

The Ministry of Health has worked closely with IPMHA service providers throughout the period of service implementation which has allowed the Ministry to respond to implementation issues as they have arisen, including those identified early on during the evaluation. As services have rolled-out and issues identified, the Ministry has provided support for model fidelity, service implementation, delivery and data management. The Ministry continues to work with IPMHA providers to understand and address needs for the successful implementation of the programme.

National implementation and service delivery support

The Ministry has taken a 'partnership' approach to the contract management, and strong relationships with the providers have been key to open discussion and collaboration around the ongoing needs of the IPMHA programme. Activities to support this include:

- The Ministry employed a part-time Implementation support lead, who is experienced in the implementation of the model in New Zealand and who is available for consultation and support for all DHBs, across their implementation and service delivery
- The Ministry has ongoing regular monthly 'Check-in' meetings with each DHB IPMHA Project Manager / DHB representative to get implementation updates, provide feedback and offer support where needed.
- The Ministry holds monthly IPMHA 'data' meetings with providers to update current data trends, provide feedback on any data issues and provide support for issues raised.

Resources developed to support the IPMHA service implementation.

Additionally, the Ministry has sought to provide an increasing number of resources to meet the wide-ranging set of needs associated with the programme delivery.

Introduction to, and understanding of the IPMHA service model

- **IPMHA 10-minute video** to introduce the model to potential practice sites and IPMHA workforce

  https://vimeo.com/504609451/ff35a656e7
- **IPMHA 3-minute video** (publicly available) to introduce the model to potential patients, practice sites and IPMHA workforce

  https://www.youtube.com/watch?v=AwAvzmFeuRU
- IPMHA Implementation Team Self- Assessment Toolkit
- IPMHA Service Implementation Toolkit
- IPMHA Implementation Framework for Onboarding New Practices
- IPMHA Practice Information Sheet
  - IPMHA Services Practice Implementation Toolkit and Self-Assessment Guide October 2021

- IPMHA Services Practice Implementation Toolkit and Self-Assessment Guide – Companion Reading Series

IPMHA Workforce integration and professional development

- IPMHA Health Coach Profile guide
- Work led by Te Pou to develop HC competencies and ensure HC training is aligned with these
- National IPMHA services collaborative forum, supported by the Ministry where IPMHA workforce gather monthly to raise issues and share solutions
- The Ministry instigated fortnightly meetings with the Te Pou team responsible for the training elements of IPMHA to identify and address emerging issues
- Te Pou has revised the Health Improvement Practitioner training to ensure it is reflective of practice in Aotearoa and has worked with both Health Coach providers to enhance their alignment and delivery against required competencies

IPMHA data collection and data management

- The Ministry undertook a consultation in early 2021 with all providers to adapt the data collection to better meet the needs of those seeking support, including Māori and Pacific patients. This led to reframing the 'presenting issues' data collection using a Te Whare Tapa Whā framework, adding additional te reo terms and conditions specific to a range of patients including Māori, Pacific and youth.