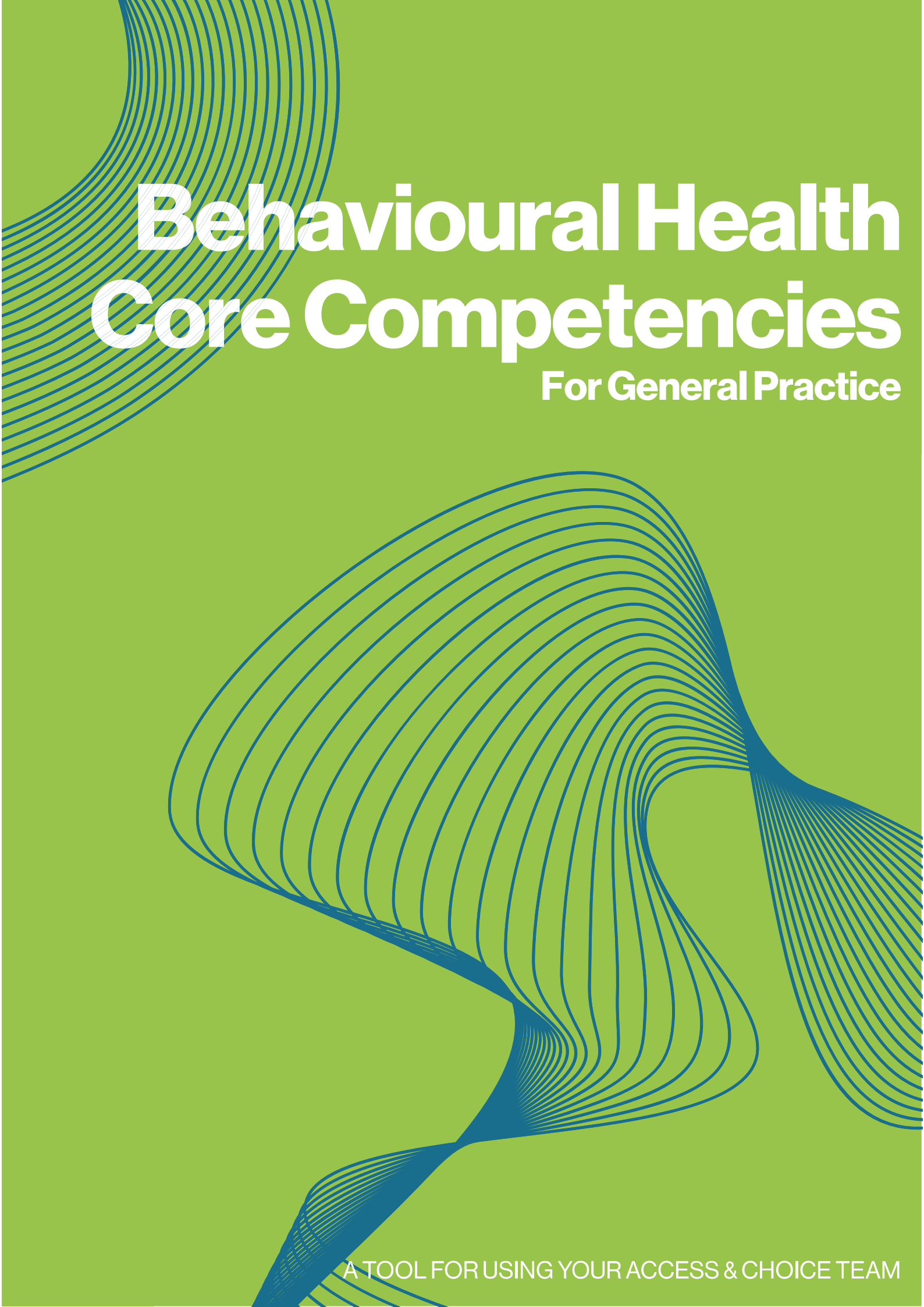
Behavioural Health Core Competencies

For General Practice



A TOOL FOR USING YOUR ACCESS & CHOICE TEAM

Contents

*Warm handover (WHO): a face-to-face introduction of a patient to an Access and Choice team member.

Same Day: adding the patient to the Access and Choice team member's template for that day.

What are Core Competencies?

Core competencies can be defined as skills or knowledge base that is central to how a company and its employees function.

'The details of applying Primary Care Behavioural Health (PCHB) competencies may vary in small ways from clinic to clinic, but mastery of the competencies below empowers the use of unique processes and enables consistency in demonstration of skillful PCBH work among team members and across clinics within a system'. (Robinson & Reiter, 2025)

These competencies are of foundational importance to getting the true value from an embedded access and choice team. The competencies apply to every person on the clinical side of the health care team. Some are also important for non-clinical staff.

Robinson, P. J., & Reiter, J. T. (2025). Behavioral consultation and primary care (3rd ed.). Springer.

How Core Competencies can help you

These Core Competencies are designed to support the integration of medical and behavioural health models in practice, providing a tool to ensure General Practice and Access and Choice teams work seamlessly together to deliver the most effective behavioural health strategies for both the practice and the wider population.

The original theory behind these can be found in the latest edition of Robinson, P. J., & Reiter, J. T. (2025). Behavioural consultation and primary care (3rd ed.). Springer. They outline the best practices and behaviours that result in outcomes that benefit the patient, the practice team, and the clinic.

These competencies guide the whole team, including the practice manager, Access and Choice team, and clinicians (GPs, nurses, HIP, HCA, HC, etc.) in their thinking, innovation, and learning, and support team leads or trainers in integrating new team members.

This tool can be applied in many ways, such as focusing on one competency per week in huddles, selecting competencies to develop over time, or using them in performance reviews and planning days.
Part one covers clinical skills all clinicians need to make behavioural health integral to the clinic, while part two focuses on team-based care and the clinic's ability to work collectively with its community.

How to use Core Competencies

For Individual Clinicians

- Review the first six competencies to see how your behaviours align with Access and Choice services.
- Use the guide as a self-assessment and continuous improvement tool.
- Refer to it regularly as a reminder of the PCBH model in everyday work.
- If you are new to the practice, familiarise yourself with the competencies and the practice's commitment to them.

For Practice Managers

- Use the competencies to identify areas for development and innovation.
- Apply them as a quality improvement framework.
- Initiate team conversations about pathways, group work, and prevention initiatives.
- Support your team in aligning competencies with population health goals.

PART A

1.Provide information about Access and Choice services

Competency:

Provide information about Access and Choice services to patients.

Regularly inform new patients about Access and Choice services.

Introduce Access and Choice services to existing patients who may benefit from them.

Provide patients with the Access and Choice brochure.

Example:

Clinicians talk with patients about first-line behavioural strategies as a normal part of routine healthcare.

Have cards/ leaflets available about the Access and Choice team in your practice.

Promote your Access and Choice team via the waiting room TV, social media, newsletters, and other channels.

Work with the Access and Choice team to provide up-to-date material that is tailored to your practice.

Offer groups and initiatives that support wellbeing (e.g., walking groups).

Routinely book 30-minute appointments.

Resources: Brochures and posters, Social media and TV tiles for digital promotion, 'On hold' phone message introducing the service,
Groups and pathways are actively advertised within the practice.

2.Identify specific focus for visit

Competency:

Help the patient identify a key issue or goal for their Access and Choice visit.

Example:

(Patient) is having problems getting to sleep. Can you work with her to find some strategies to help?

(Patient) wants to reduce his cholesterol through lifestyle change. Can you help him understand what can help?

(Patient) is at risk of falls and is quite lonely. Can you support her in finding a strength and balance group in her area?

3.Understand and support outcome measures

Competency:

Support the use of outcome measures, understand scoring, and apply them in assessing patient status and progress.

Example:

Understand the DUKE, Hua Oranga, and SDQ outcome measures and how they can be used to track a person's progress.

Resources:

The DUKE Health Profile (Figure A)

Hua Oranga (Figure B)

4.Identify and address risk

Competency:

Appropriately identify patients at risk of harm to themselves or others, and involve the Access and Choice team as needed.

Example:

Use clinic policy and SafeSide best practice guidelines, work with the Access and Choice to create the best safety plan for the patient.

Ensure that closing the loop as a concept is understood by all persons involved.

Resources:
Manawa APP
SafeSide resources
1737 cards

See your Access & Choice team for these resources

5.Support behaviour change intervention

Competency:

Have a basic understanding of interventions commonly used by Access and Choice, and assist patients in following through with plans.

Commonly used interventions include Focused Acceptance and Commitment Therapy (FACT), adapted cognitive interventions, adapted behavioural interventions, and adapted Motivational Interviewing (MI).

Example:

Review and refer to the patient notes on interventions and plans before medical visits following an Access and Choice session

Demonstrate a team-based approach to the person you are working with. For example:
"Along with starting your new SSRI medication, you'll continue using the thought diffusion techniques you discussed with the HIP, and check in with them in two weeks to see how the plan is working."

"So sounds like the regular walking is helping with your weight loss somewhat. I suggest you see the Access and Choice team now to see what else you can add to the plan to help with cravings."

6. Encourage follow-up visits with Access and Choice

Competency:

Encourage patients to attend follow-up Access and Choice appointments during medical visits, as appropriate to their needs

PART B

Support Access and Choice integrated care culture

1a. Use language and practice habits that align with the Behavioural Health context.

1b. Relates to the HIP as a consultant, rather than a "therapist" or "counsellor."

Identify patients for Access and Choice services

2a. Handover patients of all ages and with all behavioural concerns (medical, psychological, social).

2b. Prioritise handovers for patients with significant health disparities.

2c. Support the development and refinement of Access and Choice pathways aimed at improving patient access to behavioural health services for those with challenging health outcomes (e.g., chronic pain, ADHD).

2d. Identify barriers to using Access and Choice services and work to find solutions to overcome these challenges.

Resources:
Practice Package (Figure C)
Barriers Survey (Figure D)

Use WHO skilfully

3a. Referrals for initial visits are most often WHO.

3b. Able to adjust description and length of initial WHO to match individual patient needs.

3c. Understands and uses different options for initiating WHO (e.g., via electronic health record, texting HIP/HC/CSW, physically locating HIP, etc.).

3d. Completes the WHO workflow by catching up briefly with the HIP/HC/CSW after their consultation.

3e. Uses the WHO strategy to support same-day follow-up visits, when indicated.

Use Access and Choice services to improve team efficiency

4a. Use HIP/HC to save time when the Clinician's schedule is over-booked or urgent care situations arise.

Use Access and Choice to improve patient experience in clinic visits

5a. Offer preventive care visits.

Uses Access and Choice to optimise outcomes associated with prescribing medications

6a. Tries to avoid over-prescribing by referring to the HIP for behaviour change support for conditions likely to improve with such support (e.g., depression, anxiety, ADHD, and sleep issues).

6b. Uses the HIP to assist with starting new psychotropic medications.

6c. Uses HIP/HC services for patients who face barriers to taking medications as prescribed.

Use a stepped care approach in working with the Access & Choice Team

7a. Uses the HIP/HC to support patients waiting for specialist care or returning after an episode of specialist care.

Use task sharing strategies with Access & Choice Team

8a. Routinely ask the Access and Choice team to complete tasks within their scope to reduce workload.

8b. Use CSW and HC to complete tasks that improve patient experience and health outcomes.

Supports Classes and Groups that address behaviour change

9a. Advertise and promotes workshops/classes/groups offered by the Access and Choice team.

9b. Collaborates with Access and Choice staff to offer group services

Use Access and Choice metrics to improve outcomes of integrated care

10a. Understand Access and Choice metrics and support them to meet key metrics, eg, 80% of people seen within 1 week of handover

Figure 1

FORM A: FOR SELF-ADMINISTRATION BY THE RESPONDENT (revised 1-99)

DUKE HEALTH PROFILE (The DUKE)

Date Today:_____ Name: _____ ID Number:_____
Date of Birth:_____ Female____ Male____

INSTRUCTIONS: Here are some questions about your health and feelings. Please read each question carefully and check (√) your best answer. You should answer the questions in your own way. There are no right or wrong answers. (Please ignore the small scoring numbers next to each blank.)

	Yes, describes me exactly	Somewhat describes me	No, doesn't describe me at all
1. I like who I am	12	11	10
2. I am not an easy person to get along with	20	21	22
3. I am basically a healthy person	32	31	30
4. I give up too easily	40	41	42
5. I have difficulty concentrating	50	51	52
6. I am happy with my family relationships	62	61	60
7. I am comfortable being around people	72	71	70

TODAY would you have any physical trouble or difficulty:

	None	Some	A Lot
8. Walking up a flight of stairs	82	81	80
9. Running the length of a football field	92	91	90

DURING THE PAST WEEK: How much trouble have you had with:

	None	Some	A Lot
10. Sleeping	102	101	100
11. Hurting or aching in any part of your body	112	111	110
12. Getting tired easily	122	121	120
13. Feeling depressed or sad	132	131	130
14. Nervousness	142	141	140

DURING THE PAST WEEK: How often did you:

	None	Some	A Lot
15. Socialize with other people (talk or visit with friends or relatives)	150	151	152
16. Take part in social, religious, or recreation activities (meetings, church, movies, sports, parties)	160	161	162

DURING THE PAST WEEK: How often did you:

	None	1-4 Days	5-7 Days
17. Stay in your home, a nursing home, or hospital because of sickness, injury, or other health problem	172	171	170

Figure A

Figure 3. FORM B: FOR ADMINISTRATION TO THE RESPONDENT BY AN INTERVIEWER (revised 1-99)

DUKE HEALTH PROFILE (The DUKE)

Start Time:_____ Date Today:_____ Name: _____ ID Number:_____

Date of Birth:_____ Female____ Male____

Interviewer: Give these instructions: "I will ask you some questions about your health and feelings. Please listen to each question carefully and give me your best answer. You should answer the questions in your own way. There are no right or wrong answers."

Interviewer: Read each question verbatim and circle response number.	Yes, describes me exactly	Somewhat describes me	No, doesn't describe me at all
"How do the following statements describe you?"			
1. I like who I am	2	1	0
2. I am not an easy person to get along with	0	1	2
3. I am basically a healthy person	2	1	0
4. I give up too easily	0	1	2
5. I have difficulty concentrating	0	1	2
6. I am happy with my family relationships	2	1	0
7. I am comfortable being around people	2	1	0
"TODAY would you have any physical trouble or difficulty:"	None	Some	A Lot
8. Walking up a flight of stairs	2	1	0
9. Running the length of a football field	2	1	0
"DURING THE PAST WEEK: How much trouble have you had with:"	None	Some	A Lot
10. Sleeping	2	1	0
11. Hurting or aching in any part of your body	2	1	0
12. Getting tired easily	2	1	0
13. Feeling depressed or sad	2	1	0
14. Nervousness	2	1	0
"DURING THE PAST WEEK: How often did you:"			
15. Socialize with other people (talk or visit with friends or relatives)	None 0	Some 1	A Lot 2
16. Take part in social, religious, or recreation activities (meetings, church, movies, sports, parties)	0	1	2
"DURING THE PAST WEEK: How often did you:"			
17. Stay in your home, a nursing home, or hospital because of sickness, injury, or other health problem	None 2	1-4 Days 1	5-7 Days 0

Stop Time: _____ (Interviewer: _____)

Figure A

Appendix 1: Tangata Whaiora Questionnaire

HUA ORANGA – Whaiora Schedule

Whaiora Name _____ Date_____

These questions are about taha tinana or your physical health	1	2	3	4	5
At this point in time do you feel:	*Strongly disagree*				*Strongly agree*
Able to move about without pain or distress	1	2	3	4	5
I have goals to maintain or improve my physical wellbeing	1	2	3	4	5
I believe physical health improves my general wellbeing, including mental wellbeing	1	2	3	4	5
Physically healthy	1	2	3	4	5
These questions are about taha wairua or your spiritual health	1	2	3	4	5
At this point in time do you feel:	*Strongly disagree*				*Strongly agree*
My mana is intact and acknowledged/respected	1	2	3	4	5
Strong in my cultural identity	1	2	3	4	5
Content within yourself	1	2	3	4	5
Connected and healthy from a spiritual (Wairua and Mauri) perspective	1	2	3	4	5
These questions are about taha whānau or your family health	1	2	3	4	5
At this point in time do you feel:	*Strongly disagree*				*Strongly agree*
Able to talk with my whānau and others	1	2	3	4	5
My relationships with whānau and others are healthy	1	2	3	4	5
Clear about my roles within my whānau/family, and how to fulfil them.	1	2	3	4	5
Able to participate in community, or hapū and iwi activities.	1	2	3	4	5
These questions are about taha hinengaro or your mental health	1	2	3	4	5
At this point in time do you feel:	*Strongly disagree*				*Strongly agree*
I want to make changes in my life that contribute to my wellbeing	1	2	3	4	5
Able to think, feel and act in a positive manner	1	2	3	4	5
Able to manage unwelcome thoughts and feelings	1	2	3	4	5
I understand what contributes to my concerns and how to address these.	1	2	3	4	5

Figure B

Using your Health Improvement Practitioner, Health Coach and Community Support Worker

Health Improvement Practitioners, Health Coaches (HC's) and Community Support Workers (CSW's) can support the practice with a range of activities. Please consider the following suggestions as possible tasks which may help to free up clinical time and support the priorities of the practice.

Health Improvement Practitioner

Health Improvement Practitioners (HIPs) offer 30-minute sessions using wellbeing tools (Duke, Hua Oranga, or SDQ), behaviour change strategies, and education to support goal setting. They may follow up as needed, adapting plans to support progress. The service is brief, with 1–4 sessions; if more are needed, further support or referrals are considered. HIPs can see people of all ages.

1) Anxiety/Low Mood

a. Patients diagnosed with Anxiety or Low mood are booked with the HIP
b. Provides education to patients and implements clinical advice by planning towards improving well-being outcomes

2) Sleep disturbance

a. Patient to be offered/booked an appointment with a HIP – as poor sleep can be a red flag for other mental health issues
b. HIP provides education and a skills/behavioural change approach before medication is prescribed

3) Grief/Loss/Relationship Issues/Work-related stress/Life change or transition/Loneliness/Parenting Issues

a. Patients identified with these challenges are booked with the HIP
b. Provides education to patients and gives clinical advice and suggests behavioural changes to implement to help improve well-being outcomes

4) Newly pregnant/New birth/6-week check

a. Patient is offered support/booked in with the HIP service
b. Provides support looking at stress/anxiety management, relationship support and linking to agencies may prevent parents feeling isolated and support the family to have a healthy lifestyle for continued good health.

Figure C

5) High side of consumption of Alcohol/Tobacco/Gambling/Social Media/Cannabis/Other drugs

a. Patient to be offered/booked in with HIP

b. Motivational Interviewing- to work with ambivalence. Exploration of how behaviour is related to thoughts and feelings. Linking to support agencies, online resources, and printed material.

c. Develop a plan to work on contributing factors

6) Raised Blood Pressure

a. Patients signposted/booked into HIP service to discuss looking at possible contributors, provide psychological techniques to support lifestyle change

b. Provides education to the patient and supports a plan towards improving health outcomes

7) Toitū Takata and Advance Care Plans

a. Supports the completion of Personalised and Advanced Care Plans with patients

b. Supports follow-up of goals identified by patients

8) Smoking cessation

a. Patients wanting support to reduce smoking or vaping are booked with the HIP or Health Coach

b. Supports with education on tips to reduce and harm reduction techniques and can support patients to connect with helpful services e.g. Southern Stop Smoking Service, Quitline,

9) New patients to the practice

a. Offered an appointment with HIP to discuss relevant services offered e.g., Access and Choice and Long-Term Conditions support. They can capture patients' current circumstances looking at living situation/smoking status/support people they have/ health goals.

10) Pain/Concussion/Physical Injury

a. Offered an appointment/ booked in with HIP service

b. Supports with education around stress management – looking after their wellbeing whilst recovering, sleep/pacing/social connections/self-care for continued good health.

Figure C

Health Coach Appointments
Health Coaches have 30-minute appointments available where they use a wellbeing measure (Duke and/or Hua Oranga), behaviour change tools and support patients with education and goal-setting. HCs can work with people aged 18 years and over.

1) Prediabetes/Diabetes
a. Patients diagnosed with prediabetes/diabetes are booked with the HC
b. Provides education to patients and implements clinical advice by planning towards lifestyle change
c. Offers follow-up to support patient through change and adapts plans as necessary

2) Toitū Takata
a. Supports to complete Personalised and Advance Care Plans with patients
b. Supports follow-up of goals identified by patients

3) Smoking cessation
a. Patients wanting support to reduce smoking or vaping are booked with the HC
b. Supports with education on tips to reduce and harm reduction techniques
c. Supports patients to connect with helpful services e.g. Southern Stop Smoking Service, Quitline, Health Improvement Practitioner (HIP)

4) Cardiovascular Disease Risk Assessment
a. Patients booked for CVDRA with the Nurse are booked with HC after
b. Provides education to patient and supports a plan towards lifestyle change e.g. healthy eating, stress management, increasing exercise

5) Cholesterol
a. Patients with high cholesterol are booked with the HC
b. Provides education to patient and supports creating a plan towards lifestyle change
c. Offers follow-up to support patient through change

6) New patients to the practice
a. Provides orientation to the practice including talking about the online health tool (e.g., Manage My Health), booking system, relevant services offered e.g., Access and Choice and Long-Term Conditions support

Figure C

The following pathways have been designed and delegated by registered health professionals. Health Coach and Community Support Worker intervention is evidence-based and considered current best practice. HC's and CSW's have completed relevant training. Please check with your HC and CSW to ensure they have completed this training and been signed off before booking in identified patients.

Consider referring to your CSW if attending practice is a barrier for participation.

7) Irritable Bowel Syndrome First-line Advice

a. Supports patients to understand first-line dietary advice for irritable bowel syndrome
b. Supports in creating a plan towards lifestyle change and keeping a food and symptoms diary
c. Follow-up appointment booked to discuss food and symptoms diary
d. HC advises GP throughout and makes recommendations for appropriate onward care

8) Healthy Eating

a. Supports patients to understand dietary guidelines and create a plan towards dietary change

9) Strength, Balance and Fragility

a. Requests medical clearance from GP before initiating pathway
b. Teaches Strength and Balance "Super 7" Exercises for older adults who do not meet criteria for Falls and Fractures support
c. Supports to create a plan around use

Figure C

Health Coach and HIP Recalls

When the HC/HIP is not seeing patients for appointments, they are expected to assist the practice with recall/cold-call functions, using the Thalamus Dashboard/Query Builder. Please let the HC/HIP know which area you would like them to prioritise.

1) Diabetes

a. Identifies due/overdue patients for their ADR

b. Calls to make an appointment with the Nurse and problem-solve any barriers that may get in the way of the patient attending e.g. transport

2) Smoking Status

a. Calls to update the patient's smoking status and offer brief advice/cessation support

b. Refers to Southern Stop Smoking and/or offer HC/HIP appointment

3) Long-term inactive enrolled patients

a. Identifies on Thalamus enrolments set to expire in the next month

b. Rings and informs the patient, offers to book in with GP and/or Health Coach/HIP if required

4) Cervical smears

a. Identifies those due/overdue

b. Calls to make an appointment with the Nurse and problem-solve any barriers that may get in the way of the patient attending e.g. transport

5) Long-term Conditions Support (Toitū Takata)

a. Identifies patients on Thalamus who may be eligible for a funded assessment

b. Calls and offers an appointment, problem-solves any barriers that may get in the way of the patient attending

6**) Claiming/Opportunities Dashboard**

a. Identifies on Thalamus those coming into practice in the coming week who are eligible for funded appointments e.g. ADRs, CVDRAs

b. Calls patients to offer them a funded appointment on the day they are coming in

7) Cardiovascular Disease Risk Assessment (CVDRA)

a. Identifies on Thalamus patients who are eligible for a Cardiovascular Disease Risk Assessment

b. Calls and invites patients in for a CVDRA with the Nurse and reinforces need to have a blood test completed at least 2 days before the appointment

Figure C

Community Support Worker

CSW's can work with patients in the community to help them implement plans that take them towards their health goals. This may be a one-off appointment or more intensive support for up to 12 weeks. You can refer through a "new handover" in the WellSouth portal. CSW can work with people 18 years and over.

1) Community Service Card Holders

a. Supports to investigate Work and Income entitlements/disability allowance

2) High debt

a. Supports patients to connect with budget services, debt consolidation, Work and Income

3) Long-term Conditions support (Toitū Takata)

a. Provides practical support to achieve wellbeing goals e.g., attending exercise groups, Diabetes education workshops etc.

4) Advance Care Plans

a. Practice refers to CSW to complete Advance Care Plan when not able to complete within practice

b. Returns ACP to practice for Nurse to sign off and upload to Health One

c. Follow-up with ACP's that need to be reviewed

5) Vaccinations

a. Problem-solves barriers preventing engagement for vaccinations e.g., children, over 65's

6) Anxiety

a. Supports patients with graded exposure to build confidence to participate in meaningful and purposeful activity

7) Housing

a. Support to apply for transitional housing, book, or view homes to rent

8) Employment/Work Opportunities

a. Support to navigate employment agencies, volunteer work, and training options

Figure C

Barriers to using the Health Improvement Practitioner (HIP) or Health Coach (HC)

Part A: When you consider using the HIP or Health Coach in the practice, how often do these factors DETER you?	**HIP** *Almost Never (0)* *Occasionally (1)* *Frequently (2)*	**Health Coach** *Almost Never (0)* *Occasionally (1)* *Frequently (2)*
1. Patient is seeing another therapist/dietitian already.		
2. Worry about alienating the patient by recommending a behavioural health consultation.		
3. Not sure how to refer to the HIP or HC.		
4. Patient is responding well to medications alone, no need for a behavioural consultation.		
5. Not sure which patients are appropriate to send to the HIP or HC.		
6. Not sure who to send the patient to, either HIP or HC.		
7. Unlikely the HIP or HC could help with this type of problem.		
8. Medication could solve the problem alone.		
9. Patient needs specialty psych care.		N/A
Part B: Barriers to SAME DAY services.		
1. Unsure about how to make a request for warm handovers.		
2. Don't want to interrupt HIP or HC.		
3. Forgot by the end of the patients visit.		
4. Didn't have time to involve the HIP or HC.		
5. When the HIP or HC seem busy, I don't like to add to their workload.		
6. I saw the HIP or HC's schedule was full, so same day help was likely impossible.		
7. Couldn't find the HIP or HC.		
8. The patient seemed busy, was unlikely to stay for another appointment.		
9. Patient refused to see the HIP or HC, for some other reason.		
10. I do not know what same day services the HIP or HC offer.		
11. I did not know the HIP or HC prefer same day patient appointments.		
Other barriers? (please explain - can use back of page).		
Part C: Overall, how helpful is the HIP or HC's service **for your patient's?** *Please circle a number. 0 = No Benefit* 10 = *Extremely beneficial (good patient feedback)*	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Part D: Overall, how helpful is the HIP or HC's service **to you (e.g. helps you better serve patients, etc)?** *Please circle a number. 0 = No Benefit* 10 = *Extremely beneficial (good patient feedback)*	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Part E: What changes do you feel could be made to improve the helpfulness of the HIP and HC services for both you and your patients? (please use the back of the page if needed).		

Figure D