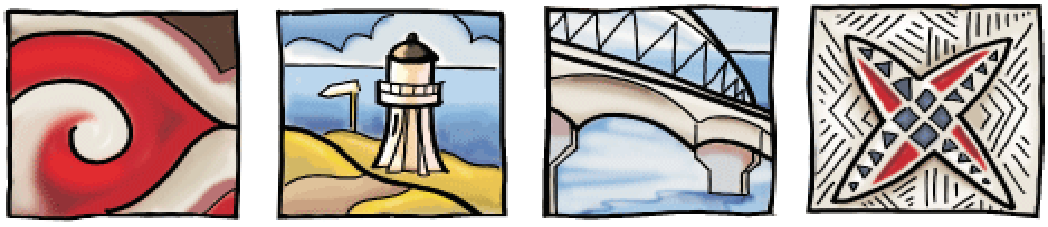

NORTHERN REGION MENTAL HEALTH & ADDICTIONS SERVICES STRATEGIC DIRECTION

2005 - 2010

Prepared for the four region District Health Boards:

Auckland District Health Board
Counties Manukau District Health Board
Northland District Health Board
Waitemata District Health Board

by the Northern DHB Support Agency and Network North Coalition

Te Poari Tautoko I Nga Rohe Ki Te Raki

Northland Health
Hauora o te Taitokerau

Foreword

October 2004

Our ability to support people in the Northern region with mental health problems, and or addictions, and to lead lives that are worth living depends on our ability to focus our collective efforts on developing and funding services in a way that addresses the problems that currently exist in the mental health sector.

It is important to acknowledge the efforts of the people currently providing mental health and addictions services in the Northern region. The majority are working under considerable stress associated with the systematic problems in the sector that this plan attempts to identify and address. Despite these problems, providers make their best endeavours to maximise service user's access to treatment and support services of the best possible quality.

This consultation document provides the medium term strategic direction for Mental Health and Addiction Services in the Northern Region. It has been developed by the Network North Coalition (NNC) drawing on the advice of many people including experts involved in funding and planning and providing Mental Health and Addiction Services, and service users and their families and whanau.

Since April 2004, people with very different perspectives have attempted to reach agreement on the most significant issues facing the mental health sector in the Northern region and what should be done to address them over the next 3-5 years. This has not been an easy task and I am grateful to the many individuals who actively participated in this process.

There are sections in the document that clearly reflect the tension in the system where we have not yet found a common understanding and agreement on the best approach. The challenge now is to continue to develop and refine the way forward.

Each District Health Board will be seeking the views of the people who live in and provide mental health and addiction services in their district on the direction proposed by NNC for the future development of mental health and alcohol and drug services in the Northern region over the next 3-5 years.

I look forward to the next phase in our work following the DHBS reaching agreement on the regional strategic direction. The NNC will implement the projects to strengthen regional service delivery to ensure people experiencing mental health problems and addictions, and their families and whanau, are able to have lives worth living.

Yours sincerely

Derek Wright
Regional Mental Health Director

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1. Executive Summary

This consultation document sets out the strategic direction for 3-5 years for mental health and addiction services for the Northern region. It is now at a stage where the District Health Boards (DHBs) can consult on it locally. Concurrently the Ministry of Health is developing the Second National Mental Health Plan, and the Mental Health Commission is reviewing Mental Health Blueprint benchmarks. It is expected that, when finalised, these documents will influence the DHBs decisions. Following consultation, and ensuring alignment with the national strategic direction, the DHBs will be in a position to agree a clear pathway forward for sustainable development of mental health and addiction services in the Northern region.

Mental health and addictions service providers currently make their best endeavours to maximise service users access to treatment and support services of the best possible quality. It is important to acknowledge that the majority of providers are working under considerable duress associated with the systematic problems in the sector that this document attempts to identify and address. The inclusive process used to agree the strategic direction was adopted to ensure we build on the commitment within the sector and the positive initiatives already underway to improve mental health outcomes.

The Regional Director, Mental Health, commissioned this document, which was developed by the Network North Coalition in conjunction with sector experts. The strategic direction is based on the advice of five work streams, child and youth, adult, older adult, alcohol and other drugs, and primary health. Sector experts included:

- People from clinical and support services
- People with mental health and addictions service user experience,
- People with family or whanau experience of mental health or addictions services, and
- People with specific knowledge of the needs and services of distinct populations;
    - Maori
    - Pacific People
    - Asian
    - Migrants and Refugees

Staff from the Northern DHB Support Agency (NDSA) actively supported the work streams and the development of the strategic direction set out below.

The strategic direction is described using the metaphor of building a house as a conceptual framework for the process[1]. House building requires a wide range of activities, from architectural planning, through makeover, alterations and additions, the development of strong foundations and good relationships within the family and with the rest of the community.

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[1] The metaphor was first developed and used by the participants of the Older Adult's work stream

The critical point of the metaphor is that only carrying out part of these activities cannot create a “home”. Similarly, to build robust mental health services for the region it is not a case of doing either this or that, but of trying to do all those things that make for a strong system, enabling people who use it to exercise their power, to be a valued member of their community and have a life worth living.

The document consists of several sections, beginning with a background, and the vision and principles on which it is based. It then outlines the general strategic goals, regional issues and their solutions. Regional activity on specific populations and their issues is summarised, as are the funding assumptions on which the plan is based. Then each service area is outlined in detail, with vision, issues, and critical success factors. Specific projects proposed by each work stream to achieve their goals can be found in a companion document. The document concludes with a section on outcomes that we will achieve if we successfully follow the direction proposed.

A set of companion documents are available that provide the detailed documentation supporting the development of this document and include:

- Detailed information on the process of plan development, including the participants
- Supporting data for each of the service areas
- Thematic analysis of sector consultation on the initial working draft document

2. Background

2.1. Regional Collaboration and the Auckland Review[2]

The review of Mental Health services in the Auckland Metropolitan Region undertaken by the Mental Health Commission in 2002 identified a number of issues that needed to be addressed. These included:

- The failure of DHBs to co-operate with one another at the planning and funding levels. Resource allocation, funding and planning decisions were being undertaken by the DHBs without proper engagement with service providers

- Failure to deliver an integrated continuum of services and a lack of procedures for co-ordinating the care of individual people with experience of mental illness across the service spectrum

Prior to the Commission review, however, there was already a strong commitment to work collaboratively across the entire Northern region, i.e. including the Northland DHB, as seen in the work undertaken by the Network North Coalition

Planning processes across the Northern region have improved since the review. This strategic direction document is but one of the products of a greatly enhanced collaborative process built around the Network North Coalition.

The document attempts to address the issues that impede a fully integrated continuum of services, with clear clinical and support pathways spanning the primary and secondary sectors. It also attempts to highlight the directions and innovations that are required to achieve the goals.

The action points from the review are included, as part of an appendix describing the process by which this document has been developed. The strategic direction should be seen within the context of the review.

This document is evidence that supports the Review's conclusion that: *'There are strongly committed people working within the sector in the (Northern) region and a strong commitment among people with experience of mental illness to assist DHBs to move forward*.'

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[2] Review of the Continuum of Mental Health Services Funded by the District Health Boards in the Auckland Region, MHC December 2002

3. Vision and Value

The Universal Declaration of Human Rights holds that ‘all human beings are born free and equal in dignity and rights’ (UDHR Art 1). Acknowledgement of this fundamental concept is essential to the planning and delivery of mental health and addiction services. To undertake such planning, we must recognise that all service delivery is a joint human endeavour, a partnership between those who provide services, and those who use them. Our vision is two-fold reflecting both improving delivery of high quality clinical treatment and support services and a positive future for people with experience of mental illness or addiction, for their friends, families and whanau, and for the communities in which we all live.

Vision[3]:

A community that empowers us to live enriched lives where all people with experience of mental illness or addiction[4] in the Northern Region have personal power, easily accessible quality services that support us to lead our own recovery, and a valued place in our families/whanau and in our community.

A Northern Region that consists of enlightened communities who foster an environment that promotes the mental health of all. The community will support people with serious mental illness and/or addiction problems and their families to achieve a life worth living by ensuring ready access to effective and appropriate clinical treatment and support services.

People with experience of mental illness have defined “Personal Power” as meaning:

We lead our own recovery by:

- *Experiencing hope and optimism*
- *Making sense of our experience*
- *Managing our mental health*
- *Knowing how to get the most out of services*
- *Advocating for our rights and inclusion*
- *Belonging to the culture and lifestyles we identify with*
- *Fulfilling our goals, roles and responsibilities*
- *Maintaining our personal relationships.*

[3] This vision is based in part on the vision developed nationally by people with experience of mental illness as a basis for the second National Mental Health Plan. People with experience of mental illness in the northern region have subsequently endorsed the national vision at their regional caucus.

[4] We have used the term people with experience of mental illness as an inclusive term used by people who are challenging stigma and discrimination in respect of mental health and addictions. Further comment on terminology is included in the appendix.

4. Strategic Goals

As with a building project, to develop robust mental health and addiction services for the region we need to agree the strategic direction that addresses all the aspects of a strong and effective structure. It is not a case of our doing one thing instead of something else, but of building good foundations, ample space and capacity, flexibility to alter and improve, within a mutually agreed framework. If we try to do all those things that make for a strong system, we help enable people who use it, within the context of their family and whanau and their community, to exercise their personal power, and to live a life worth living.

Our overarching strategic goals for building robust mental health and addictions services are to:

- Implement regional sustainable strategies based on strong leadership and collaborative planning to improve health outcomes
- Use funding to produce more and better services, that better meet the needs of those people with experience of mental illness or addictions, according to agreed regional priorities
- Ensure regionally consistent access to quality services
- Improve quality of existing services through service makeover and redesign
- Increase service capacity to match need
- Establish new services to improve continuum of service delivery
- Raise awareness, understanding and practical support among families, friends and communities
- Develop robust infrastructure to support service delivery

Those sector wide issues and potential solutions that have been identified across the range of services are discussed in the next section. Specific populations and their needs form the following section. Each service also has specific critical success factors that are aligned with the overall strategic goals set out above. Those service specific issues and strategies are outlined in detail in section 8.

5. Strategic Issues and Solutions

This section summarises the solutions developed by the individual work streams to address issues that are common to all mental health and addiction services. We have used the metaphor of a project to develop a house that provides a family home in a supportive community as the framework to identify and develop the future direction for the sector. The solutions proposed aim to strengthen mental health and addiction services across the region

Solution	Proposed Actions	Problem that will be addressed
1. Architect	• Support leadership and collaborative planning • Focus on achieving improved health outcomes • Challenge other agencies to help achieve our vision	• Lack of agreed regional direction to achieve our vision • Focus on service inputs and lack of ability to determine impact on health outcomes
2. Makeover or redesign	• Promote integrated service delivery across primary secondary and tertiary health services • Support focus on prevention and early intervention • Promote increased family/whanau participation and consumer led services • Promote integration with other sectors	• Poor coordination within mental health services • Regionally inconsistent service access and quality • Unused and limited capability • Pressure to refer for specialist treatment • Lack of integration with health services • Poor links to other Government agencies eg Justice, housing, employment
3. Extensions	• Increase capacity of existing services	• Inadequate capacity
4. Additions	• Establish new services	Unmet need eg • Maternal mental health • Asian, Migrants and refugees • Maori Mental Health • Pacific Mental Health
5. Community setting	• Promote increased family/whanau participation • Promote integration with other sectors • Promote health promotion programs to develop enlightened communities	• Service users need to be valued members of the community • Undervalued participation of family whanau and friends in service planning and delivery • Lack of integration with other sectors
6. Foundations	• Workforce development • Information systems development	• Inadequate capacity • Unused and limited capability • Lack of timely and meaningful information

Table 1: Strategic Issues and Problems

5.1. Architect - Leadership and Collaborative Planning

1. Establish and resource a developmental strategic leadership group for each work stream to:
    - Maintain a systemic overview of where we need to be in the next 10-20 years
    - Retain direction and focus as the building blocks are put in place
    - Maintain linkages across work streams
    - Support ‘Project Manager(s)’ with responsibility for making development plans operational
    - Support development of leaders to bring about a culture change that enables collaboration across the region.

2. Develop and implement a strategy to influence and challenge other sectors and the community at large that having a life worth living for all citizens is a mental health goal to which we can all contribute and aspire.

3. Plan the development or enhancement of services to address the specific mental health needs of the Asian populations (as recently completed for Maori and Pacific populations).

4. Plan the development or enhancement of services to address the specific mental health needs of Migrants and Refugees.

5.1.1. Strategic Issues: lack of regional strategic direction

There is a lack of consistent long term strategic planning across all mental health and addiction services to achieve improved health outcomes. In the past regional planning has been short-term and undertaken with a focus on service inputs. The inability to systematically determine the impact of services on health outcomes is an important issue.

5.2. Service Makeover and Redesign

5. Promote integrated continuums of mental health care across and within community, primary and secondary services (including physical health services) including provision of discharge and re-entry as needed

6. Develop integrated service delivery mechanisms across other government sectors, including housing, welfare, education, employment, justice

7. Focus on supporting prevention and early intervention of mental illness

8. Develop innovative solutions to address specialist workforce shortages in Northland eg contract for outreach services to be delivered by clinical teams from Waitemata DHB

5.2.1. Strategic Issue: Poor Coordination and Integration

There is a lack of consistent systems and processes to ensure continuity of services between mental health service providers and other health services providers. Service users with complex physical health problems in addition to mental illness, or dual diagnoses, have significant problems accessing the care they need from multiple providers. Providers may be part of a team of caregivers yet be unaware of other problems under treatment.

Mental health service users often need assistance with income support, education, employment, housing, Child Youth and Family services, and managing issues with the justice system. These services are critical to ensuring the wellbeing of the client and their family or whanau but there are poor processes for ensuring access and coordination.

5.2.2. Strategic Issue: Inconsistent Service Access and Quality

Regionally the level of access and quality of services available are inconsistent. Of particular concern is the low level of services available to those living in rural Northland. Analysis of data by service indicates significant variation in the levels of services provided for many services between DHBs in the Northern region.

Little is known about the overall quality of services provided regionally but the inability to meet demand in many areas is likely to compromise the quality of services provided. The converse applies in some districts where centres of excellence based on best practice and innovation have been established.

5.2.3. Strategic Issue: Pressure to Refer for Specialist Treatment

There is a shortage of trained field worker on the ground including adequately trained general practitioners and practice nurses. Pressure for mental health service in the primary sector, which is unable to be met due to workforce capability constraints, flows through to the secondary services in the community, which cannot meet them due to workforce capacity (935 FTEs short) then flows through to secondary inpatient services, whose Blueprint capacity equates to 0.122% of the prevalence of need at the primary sector. The pressure is exacerbated by a lack of common information systems and clear clinical pathways for the service users who moves from primary to secondary mental health service delivery and back.

We have a miss-match between capacity and capability. At each level, we are unable to increase capacity to meet the demand from the previous level that arises from lack of capacity or capability. There are a number of consequences of this situation that are not satisfactory, including the unavailability of services in the least restrictive environment, the inability to fully utilise natural supports, and the lack of care and treatment in situ. The opportunity exists to leverage available capability by training and up skilling its referrers at each level.

The diagram below demonstrates a paradigm operating in New Zealand that results in people tending to present late in their illness only once they are in crisis. This situation is inconsistent with the model of health care based on prevention and early intervention.

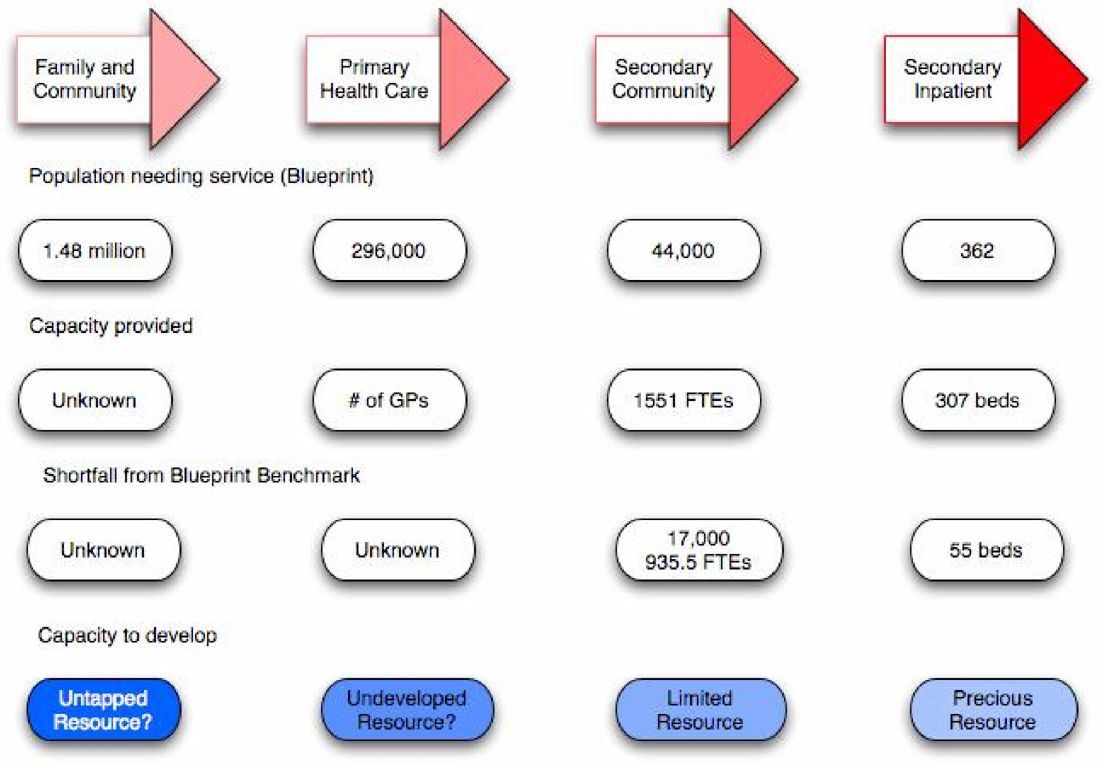

Figure 1: System under Pressure

5.3. Service Extensions - Increasing Capacity

9. Increase service volumes to match population growth and to close service gaps

10. Develop additional services that are managed and governed by service users

11. Enhance liaison psychiatry services across the sector, and particularly for the primary sector

5.3.1. Strategic Issue: Inadequate Capacity

Services are unable to meet demand in many areas due to a combination of rapid population growth, relatively low funding against Blueprint benchmarks and increased specialisation of services.

Auckland is growing faster than any other city in Australasia[5] with a population growth of approximately 1.5% per annum across the region. Northland is a primarily rural community and is experiencing growth particularly in the Maori population and in those over 65 years of age[6].

Baseline Government funding is currently at 65% of Blueprint which is significantly below the national average. Annual funding increases aim to move the Northern region funding closer to Blueprint but in effect have done little more than recognise population growth and fails to recognise additional resources needed to provide rural services. In recent years there has been increasing specialisation of service provision. The combination of these factors has jointly led to an inability to meet demand. Inpatient services are near crisis with a shortfall of 55 beds regionally and community specialist services are unable to meet needs for approximately 40% of clients (estimate approx 17,000 clients with unmet need)

5.4. Additions - Establishing New Services

12. Develop new services as identified within each service work stream

13. Develop new services to meet the needs of specific populations

5.4.1. Strategic Issue: Significant Unmet Need

All mental health and addictions work streams identified significant areas of unmet need that will require new ways of providing services eg a d dedicated maternal mental health service, liaison psychiatry to primary care and youth addiction outreach services. The planning process also identified some Asian populations, and Refugees and Migrant populations with high levels of need that are not addressed by current services. The Maori and the Pacific Mental Health Plans have been agreed and provide for the development of new services to address unmet need in these populations.

5.5. Community – Strengthen Links

14. Acknowledge the importance of and promote increased family/whanau participation in service planning and delivery

15. Establish commitment with other sectors eg housing, justice, employment to achieve common goals and resource joint initiatives

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[5] Sunday Star Times 20 June 2004. Quote John Banks "Auckland population grows every three years by the size of Dunedin city."

[6] See Table 3, page 58 for population projections 2004-2010 which indicate Northern region is projected to grow at almost twice the national rate over the next decade. Northland DHB Needs Assessment (2001) projects the population will grow at just under the national projected growth rate (7.3%) rate overall but Maori population growth (17.3%) is expected to be greater than the national Maori growth rate (15.7%).

16. Support promotion of de-stigmatisation of mental illness to assist communities to be more enlightened

5.5.1. Strategic Issue: Service Users Need to be Valued Members of their Community

The participation of family whanau and friends in service planning and delivery is often not recognised and undervalued. There is a lack of integration with other sectors such as the Ministry of Justice, Housing NZ, Work and Income NZ (WINZ) and Child Youth and Family.

5.6. Foundations - Information infrastructure

17. Evaluate data currently collected and how to use it better

18. Determine useful systematic analysis and reporting.

19. Develop information systems that support integrated continuums of mental health care across the health system.

20. Develop information systems that support integrated service delivery mechanisms across other government sectors, including housing, welfare, education, employment, and justice.

21. Repeat the Camberwell Assessment of Need study, last undertaken 7 years ago, to update regional information on service and support needs.

22. Scope the data needed to inform service planning and delivery.

23. Develop systems that simplify service users accessing and using information so that they know how to get the best services

5.6.1. Strategic Issue: Lack of Timely and Meaningful Information

Critical analysis of quantitative data indicates a lack of quality information for planning. There are problems with completeness and timeliness of data capture, lack of consistent data definitions and lack of resources to undertake data analysis. This situation is particularly the case for services where regional planning has been limited to date. As a result it is not always possible to use this information to ensure contact compliance and performance measures are of limited use.

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5.7. Foundations - Workforce infrastructure

24. Implement recommendations of the Northern Regional Mental Health Workforce Development Action Plan (NDSA. June 2003), including the stock take of the regional workforce, identification of all existing training programmes, and forecast of new training requirements.

25. Develop workforce capacity and capability in all areas, including attracting clinical staff with transferable skills into mental health in accordance with the Northern Regional Mental Health Workforce Development Action Plan (NDSA. June 2003)

26. Increase the number of skilled field workers in the community

27. Support initiatives to bring about attitudinal changes that are consistent with achieving our vision and values and necessary to work in a truly collaborative manner with service users and their families and with other service providers in the Northern region

5.7.1. Strategic Issue: Inadequate Capacity

There is a shortage of specialist staff across all mental health and addiction services. Competition exists between DHBs to recruit new staff and the DHBs with fewer vacancies tend to be more attractive to applicants. This situation leads to regional variation in staffing levels with some units working under considerable stress due to inadequate staff levels.

5.7.2. Strategic Issue: Unused and Limited Capability

While there is a perception of significant capacity in the primary sector (GPs, practice nurses, CHW, pharmacists, OTs etc) there is thought to be limited capability. Similarly there is considered to be significant undervalued and untapped capacity in the community and in families, but limited capability. Friends and family consider they are overburdened and under-recognised as a resource. However, there is limited information to confirm these perceptions or assumptions. Further work will be required to evaluate the degree to which they are correct.

6. Specific Populations and their Issues

The Mental Health Commission and the Mental Health Foundation identifies four population groups experiencing high risk of mental health illness. This section provides a discussion on each group and how their special needs will be met. The section for Maori and Pacific island peoples is essentially a summary of the region's strategic plans that have been recently completed to meet the needs of these populations. Planning to meet the mental health needs of the Asian populations, and migrant and refugees populations is less advanced so the available relevant information is presented.

6.1. Maori

The following section highlights key points from Whanau Oranga Hinengaro Northern Region Maori Mental Health and Addictions Plan (March 2004).

6.1.1. Vision

To provide an integrated range of mental health services for tangata whaiora and their whanau so that they may achieve whanau ora.

6.1.2. Strategic issues

- Approximately one third of New Zealand Maori live in the Northern region
- Maori mental health needs are comparatively high
    - o Almost half the Maori population are under 19 years of age i.e. they access Child and Youth Services for which the overall prevalence rate is known to be higher than for adults (5% compared to 3%)
    - o Assume that prevalence rates of serious mental health disorders requiring specialist treatment in adult Maori are double the rate compared to non-Maori (6% compared to 3%) will be confirmed by MOH study[7]
    - o Acute admission rates for Maori are 5 times the rates experienced by non-Maori, presentation is later and hospital stays are shorter
    - o Rates of Maori suicide are comparatively high and are not declining as seen in non-Maori
- Essential components of mental health services to meet the needs of Maori are defined in the Blueprint (1998 page 60)
- Problems accessing appropriate services in a timely manner
- Lack of integrated planning for Maori mental health services across the region

[7] The New Zealand Mental Health and Wellbeing Survey, Te Rau Hinengaro

6.1.3. Strategic themes

- Focus on wellness
- Promoting holistic models of wellbeing that integrate clinical excellence and cultural responsiveness
- Ensuring the provision of high quality, clinically safe, culturally effective and efficient services
- Fostering collaboration within the mental health sector, the health sector and across other sectors

6.1.4. Strategic priority areas (3-5 years)

- Strategies for priority Mental Health Services for Maori
- Capacity and capability development
- Information, research and analysis relevant to Maori mental health
- Quality and risk management
- Appropriate levels of service resourcing

6.1.5. High level key result areas

- By 2006, every funded provider will be able to initiate cultural assessment for at least 60% of the Maori people accepted into their service, within seven days (except where the person has already had such an assessment within the previous 6 months). These assessments will include the person's whanau, and be based on both clinical and Maori models of care, assessment and treatment (including traditional Maori healing).
- By 2007, at least 50% of the staff of all providers will have received training in cross cultural communication with Maori, with a view to reducing cross cultural misdiagnosis and improving health outcomes for Maori.
- The reduction of the negative impacts of mental illness and disorders for Maori is a priority, so the establishment of a network of Maori recovery programmes for tangata whaiora across the region will have occurred by 1 July 2007.

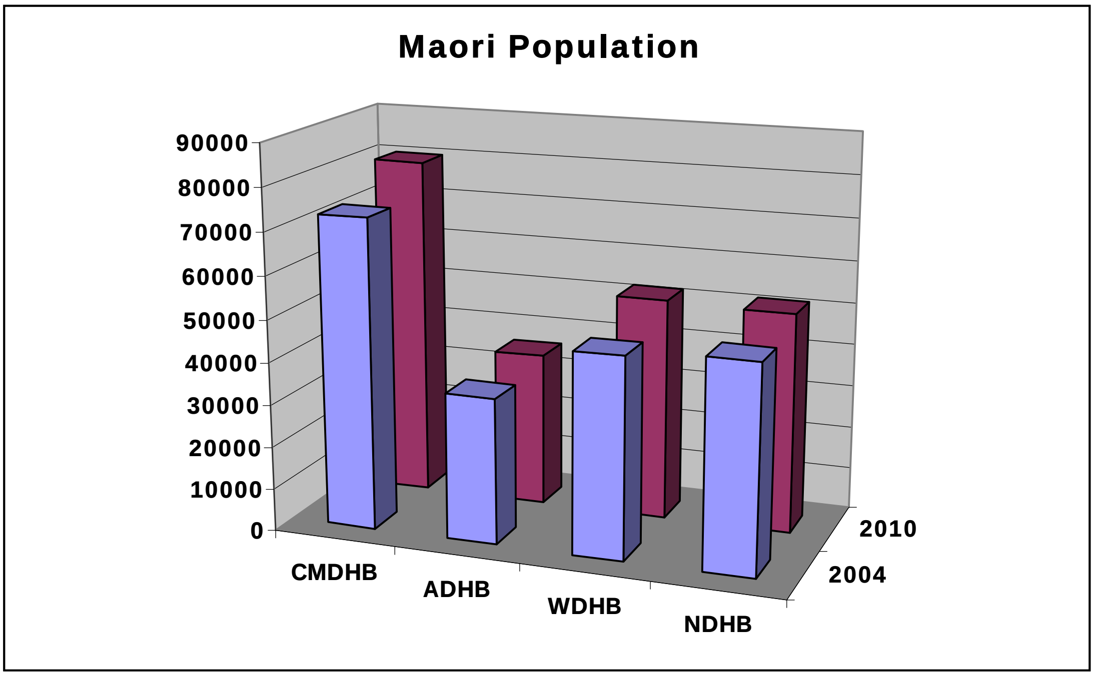

Figure 2: Maori Population Projection by DHB

Maori sector feedback endorses the NNC approach to priority setting for funding allocation (refer to section 9).

6.2. *Pacific*

The following section highlights key points from The Northern Regional Pacific Mental Health and Addictions Plan 2003/04.

6.2.1. Vision

Healthy Pacific people achieving their full potential throughout their lives

6.2.2. Values

Compassion, courage, total commitment, generosity, humility, empathy and service[8]

6.2.3. Key issues for Pacific Mental Health

Access to services

- Pacific peoples comprise 6% of the total New Zealand population and are the fastest growing ethnic group with a median age of 21 years
- 70 % of the total Pacific population live in the Northern region
- Counties Manukau Pacific population is 25% of the total population
- NHIS and MHINC data indicate Pacific discharges from mental health services were lower than any other ethnic group. Comparative under-utilisation of services was particularly marked for Pacific youth
- In 2002 expenditure on Pacific mental health services was $8.4m
- There are no specific Pacific mental health services for Child and Youth or Older Adults

Partnerships

- Working relationships with communities needed to reduce stigma and discrimination
- Fonofale model requires partnerships with people to support recovery in all aspects of life
- To support recovery Pacific providers need relationships across other sectors (employers, landlords, education programs etc)
- Acknowledge and support other models of care

Workforce

- Inadequate capacity and capability in Pacific workforce across the mental health system
- Mental Health Commission identified building Pacific workforce as a priority

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[8] Our long term vision for Pacific Mental health is well informed Pacific communities, able to protect and preserve the mental health of their residents, able to recognise when help is needed and where to go for that help, and able to support people with serious mental health problems to achieve recovery. Our vision is of a time when there are no l9onger disparities for Pacific people and when people can live well in the presence of absence of his or her mental illness.

Information Research

- There is a shortage of
  - Information for the public on how to stay well and what services are available
  - Information for Planning and Evaluation
  - Research to inform planning and improve service delivery

Quality of Services

- Lack of regional consistency of services
- Many mainstream mental health staff do not have the skills to provide culturally safe services for Pacific peoples

6.2.4. Goals and Objectives for Pacific Mental Health

To follow are the key directions and objectives for Pacific mental health for 2003-2005.

1. To develop Pacific primary mental health services
2. To improve access for pacific peoples to mental health services
3. To develop partnerships with organisations, people with experience of mental illness or addiction, families of people with experience of mental illness or addiction, which will maximise opportunities for Pacific peoples involved with mental health and addictions services
4. To develop a competent and qualified Pacific mental health workforce that will meet the needs of Pacific peoples
5. To ensure that information and research on Pacific mental health will inform policy planning and service development
6. To improve the quality of mental health services

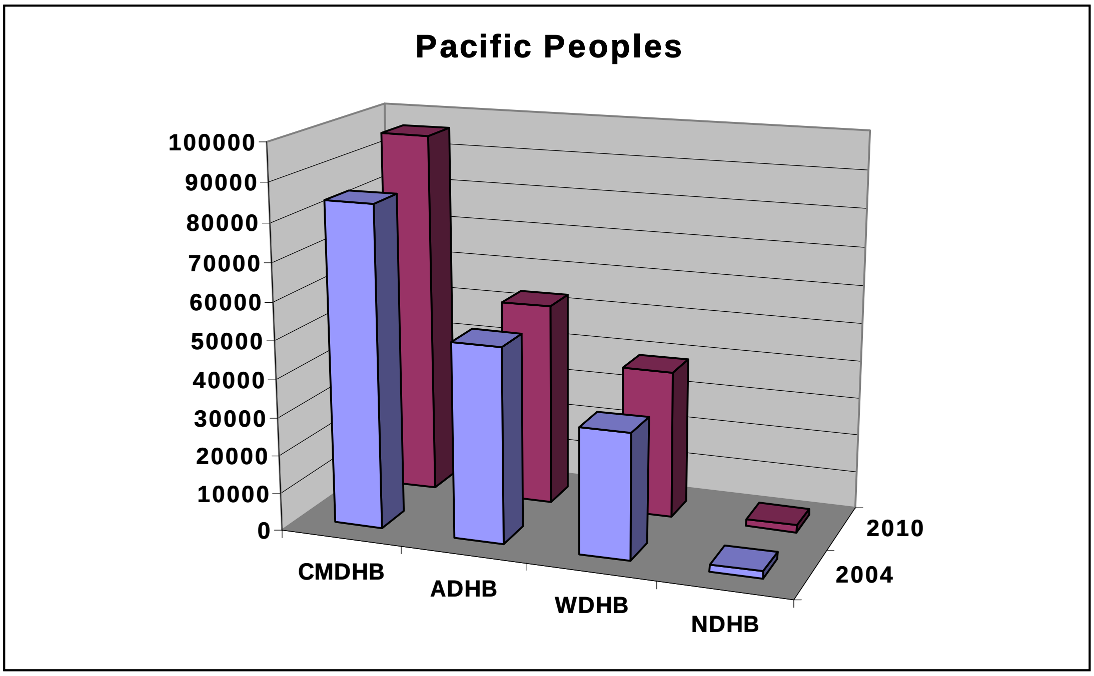

Figure 3: Pacific Peoples Populations Projected by DHB

7.3 Refugees and Recent Asian Migrants

There is no agreed vision or direction for the development of Northern region mental health services to address the specific mental health needs of new migrant populations, notably of Asian origins, as well as refugees from a wide range of source countries.

The 2001 census found that the number of people of Asian ethnicity had more than doubled between 1991 and 2001, and there are now more people of Asian than Pacific ethnicity in New Zealand. Two-thirds of people of Asian ethnicity live in the Auckland region, constituting approximately 12 percent of the population.

Development of detailed strategy work will be undertaken as a regional priority. A recent literature review on *Mental Health Issues for Asians in New Zealand* prepared for the Mental Health Commission[9] and the Ministry of Health's *Asian Public Health Report* provide useful starting points[10].

7.3.1 Proposed Vision

- Equal opportunity to access quality services delivered in a culturally appropriate manner for refugee and recent Asian migrant clients and their families
- Access to professionally trained and qualified interpreting services to meet the needs of migrants and refugees with experience of mental illness and their families.

7.3.2 Key issues for Asian Mental Health

The term 'Asian' includes an extremely diverse population from Pakistan and Afghanistan to Japan (Statistics New Zealand 2001). It encompasses people from over thirty ethnic groups, predominantly Chinese, Indian, and Korean, but also every other country in the same region, with widely diverse languages, cultures and migration experiences, as well as third and fourth generation New Zealanders.

Table: Number and percentage of Asian population by DHB 2000

DHB	Number of Asian	%Asian
Auckland	63,2443	27.9
Counties Manukau	42,498	18.8
Waitemata	40,362	17.8

The demographic and socio-economic profile of Auckland's Asian population is also extremely diverse.

[9] Mental health issues for Asians in New Zealand: a literature review. MHC 2002
[10] The Asian Public Health Project Report. Ministry of Health 2003

It includes every category of immigrant, including those with professional skills and investment capital, foreign fee-paying students, as well as refugees, with diverse social and economic resources and health needs. The particular characteristics of the refugee population are discussed below.

Overall the Asian population has above average education, but below average income. This reflects the youthfulness of the immigrant population, including the large number of students. However, many better-educated Asian migrants may also be still seeking work or underemployed, with associated loss of social status, frustration and financial stress. Language skills and the challenge of coping with cultural adaptation affect almost all migrants.

The general health status of the Asian population is good, with predominant causes of mortality and morbidity similar to the general population. But the Asian Public Health Report identified concerns regarding mental health, cardiovascular disease and diabetes, sexual health, tuberculosis and traffic injuries. Migrants may experience mental health problems two or three years after the ‘honeymoon period’ is over (i.e. getting residency and getting settled). These may be due to the differences between expectations and experience, the effects of discrimination, problems in adapting and so on.

The MHC review identifies a number of key adaptation problems:

- Language difficulties, especially for women, older migrants and refugees
- Employment problems, even when the language barrier is overcome because qualifications may not be accepted, or prior local work experience is required
- Disruption of family and social support networks
- Acculturation attitudes. That is, the extent to which migrants have integrated into the local culture.

Research gaps are also identified:

- Prevalence studies. Because of the relatively small and rapidly changing population it is difficult to obtain representative samples.
- Overseas studies as well as the limited New Zealand research indicates particular mental health problems associated with particular migration experiences. For example, high rates of depression among older Chinese migrants; post-traumatic stress disorder among Cambodian refugees; loneliness among students.
- High risk groups requiring further research include women, students, older people, and refugees.

Other key issues identified in the consultation and submissions on this strategy include:

- Poor representation of Asian perspectives at different policy-making levels, and a sense that Asian voices and stories are rarely heard.
- Responsiveness of mental health services is hampered by the fact that urban services have fallen behind population growth

- There is a lack of understanding of the belief systems about mental health illness in Asian cultures.
- Asian usage of mental health service is disproportionately low compared with the population in the region and reasons for this are not known

7.3.4 Key Issues for Refugee mental health

Refugees are an important sub-set of immigrants.. Each year New Zealand accepts 750 people selected by the United Nations Quota programme, and approximately 200-500 asylum seekers whose refugee status has been recognised by the New Zealand Government. The main source countries for refugees in recent years are Iraq, Somalia, Ethiopia, Afghanistan, Burma/Myanmar, Iran and Sri Lanka. In previous years there have also been significant numbers from Cambodia and Vietnam.

In November 2003 the Mental Health Foundation consulted on what it is like to be a migrant or refugee living in New Zealand[11]. The purpose was to help identify initiatives that would support the mental wellbeing of migrants and refugees in the Auckland area. Some of the issues appear to be the same for both migrants and refugees, however there are some important differences. A more general report on refugee experiences of settlement in New Zealand was also published by the NZ Immigration Service in June 2004[12].

The biggest issues for refugees – as for migrants - are around resettlement. Economic issues, finding accommodation, settling into the community and adapting to New Zealand culture were always given as the main concerns on arrival and for some time afterwards.

But while migrants are ‘pulled’ to New Zealand by a set of expectations, desires, hopes and dreams, refugees are usually ‘pushed’ from their homeland, with little or no choice, by a series of traumatic, damaging and terrifying circumstances. The two groups therefore have different issues, expectations and needs.

Refugees arrive with particular health problems, including post-traumatic stress syndrome and poor general health as a result of their refugee experience. While most report early improvement owing to a sense of safety and security, around one third continue to experience emotional problems, often associated with cultural adaptation. Women are more likely than men to continue to experience poor mental health.

The experience of some mental health problems may be delayed by ‘deferring’ the effects of trauma (torture, witnessing or being subjected to violence, losing friends and family) while the immediate issues of resettlement are dealt with.

[11] Important factors in the experience of migrants and refugees. Summary of a consultation process, Mental Health Foundation, November 2003
[12] Refugee Voices: A Journey Towards Resettlement. Department of Labour 2004

Both migrants and refugees share the universal experience of acculturation. Acculturation was defined during the consultation as keeping your own culture alive, but assuming enough of NZ culture to operate effectively. Family members do it at different rates e.g. children acculturate quickly but men take the longest time. If their expectations are not met they may became withdrawn, depressed, and unable to learn the language or to find work. People may become partly acculturated, but not assimilated.

It is thought to take 3-5 years for refugees to regain a sense of confidence and a sense of control of their new lives[13]:

On arrival	• They were happy and excited
By 6 months	• Morale sank while they dealt with the problems of finding accommodation, employment, learning the language etc
Late in 1st year	• Depression peaked
Next 2-3 years	• Morale rose gradually
By 3rd year	• Approaching normal

It is essential that primary care providers have some understanding of these concepts and processes if they are to respond adequately to the mental health needs of refugees and migrants.

7.3.5 Goals and Objectives for Asian mental health

The Mental Health Commission's literature review points out the limitations of current research on the mental health of Asian New Zealanders. Most has focused on recent immigrants and has involved Chinese, and to a lesser extent Koreans and Indians, while the research on refugees has focused on Cambodians. There are few studies of the prevalence of mental illness among Asian ethnic groups and none claims to be based on a representative sample. The focus has been on the adaptation problems, mental health status, utilisation of (and barriers to) mental health services and traditional healing practices.

In spite of these limitations, the Review recommends the following strategies as a useful starting point for working with other organizations that impact on the mental health of Asian communities and for developing mental health services to better meet their mental health needs.

Promote Mental Health in Asian Communities

1. Increase service providers' awareness of Asian cultural issues

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[13] Quoted in "**Towards a successful resettlement of refugees" Dr San Duy Nguyen, 1989**

Health care providers can deal with their clients more competently if they are knowledgeable of their clients' cultural beliefs, their interpretation of mental illness and mental well being, their help seeking patterns and choice of traditional alternative health practices.

2. Increase public support for cultural diversity

The host societies' receptivity towards newcomers and their tolerance for cultural diversity are major determinants of immigration as a positive experience. Public education can improve receptivity by increasing awareness of the benefits of cultural diversity to New Zealand society.

3. Provide extensive information before and after migration

Access to information and support networks is a vital part of the settlement process. Topics addressed should include employment, housing, schooling, language training, and social and cultural relations.

4. Improve access to English language education

Inability to speak the language of the host country is a major factor affecting the mental health of newcomers. Besides the isolation and loneliness it imposes, it is also a barrier to utilisation of mainstream services in various areas. It compromises their opportunities in employment and higher education needed for their full and equal participation in the New Zealand society.

5. Encourage and support the development of community support programmes

The provision of practical assistance in housing, transportation and employment at the time of arrival will have long lasting effects on their mental well-being.

Improve Cultural Responsiveness in Mental Health Services

6. Promote the development of educational materials and professional interpreter services

Information on mental illness needs to be developed and made available in Asian language and working with interpreters needs to be supported. Stigma is a major obstacle preventing Asians from using mainstream mental health services. Ethnic press, radio and television outlets, as well as the church, should be used to disseminate information promoting the use of services. There is also a need to improve professional interpreter services for each ethnic group.

7. Funding Assumptions

Mental Health services are funded as public health services from government revenue. Decisions about funding are first made through the government budget process, then through allocations from the Ministry of Health. Ultimately, the District Health Board decides the application of mental health funding in any district. That decision is informed by advice from the Network North Coalition, the NDSA, and consultation with the sector and the wider population.

Naturally then, any strategic direction for a five-year period must make some assumptions about the availability of funding during that time. This document has been based on the following assumptions:

- That additional Blueprint funding of $25 million (inclusive of GST) per annum will be available nationally, based on Government decisions in Budget 2004/05
- That the Northern region allocation of that additional funding will be on the order of $8 (exclusive of GST) million annually

The Ministry of Health has now confirmed the funding split for $2005/06. The allocation for the Northern Region is $13.7 million (exclusive of GST.) The Ministry has also confirmed the sum (but not the split) of additional Blueprint funding through until the 2007/08 financial year. However, as the government is committed to fully funding services to the Mental Health Commission Blueprint level, assuming a similar level of funding beyond 2007/08 is a reasonably conservative assumption.

Detailed discussion of additional mental health funding is included in a separate appendix. Population growth[14] and service cost inflation are addressed in some detail there, and are included in the figures and tables in this section.

7.1. Funding Priorities

In order to decide how money is allocated, and what existing services are expanded, or new services are initiated, a prioritising process is required. Priorities can be determined on a range of different factors, such as utility, efficiency, effectiveness, or equity. The Network North Coalition has identified the following Strategic Priority Objectives for the Northern Region:

- Achieve regional equity of access to and levels of services[15]
- Regional collaboration to achieve gains
- Infrastructure development
- Priority service areas

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[14] All population data used in this report has been supplied to NDSA by Statistics New Zealand, and the use thereof is gratefully acknowledged.
[15] But only where the level of service is below Blueprint benchmark levels

1. Increase level of services for children and adolescents
2. Increase level of services for older people
3. Enhance Maori and Pacific Services

In order to translate those priorities into funding allocation at the regional level, the Coalition has proposed the following criteria for guiding DHB funding allocations to specific Service Areas[16]

Regionally

- Close the Greatest Gap from Blueprint
- Achieve regionally consistent access
- Address identified health inequities
- Achieve 50% access for Maori to Kaupapa Maori services
- Achieve 50% access for Pacific to by Pacific services

Locally

- The feasibility of service developments
- Identified local priorities for specific high needs

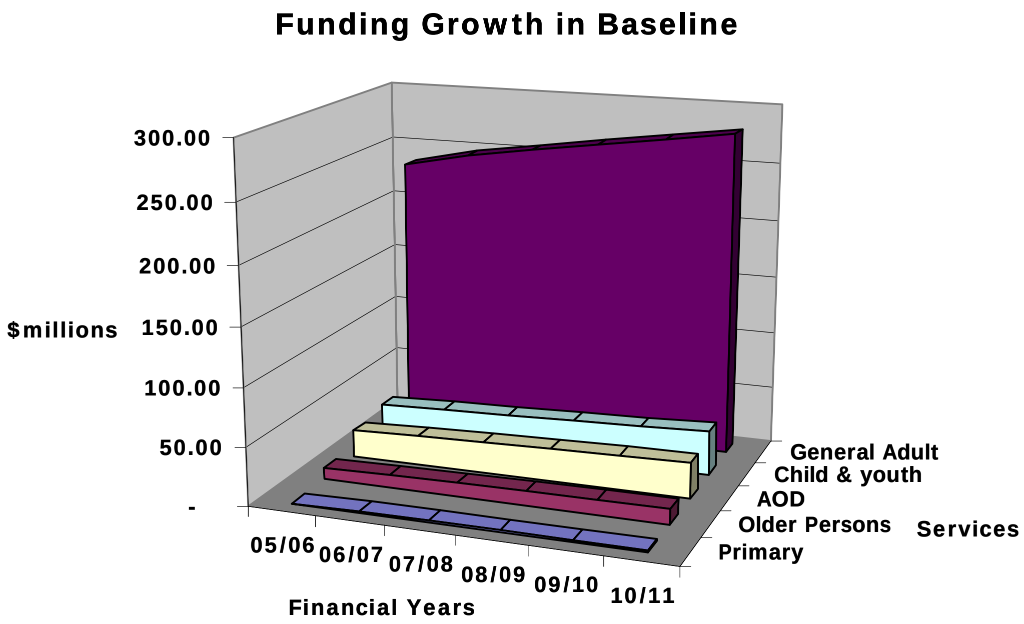
7.2. Regional Equity

Regional funding of services is supported in order to ensure true regional collaboration and regional equity of access to services, given that allocation across services and districts is based on clear and transparent criteria.

7.3. Effect of Funding Changes

The following graph sets out the funding growth in baseline over the term of the plan, based on the assumptions and priority setting approach above, for each of the service areas. Detailed changes in funding and priority ranking are included in the funding appendix.

[16] Based on Counties Manukau DHB Planning work, and approved by each of the DHBs as part of the 2004/05 Regional Mental Health Plan.



	05/06	06/07	07/08	08/09	09/10	10/11
Primary	-	0.86	1.17	1.18	1.20	1.52
Older Persons	9.92	10.93	11.59	12.24	12.91	13.47
AOD	23.46	25.53	27.09	28.46	29.84	30.93
Child & youth	28.43	30.59	32.02	33.95	35.90	38.37
General Adult	234.29	246.49	254.98	263.43	271.92	280.16

Figure 4: Northern Region Projected Mental Health Funding 2005-2010

The end result of additional planned funding is still well short of the current Blueprint targets, though these are being revised at present.

8. Service Strategies

In order to manage the wide range of issues impacting on the future delivery of mental health and addiction services, five clinical work streams were created, being child and youth, adult, older adult, alcohol and other drugs, and primary health. Work streams were led by acknowledged experts in the field, and included a range of expertise from the sector including:

- People from clinical and support services
- People with mental health service user experience,
- People with family or whanau experience of mental health services, and
- People with specific knowledge of the needs and services of distinct populations;
    - Maori
    - Pacific People
    - Asian
    - Migrants and Refugees

Work streams worked under the auspices of the Network North Coalition, with support provided by the Northern DHB Support Agency (NDSA). Work streams developed their section of the plan, and cross checking and collaboration occurred both at combined work stream leaders meeting, and at meetings of the Network North Coalition. The process has provided a high degree of inclusion, with over 120 people involved in the initial drafting of the strategic direction document.

Each work stream has a separate section below, that reports on the work stream progress to date. Work streams are at different stages of development, depending in part on the complexity of the issues they are grappling with, and also on the prior state of that section of the mental health sector.

This process has focused on the high level strategic issues. Much of the feedback to the working draft concerned detailed operational issues, and these have been forwarded to the work stream for inclusion in future planning. Detailed project planning is also included in a separate companion document to this one.

8.1. Child and Adolescent

8.1.1. Vision

That, regardless of where they live, all children and adolescents with mental health needs have access to expert assessment and evidence-based care that is culturally appropriate and family and whanau inclusive, from a workforce that has the appropriate clinical and cultural skills and is well-supported.

8.1.2. Issues - Child and Youth

Changing pattern of demand for services

There is a need to define the population; there are variations across agencies and DHB's in the age brackets used to define the target population of children and young people.

- CYFS serve the population up to 17yrs.
- Alcohol and Other Drugs 0-17 year olds.
- Starship deals with 0-14 year olds.
- The Child and Family Unit take adolescents up to the age of 19.

The MOH national strategy sets targets for 0-9, 10-14, and 15-19 years. Across the region there are varying definitions for both "child" and "youth". In particular "youth", often used for 15-19 year olds, may be used for young people from 13 up to the age of 25. In the older age groups the issue of emancipation impacts on appropriateness of services, as many no longer live at home.

Given this huge variation it was agreed that the term "adolescent" would be more appropriate when referring to this age group and should refer to 13 – 17 year olds. It was felt that the most appropriate developmental levels for child and adolescent mental health services would be:

- Services for infants and preschoolers (< 5 years old)
- Child services for age 5-12 (primary and intermediate school level)
- Adolescent services for 13 – 17 year olds.

Current Blueprint, funding and contractual arrangements include the provision of services for those aged 18-19 within both Child and Adolescent and Adult mental health services. The explicit presumption within contracts is that services will be provided within Child and Adolescent services, unless Adult service are more appropriate to the particular service user's needs and situation.

The majority of those people aged 18-19 function as young adults. Their mental health needs would be most appropriately dealt with in services designed to meet the particular developmental needs of young adults. Neither Child and Adolescent nor Adult services can at present be said to have services designed to meet those explicit needs. There may be a small number of 18-19 year olds who specifically need child and adolescent services.

Both Child and Adolescent and Adult service work streams have agreed that the mental health service needs of young adults (18 – 25 year olds) are a priority. It is recognised that criteria for deciding on service access would need to be agreed between both. Given ongoing difficulties around service access for this age group, specific work is needed to resolve this in conjunction with adult services.

A process of joint planning is proposed to better meet the needs of this specific group, which may result in the development of additional services, or other models such as joint or virtual teams, specifically targeting young adults.

It is important that the cost of service to this group, which is considerable, is teased out and that the resources are made available to the services that are dealing with them, be they adult or adolescent services. Funding transparency will be required to ensure this.

Services for children have been eroded or left undeveloped. Services for infants and preschoolers are absent. This means that valuable opportunities for early intervention are being lost. This results in a greater load on services as the children grow up and problems become entrenched.

Capacity and capability

Workforce development is one of the main priorities for child and adolescent services. There is an urgent need to improve both capacity and capability. The Northern region lags behind the rest of the country in progress towards meeting the Blueprint levels of service provision, and child and adolescent services are the furthest behind.

There is a misperception that if it is not possible to recruit people to Child and Youth services as numbers of skilled professionals are low, further recruiting to one service will leave another service unable to recruit. This belief has led to continued inadequate funding and a nihilistic approach to recruitment. This notion must be challenged by a high profile regionally coordinated recruitment drive with strong promotion to potential staff.

It is important to ensure that staff has the ability to do the work. Apart from child and adolescent psychiatrists and child psychotherapists, most new graduates from health professional training in New Zealand have not had sufficient specific training in child and adolescent mental health to equip them to carry out the complex work required in the CAMHS. NGO's also report a lack in training in specific skills required. This is particularly problematic given the paucity of training available in child and adolescent mental health. However it should also be noted that not all training places are filled in the postgraduate training programmes in child and adolescent mental health. There is an opportunity to ensure full take up of the positions to expand the workforce and to ensure adequate training.

Although there is a shortage of workers, there is also a marked difference in staffing levels in services across the region. Reasons for this should be explored. There is the potential for improving recruitment and retention based on the practices of services that have managed to recruit and retain staff.

There is no overall plan for services across the region, which results in inconsistent access for children, adolescent and their families.

There is a lack of services that are culturally appropriate – particularly for Maori and Pacific people.

There is a need to establish a mechanism to ensure input from people with experience of mental illness including children, adolescents and their families.

Flexible models of delivery of care are needed in the region e.g. to meet rural need. Funding needs to take into account potentially greater costs of delivery of service to remote areas.

Coordination and integration

There is a lack of regionally consistent entry, exit and transfer criteria.

There is no agreed standard of assessment and no agreement about what constitutes best practice in management that is based on the evidence available.

Care is fragmented across primary – secondary – tertiary care services. Care between agencies is poorly coordinated.

Access to care is likely to be enhanced if there is planning and coordination around care at different levels. It is important that the notion of shared care is developed as many children and adolescents with mental health problems will need to move from one tier of care to another.

8.1.3. Critical Success Factors Child and Youth

Architect - Planning

- It should be recognised that services for children and adolescents are the most under-developed and should be the first priority for the region.
- Key people with clinical expertise in child and adolescent mental health should be identified and resourced to lead the regional planning and coordination
- Sustainable regional planning and coordination of services is required to ensure best use of resources and most effective service delivery.
- Joint planning is needed:
    - To ensure seamless service provision with primary care services and child health
    - With adult services to establish a system to deal effectively with young adults aged 17-19.
    - Between child and adolescent mental health and addictions services to ensure clarity of responsibility and appropriate linkages and resources
- Planning and developing a strategic approach to increasing capacity and capability of the workforce is critical.

Makeover - Service Redesign

- Service re-design needs to involve children, adolescents and their families who use mental health services in planning processes and service delivery.

Extensions - Increase capacity

- Increase levels of service delivery regionally
- Establish services for under 5's.
- Increase service for 5-12 year olds
- Increase services to Maori children and their whanau
- Improve access to consultation and liaison services
- Improve levels of consultation and liaison services to welfare, justice and disability services

Additions - New Services

- Develop services for children aged 5 years and under
- Developing appropriate services for Pacific children and their families
- Evaluate " one stop shop service for youth"
- Develop consult liaison services for children and adolescents in all hospitals in the regions (none currently in Kidzfirst, North Shore or Whangarei).

Community – Strengthen Links

- Coordination between the agencies and services involved with children and adolescents must be developed. This should take into account local differences.
- Services for adolescents with Alcohol or Other Drug problems need effective coordination between Child and Adolescent and Alcohol and Other Drug services.

Foundations - Information and Workforce

- Provide training to develop capability in adult mental health to provide expert treatment to youth and their families.
- Ensure provider training is based on identified competencies for CAMHS staff.
- Research is needed to support principles for services delivery for Pacific Peoples.
- Research is also needed to support services for Asian and migrant and refugee communities.

8.2. Adult

8.2.1. Vision

> To provide integrated care across a robust continuum of clinical and support services delivered by competent DHB and community based NGO providers that support early diagnosis and rapid acute treatment, and rehabilitation and recovery services that respond to meet the needs of individuals.

Mental health service providers currently make their best endeavours to maximise people with experience of mental illness access to clinical treatment services and support services of the highest possible quality. It is important to acknowledge that the majority of providers are working under considerable duress associated with the systematic problems and resource deficits identified in this section of the plan. Despite these problems there is a high level of commitment within the sector and many positive initiatives already underway to improve mental health outcomes across the region.

This section of the plan covers specialty services including Intellectual Disability, Eating Disorders, Liaison Psychiatry Psychotherapy, and Maternal Mental Health. While detailed information relating to these services is not included in this document it is intended that specific regional plans for these services will be developed as priority projects under this work stream.

8.2.2. Issues - Adult

Changing pattern of demand for services

The estimated number of adult people with experience of mental illness with complex long-term needs in the Northern region is approximately 5,350 (0.06% of the adult population). [17]. This may be an underestimation and while we are awaiting accurate information on who these people are and what they need, we know there are a number of client groups that are not homogenous.

There are a further approximately 21,000 adults with serious mental health needs to whom services should be readily accessible at any one time. Furthermore, a much larger group of approximately 180,000 (20 percent of the adult population) across the region have mental health symptoms that could be managed by primary care interventions.

Capacity and Capability

Adult mental health services have suffered from multiple system failures, which are well known, repetitive, and predictable. Some of these problems have been resolved but many still exist and could be addressed.

[17] Applying estimates used in Moving Forward, Ministry of Health, 1997, to the current regional population.

There are service bottlenecks due to lack of streamlined approach, and current service variations between DHBs are a consequence of the gaps, rather than an intention to provide substantially different services. Perverse incentives exist to providing high quality services such as the pricing flow through from forensic impacting on other services. Acute services have difficulty responding appropriately due to high demand and barriers to access that have been developed in the absence of appropriate entry criteria needed to manage acute demand (refer diagram below (change to black and white S51).)

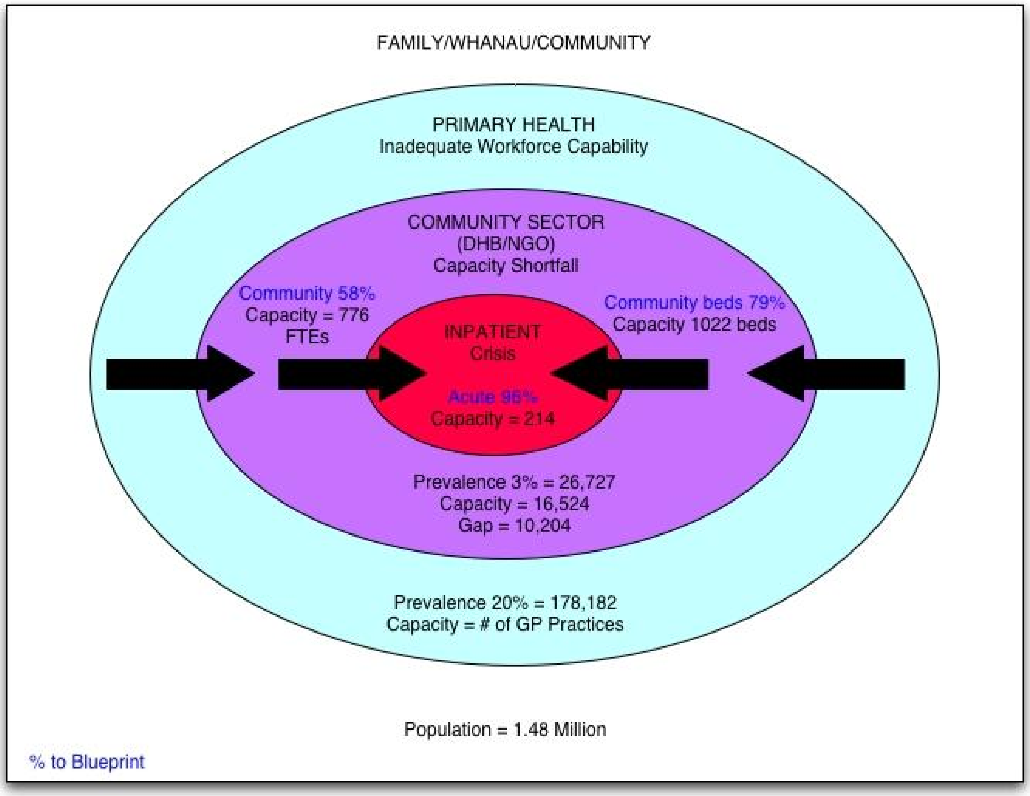


Figure 5 Impending Systems Failure

The development of clinical pathways is progressing but there are still some identified areas of deficit in care planning needed to standardise care for people with experience of mental illness. Clarity around after treatment options does not exist. While there are some excellent examples of explicit partnership arrangements across teams of caregivers, they are not common practice. There is generally, therefore, a lack of clarity with regard to the role and responsibility of the clinical team, NGO staff, support providers and primary care providers.

Acute services lack a comprehensive systematized approach to inpatient care; neither do they provide appropriately individualised care. There is a lack of clearly defined roles and responsibilities associated with the clinical component and NGO component of the acute response.

There is no agreed timeliness for appropriate responses or treatment options for both pre and post inpatient care.

Care for those with long-term complex needs is resource intensive and often without clear outcomes. NGOs are providing a greater clinical component of care in this context. There tends to be a lack of inter-sectoral approaches despite the clear need for support from other agencies.

The NGO sector has grown and changed over the past 20 years largely in response to institutional closure. It now comprises 29 percent of the spending on mental health services. It has developed from a relatively unsophisticated workforce providing primarily a residential style service to deliver more flexible housing and support models using a mobile and more skilled workforce. The requirement to meet the Mental Health Standards MOH by October 2004 may not be met by some providers. This is a particular concern for smaller organizations still providing old style residential services without pre-assessment and requiring remedial work to be completed.

An integrated quality system to assure consistent service quality across the region for DHB clinical services and NGO services does not exist. MOH Certification will require training to up-skill the workforce. There is no agreement on the required workforce numbers i.e. those required now and into the future nor are the necessary staff being trained. As NGOs increase their capacity new models for coaching and mentoring and development of capability will be needed.

Coordination and integration

There is a commitment to better coordination of care across service providers, and across sectors. There is, however, a lack of system alignment across primary/ clinical/ NGO/ inter-sectoral roles and functions.

Dual diagnosis (a person with mental health illness and an addiction) has been separated out but is actually core business that should be an integral part of the adult service. Liaison and emergency psychiatry is not strong, with limited access to advice for clients being treated in the primary sector. Maternal mental health services have been neglected, as responsibility for their provision is unclear between the adult and Child and youth services. Eating disorders are often managed by medical teams and not as a shared care partnership.

There is poor coordination across the intellectual disability interface leading to this group having high needs but poor access to services. There are also problems with the Northland rural/urban interface. A lack of robust clinical pathways and clarity of partnership arrangements, previously mentioned, compound these problems.

Access to appropriate housing for clients is a major issue. Flexible options such as community housing groups where there are no rentals to individuals are developing at market rentals as per the NZ Housing strategy.

There is also the need to coordinate the separate functions of housing support and landlord responsibilities.

Adult Forensic services

Changing pattern of demand for services

The demand for adult forensic services is increasing. Nationally prisoner numbers are expected to rise at 3.5% per annum, but the construction of 3 new prisons in this region predicts that prisoner numbers will rise from 1500 currently to 2000 in 18 months. This includes a 350 bed women's prison, which will increase demand on female secure beds significantly. Further, demand around the interface with the "difficult to engage" consumers with high and complex needs between General Adult mental health services and forensic services remains an area that is difficult to define.

New legislation with new legal powers remains an uncertain factor in determining future demand.

Capacity and Capability

Capacity and capability is a major issue. The MOH Forensic Framework is attempting to address reduced workforce capability in general adult services. Bed blockages are significant but services are required to grow to meet the increased demand leading to capability issues. There is a lack of clarity about the use of the Mental Health Act in prisons. There are poor links with adult rehabilitation services and a need to develop after treatment options. The Full Active Community treatment (ACT) model could significantly assist in easing these pressures.

Coordination and integration

Forensic service interface with General Adult services lacks agreement on access criteria. There is also a lack of integration across Forensics/ Primary Care/ NGO/ family/ supports from other Government agencies eg Child Youth and Family for children of parents with mental illness. Poor links exist between clinical services and Housing New Zealand. The Risk Guidelines are being upgraded in a joint project with the MOH.

8.2.3. Critical Success Factors – Adult

To follow are the critical success factors required to move the service from a system under pressure to one capable of meeting community needs.

Architect – Planning

- Define the components of comprehensive services at regional and district levels
- Ensuring the correct balance of treatment and support services exist

- Clarify who are we serving
- Determine where are our interventions going to have the highest value
- Support for the use of geographical and population modelling to associate need with distribution of services, and improve access and equity
- Develop key comparators, contextual indicators; what we measure and publish transparently will rapidly influence the shape of service delivery
- Predict that there will be significant advances in treatment in the next twenty years, and while we don't know exactly what they are, we need to be identifying the assumptions that should drive our service and workforce planning over the next five years
- Develop specialist service strategies in priority areas

Makeover - Service Redesign

- Co-ordinated service delivery targeting high risk families, through primary health, maternal mental health, liaison services and inter sectoral approaches, to prevent and intervene early in the development of future users of mental health services

Extensions - Increase capacity

- Increase inpatient beds to ensure ability to manage acute risk
- Increase community based services to more closely align supply with need

Additions - New Services

- Alternative models of community based support
- Sub specialist services eg maternal mental health, eating disorders, psychological treatments available in all areas

Community – Strengthen Links

- Integrated specialist inpatient, NGO community based services and primary care services
- Active support initiatives to promote community awareness and understanding of mental illness eg de-stigmatisation programs

Foundations - Information and Workforce

- Development of current workforce to ensure strong leadership and appropriate staff skills and attitudes to bring about the culture change needed to achieve our vision
- Workforce development begins targeting secondary schools, identifying mental health services as desirable career choices, as Te Rau Matatini is beginning to do

- Tertiary educational establishments must be sourced for recruits to medical, nursing and allied health professional work streams
- Current employees must be supported, given access to relevant training and mentorship to improve both clinical skills and experience but also to improve staff retention.

The following diagram provides a description of how the proposed solutions will improve access to mental health services leading to increased diagnosis and treatment of problems in the community.

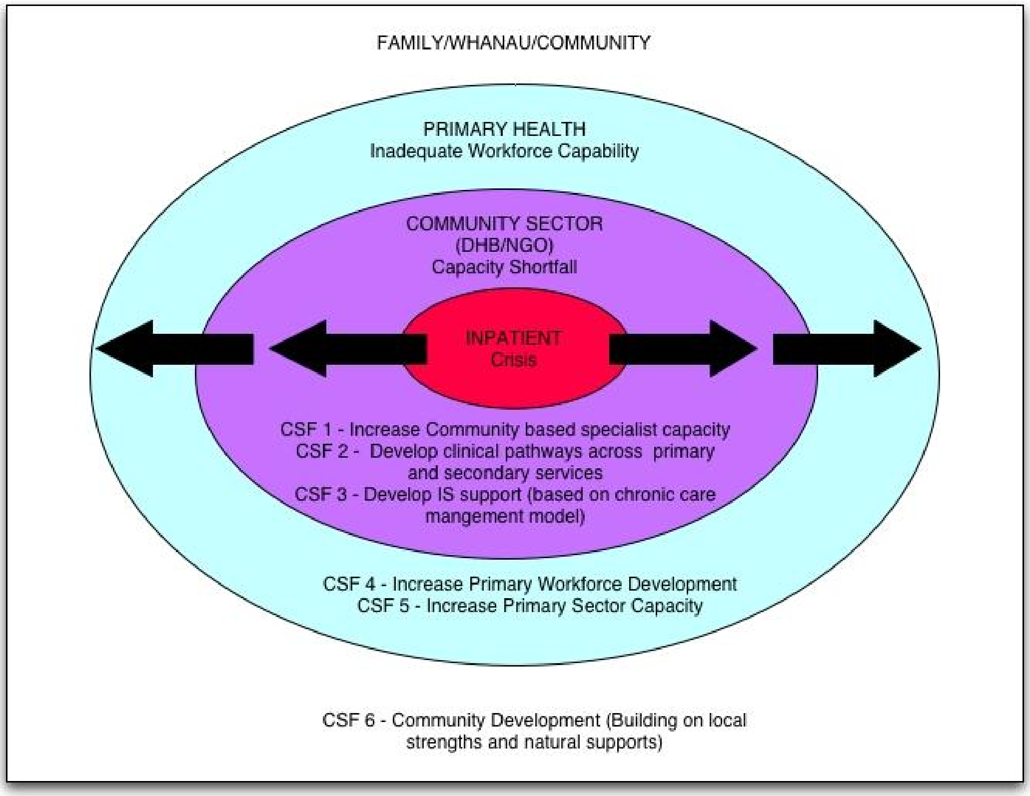


Figure 6: Applying Solutions

8.3. Older Adult

8.3.1. Vision

Support older people to remain as independent, and as well as possible, for as long as possible, through Older Adult Mental Health Services that are regionally consistent and locally responsive to the needs of older adults, their Whanau and family.

Services maximise client participation, independence and choice, respond to the increasing demand for services as the population ages, and recognise the priorities of older people and their families. They develop innovative and evidence based ways of resourcing and delivering holistic treatment and integrated service provision.

8.3.2. Issues – Older Adult

Strategic development of community, primary and services for older adults must first recognise and respond to the major demographic and societal changes for the ageing population.

Older adults span a number of decades and their mental health needs are diverse. Some have needs more similar to general adult mental health and others with complex needs are more closely aligned with health services for older people.

Changing pattern of demand for services

The ageing population will result in dramatic increase in service demand. The ageing Maori population will result in increased demand for Kaupapa Maori services. Similarly, the ageing Pacific population, and aged migrants e.g. Asian, will require the provision of culturally safe and appropriate services.

Older Adults are not homogenous and there are changing roles and expectations. The 85+ are high users of services and have high levels of disability whereas younger ones may still be very active in their community or even continuing to work. Almost 20% of the population aged 55+ experience specific mental disorders that are not part of normal ageing, and are frequently linked to neuro-degenerative disorders and complex needs. Mental illness is often associated with, and complicated by, multiple medical problems associated with ageing.

Older adults tend to present late for a number of reasons. There may be a reluctance due to the associated stigma, they may not feel their problems are "bad enough", or they may not know where to go for help.

A quality of life worth living, regardless of age and illness is what recovery means for older people. It emphasises concepts of hope, autonomy, choice and service user and family/whanau centred practice, and the need for interdependence. There is an Increasing need for public health strategies to enhance quality of life, and which recognise the potential of older people to respond to early advice, and prevent or delay disability

Capacity and Capability

There is little recognition of the capacity for older people to grow, develop and provide support to each other. Potential exists for capability development and greater involved of older people in service delivery.

Double stigmatisation of both mental illness and age, has led to historically inadequate resource allocation. Combined with increasing demand for services there is now seriously inadequate capacity to meet the current and projected demand for specialist services e.g. resources and workforce

The legislative framework is inadequate to ensure protection of severely disabled clients. There is poor recognition of, and response to, the individual's and their families' priorities for care. There is also a need for improved interdisciplinary and inter-sectoral co-operation.

The public health and primary sectors lacks capacity and capability to provide health promotion programmes and early detection and management of problems.

Co-ordination and Integration

Fragmentation of services exists, rather than an application integrated continuum of care for older adults. There is a lack of co-ordination with the disability sector for home based and social support services e.g. housing and respite care.

Lack of funding co-ordination within and across government sectors e.g. mental health, Disability Support Services, ACC. and Housing New Zealand, preventing fair and co-ordinated access to care and support.

For people with dementia there is fragmentation of policy, funding and service delivery.

Mechanisms are needed to integrate information and service delivery across community, primary and secondary health sectors.

Increased mandated service provision is required to tackle and prevent elder abuse and neglect, process applications of PPPR Act, and attend to other care and safety issues.

8.3.3. Critical Success Factors

Architect – Planning

- Resource key people to lead the change process
- Jointly commission a MH / DSS process to resolve an integrated policy funding and service delivery framework for dementia service[18]
- Advocate for the development of legislation or other mandated frameworks to ensure the protection and safety of older people with mental health disorders.

Makeover – Service Redesign

- Involve older people in service delivery and planning and promote environments responsive to their abilities as well as disabilities
- Develop service models that can demonstrate how integrated services can be delivered
- Provide packages of care that reflect service user preferences and values.

Extensions – Increase capacity

- In partnership with public and primary health, contribute to building capacity to deliver positive ageing, and problem prevention programmes to enhance quality of life for people with experience of mental illness and their carers
- Work with primary care to implement early detection and management of mental health problems in older people

Additions – New Services

- Introduce rural (Northland) and urban "one stop shop" / Third Age centres as demonstration projects to provide user friendly early access to information, resources, co-ordinated care and integrated treatment processes.

Community – Strengthen Links

- Develop clinical pathways in partnership with Older Person's Health, community primary and other secondary services e.g. dementia, depression
- Respond to the increasing cultural diversity of older people

[18] This issue affects the region, but is also of national importance. Any work undertaken in the region could influence and inform national policy development and planning processes.

Foundations – Information & Workforce

- Build upon and enhance specialist skills of current workforce, and attract new workers to the speciality
- Develop integrated patient management systems across and within primary and secondary services e.g. MHSOP / OPH / NASC / NGO / PHO
- Develop appropriate outcome indicators acceptable to people with experience of mental illness, families / whanau and the workforce.

8.4. *Addiction Services*

8.4.1. Vision

> To minimise the harm to both individuals and their communities caused by addiction to gambling, tobacco, alcohol and other substance use and misuse by ensuring access to local services that support individuals, their families and local communities to make choices that enhance their well-being.

The defining characteristic of harm reduction is a paramount focus on reducing a broad range of adverse health, social and economic consequences of addictive behaviours.

8.4.2. Issues - Alcohol and Other Drugs

Changing pattern of demand for services

The Addictions Service sector faces an increasing diversity and problem complexity in the social and psychological backgrounds of its people with experience of addictions. In addition, the range of drugs that people with experience of addictions present as using continues to expand.

Increased alcohol and drug abuse amongst young people is a major concern.

Many people with experience of alcohol or other drug addictions also present with other behavioural addictions involving for example gambling or smoking.

Effective interventions with the high proportion of prison inmates and people sentenced to community-based sentences who have major alcohol and drug abuse problems remains unresolved. The increase in prison and parole populations is a major challenge for the sector.

The sector is keen to respond to increased demand for effective family participation.

Capacity and Capability

Access to specialist alcohol and drug services, in particular in rural areas in Northland, is a concern.

Access for young people and their families to dedicated residential as well as community alcohol and drug services needs to be improved.

Access for young mothers and babies to dedicated residential as well as community alcohol and drug services needs to be improved.

Alcohol and drug services that provide interventions within a Maori or Pacific Island cultural context need to be nurtured and extended.

There is no dedicated alcohol and drug 24-hour crisis detoxification and support centre. Evidence suggests that many alcohol and drug people with experience of mental illness end up in emergency departments, general hospitals, mental health crisis teams, accommodation for the homeless or prison cells by default. Opportunities for effective interventions are missed, in particular with more transient service user groups like methamphetamine users.

There is a waiting list for methadone treatment and for residential alcohol and drug services.

The links between the alcohol and drug sector and the primary health and social services, as well as with general hospitals needs to be strengthened. This should result in greater ability of these sectors to respond to opportunities for brief interventions and to support existing addictions service consumers.

Inclusion of family members in the treatment of alcohol and drug people with experience of mental illness leads to better outcomes for many, but also increases problem complexity for staff.

All alcohol and drug services should be accredited against the NZS Alcohol and Other Drug Treatment Sector Standards.

Coordination and integration

Mental health services and alcohol and drug services serve distinct service user groups. However, a significant number of people with experience of mental illness experience alcohol and drug abuse problems. Greater integration and cooperation between the services will improve service user outcomes.

There are very high rates of alcohol and drug abuse disorders amongst prison inmates and individuals serving a community based sentence. Improved communication between the alcohol and drug sector and the Courts and Community Corrections plus a joint commitment and resourcing for programs should lead to better recovery rates amongst these populations. In particular the transition from prison back into the community is a significant concern.

Evidence based local practice with alcohol and drug interventions are largely based on overseas research. There is a lack of a cohesive local research strategy to advance local evidence based practice.

8.4.3. Critical Success Factors

Architect – Planning

- The development of adequate local screening instruments should assist in identifying alcohol and drug problems in a primary, hospital or corrections setting.
- Effective outreach and early prevention strategies need to be designed.
- In collaboration with older person's services, design and monitor effective strategies for engagement of older persons in alcohol and drug treatment.

Makeover – Service Redesign

- A robust interface with mental health services should lead to clear pathways for people with experience of mental illness based on a one-service user one-service principle.
- The development of a 24-hour crisis centre will improve effective engagement of transient and often chaotic service user populations and reduce the resource impact that these people with experience of addictions make on other services.

Extensions – Increase capacity

- Access to treatment services should be strengthened in particular for youth and cultural specific alcohol and drug services.
- Access to alcohol and drug crisis interventions should be improved in close partnership with mental health services.

Community – Strengthen Links

- A focus on alcohol and drug training for community correction, primary health and social services should improve the delivery of brief alcohol and drug interventions to a wide service user audience.
- The alcohol and drug sector meets on a regular basis and needs to continue to review service development in partnership with the DHB funders. Particular emphasis should be place on developing a robust interface between the sector and mental health, as well as primary health and social services providers.

Foundations – Information and Workforce

- Central to the development of a strong alcohol and drug sector is the further development and retention of a strong alcohol and drug workforce. Implementation of the Practitioner Competencies for Alcohol and Drug Workers has a high priority.
- Training the mental health workforce in effective alcohol and drug interventions is a priority.
- Many non-government services are not reporting through a centralised database. The development of a central alcohol and drug database is a major strategy to improve service delivery.

- To assure quality of service delivery, the alcohol and drug field is working towards an agreed system of outcome measures. This system should be implemented.

8.5. Primary Health Services

8.5.1. Vision

> All people with experience of mental illness can afford to use primary services and know how to access them.
>
> People who deliver primary services have the skills and resources to recognise psychological, social and spiritual dimensions and to support recovery.
>
> People, including people with experience of mental illness, will be part of local primary health care services that improve our health, keep us well, are easy to get to and coordinate our ongoing care.
>
> Primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups.[19]

Planning for mental health service delivery and improvement must of necessity involve the primary health sector. The primary work stream has included a wide mix of both primary and secondary mental health participants. The work stream acknowledges that mental health is only one of many primary health facets and activities. Key to future service improvements is therefore joint activity, particularly at the planning and design stages.

8.5.2. Issues - Primary

Changing pattern of demand for services

Mental physical and social health cannot be separated, one affects the other and vice versa; physiology affects mental health, behaviour affects physical health, and social factors (deprivation, social structures) affect both.

Mental health is an independent risk factor for the development of physical disease. There is an increased incidence of mental health disorders in those with chronic physical problems. There is also an increased rate of physical health problems in those with mental health disorders.

The key role of family and/or whanau in the maintenance of mental health and the role of primary health services as a key support to family whanau must not be undervalued.

Mental health disorders are common throughout the population, with an estimated prevalence of 20-25%.

[19] The Primary Health Care Strategy, Feb 2001

There is an increasing prevalence of some mental health disorders, for example depression, together with an associated increase in disability.

Uptake of mental health services is limited, influenced by factors such as stigmatisation and service suitability.

Capacity and capability

The existence of significant untapped primary care capacity is questionable. Although there has been some work to identify the capability issues there are expectations of increased capability across so many aspects of the primary care strategy (in addition to mental health there's also smoking, drinking, nutrition and physical exercise, to name a few) that a major issue may be the availability of a workforce to do it.

There has been a decline in the numbers of GPs and nurses since 2000, which raises concern about the ability of primary care to contribute additional capacity.

Many of the people who experience mental health disorders do not receive any treatment reflecting multiple barriers to access such as:

- Lack of individual and family/whanau awareness and knowledge of mental illness
- Stigma associated with mental health illness
- Cost
- Geographic access to primary care services particularly in rural settings
- Cultural/language barriers

There is a perceived inability of primary care providers to make early diagnosis and provide treatment:

- Lack of routine use of standard screening and diagnostic tools for mental illness in primary care
- Lack of CME training and support by specialist mental health services for primary care
- Low rates of treatment for Maori with symptoms of depression and anxiety in general practice settings compared to non Maori

Integration and Coordination

Community-based services are neither comprehensive nor consistent across the region, resulting in fragmentation and avoidable difficulties for patients accessing support.

8.5.3. Critical Success Factors

Architect – Planning

- Integrated planning with mental health services providers to develop and support primary care providers

Makeover - Service Redesign

- Develop primary health services to deliver mental health care in the community as part of a comprehensive system.
- Primary mental health services are delivered as part of a 'whole of person' approach to health need to increase the uptake rates of mental health service.
- Integrated primary and secondary mental health service delivery is based on a mutual commitment to deliver, and mutual respect.
- Services are delivered that ensure the people with experience of mental illness physical health needs are not being subordinated to their mental health status and vice versa.
- Appropriate payment mechanisms for providing treatment for patients with both mental and physical illnesses.
- Specialist services are delivered in primary health settings to improve the integration of service delivery

Extensions - Increase capacity

    - Ensure primary mental health treatment that includes access to appropriate medication
    - Focused effective interventions eg Psychotherapy
    - Recovery focused support services

- Recognise the benefits of treating secondary mental health problems in patients presenting with significant physical illness eg depression associated with IHD
- Improve the morale and level of satisfaction among primary care providers with regard to delivering mental health services by recognising and valuing their contribution and providing the necessary support.
- DHB – recognition/prioritising leading to equitable funding arrangements, in addition to capability training, for primary health services to substantially increase their delivery of mental health services,
- Promote the concept of "Life worth living" through service user involvement to improve client satisfaction with primary care services.
- Recognise and encourage the role of primary health practitioners as patient advocates.

Additions - New Services

- Improve access to mental health services information
- Promote awareness of the impact of unmet mental health need to generate the will to improve access
- Develop enhanced opportunity for service user involvement in all aspects of service provision, including budget-holding and governance

Community – Strengthen Links

- Improve community awareness and knowledge of mental illnesses and how to reduce their impact
- Increase level of mental health promotion
- Improve access to liaison and emergency psychiatry services based on shared care concepts
- Recognise and support the contribution of people with experience of mental illness and service use as advisers/advocates in primary mental health care services (as in secondary services)

Foundations - Information and Workforce

- Support Research & Development to develop more effective primary care programs
- Use chronic disease management IS models to help address mental health disorders within primary settings
- Mental health outcomes are developed and integrated into the PHO clinical performance indicators framework.
- Improve primary care provider capability to provide early intervention and treatment to reduce or delay onset of mental health disorders, and improve outcomes.
- Provide training and skill development in primary care to change provider attitudes to mental illness, and to reduce the stigmatisation of people who experience mental health disorders.
- Promote attitude changes in health care providers

    - Illness – wellness
    - Service – partnership
    - Innovative fund holding approaches

9. Successful Outcomes

It is important to monitor the impact of our strategies and related projects to ensure they are achieving the desired result. Strategic level outcomes reflect the impact of the actions we take, in line with our planned intentions.

9.1. Proposed Outcome Measures

Within the period 2005 to 2010:

- The Network North Coalition will function as the forum for mental health and addictions regional planning and collaboration and be acknowledged as inclusive and representative of the sector.

- NNC work streams will be led by recognised sector experts, adequately resourced, and lead the development of sustainable and effective services that are valued by people who experience mental illness, their families, whanau, and community.

- Additional mental health funding within the region will grow to at least the level proposed within this document, and the allocation and use of those funds will reflect the priorities established within it.

- Access to services by people with experience of mental illness or addictions within the region will be equitable between districts, and will increase at the rate of funding increase or better.

- Service capacity will increase at the rate of funding increase or faster.

- Additional services will be established which improve the continuum of services available to people who experience mental illness or addiction.

- Additional services will be established to improve the access of specific populations to mental health services.

- Families, communities, and other agencies that impact on the mental health sector become integral participants in service planning and delivery

- Information/Workforce

10. Appendix

10.1. Terminology

It has been very difficult to come to a point whereby we can honour the language used by various people who access services and identify with these services as customers.

People who access mental health services in the Auckland Region have requested that the National Consumer Vision – Our Lives in 2014 be adopted. In this vision Tangata Motuhake has been identified as the preferred terminology. Tangata Motuhake has been defined as (unique/special) people. It is a term used for and adopted by people with mental illness. It does not include alcohol and other drug service users who are developing their own vision.

People who access alcohol and other drug services however, support the use of Tangata Whaiora,

People who utilise the services in Northland have also identified Tangata Whaiora as the preferred title.

For some the more traditional terminologies i.e. service user and consumer hold more sway.

If we are to respect people's right to self-define we need to honour all of the above as legitimate descriptions of people who access services.

For the purposes of this document we have used one consistent term and that is *people with experience of mental illness or addictions*. We would ask that people understand our intent that the term is read to also mean, Tangata Whaiora, Tangata Motuhake, service user, and consumer.

10.2. Principles

Our vision sets out what we seek to achieve. Supporting our vision is a set of guiding principles that form the basis of how we seek to deliver on that vision. Those first principles are of general applicability. Applying our values in the way we deliver services provides a means for ensuring that services provided are consistent across the region, responsive to local variation in needs, well integrated, and appropriate to the people receiving them. Without action, our vision is meaningless. Values lead to a set of 'rules' or guidelines for action that set the tone for all our mental health service delivery.

First principle: Individuals have free will (decision making capability, which may be limited) subject to the circumstances of their lives

Values	"Rules" for Action
Autonomy / choice Cultural autonomy Respect for legal rights Service user participation Life can be worth living	Ensure least restrictive services Honour the Treaty Of Waitangi When appropriate: • Provide recovery focused services • Employ the strengths based approach

First principle: "No man (or woman) is an Island[20]"

Values	"Rules" for Action
Recognise interdependence	Involve service users and their family, whanau and friends in decision making on their care and treatment Strengthen links with other sectors

First principle: Planning is essential

Values	"Rules" for Action
Collaboration	Promote integration across the sector from public health – tertiary services
Coordination	Actively involve stakeholders (service users, families/ whanau, communities/iwi etc) in the decision making process
Consistency	Recognise service users as primary rights holders21/stakeholders
Achievability	Be service user driven • Service user leadership of services • Be guided by service user views and perceptions

[20] John Donne – Elizabethan metaphysical poet and rake

[21] Those people who are the primary reason for the existence of the Mental Health Services and who therefore have just and moral entitlement to define service delivery.

	Do the most important things first • Ensure the fundamental infrastructure is in place • Increase workforce capacity i.e. quality and quantity

First principle: Each person is an end in themselves – which implies Equality

Values	"Rules" for Action
Equity	Ensure fair access to services

First principle: Maximise the good (prevention is better than cure)

Values	"Rules" for Action
Quality Affordable Effectiveness Efficiency Accountability Wellness focus	Quality Assurance Maximise cost effectiveness Use best available evidence and measure outcomes Invest in promoting wellness, preventing illness and early intervention

10.3. Funding

Additional mental health funding to meet the Blueprint targets is not the only funding to maintain and improve mental health and addiction services. Two additional funding streams impact on the future sustainability and development of mental health services. Population Based Funding Formula (PBFF) adjustments take place on an annual basis, and should offset the effect of the population growth in the region. Future Funding Track (FFT) adjustments provide an annual adjustment for price increases, and are on the order of 2.5% per annum. In order to ensure the sustainability of current services, it has been assumed that the FFT is applied equitably across the sector. The 2004/05 Regional Annual Plan proposed a regional pricing project to ensure that all services remain sustainable. The outcome of this project may change the future funding distribution of FFT within the mental health sector.

The following table sets out the projected mental health funding for the region during the lifetime of this plan.

Year	05/06	05/06	05/06	06/07	06/07	06/07	07/08	07/08	07/08
	Baseline[22]	PBFF	Blueprint	Baseline	PBFF	Blueprint	Baseline	PBFF	Blueprint
Child & youth	28.43	0.44	1.71	30.58	0.43	1.00	32.02	0.43	1.50
Older Persons	9.92	0.15	0.86	10.93	0.15	0.50	11.58	0.16	0.50
Addictions	23.46	0.36	1.71	25.54	0.36	1.20	27.10	0.37	1.00
Primary	-		0.86	0.86	0.01	0.30	1.17	0.02	0.00
General Adult	234.29	3.64	8.56	246.49	3.49	5.00	254.98	3.46	5.00
Infrastructure	0.16		10.00%[23]			10.00%			10.00%
Total per year	296.26	4.59	13.70	314.39	4.45	8.00	326.84	4.43	8.00

Year	08/09	08/09	08/09	09/10	09/10	09/10	10/11	Total additional $m	Gap from Blueprint[24]
	Baseline	PBFF	Blueprint	Baseline	PBFF	Blueprint	Baseline	Blueprint	
Child & youth	33.95	0.45	1.50	35.90	0.47	2.00	38.37	7.71	19.50
Older Persons	12.24	0.16	0.50	12.90	0.17	0.40	13.47	2.76	6.80
Addictions	28.47	0.38	1.00	29.84	0.39	0.70	30.93	5.61	13.70
Primary	1.18	0.02	0.00	1.20	0.02	0.30	1.52	1.46	3.00
General Adult	263.43	3.49	5.00	271.92	3.54	4.70	280.16	28.26	69.10
Infrastructure			10.00%			10.00%			
Total per year	339.27	4.49	8.00	351.77	4.58	8.10	364.45	45.80	112.10

Table 2: Northern Region Projected Mental Health Funding 2005-2010

Figures in the table are based on the annual increase in Blueprint funding, medium projections of the regions population growth, and the assumption that population increases will be met by additional PBFF funding. Price increases have been ignored, on the basis that FFT will offset those, and the FFT has thus not been applied to the table

Gap to Blueprint Targets

The following table illustrates the effect of our assumptions on the gap to Blueprint in the region. Using the baseline figures from Table 2 as the funding in each year, we have increased the annual target to account for population increase, but have not built in a health inflation factor, assuming that FFT will cover the increased costs.

[22] Baseline is the amount of money available for a particular financial year, at the commencement of that year. Population is additional money allocated to meet projected growth in population (PBFF). It ranges form 1.55% to 1.30% over the period of the plan. Blueprint is money specifically allocated for additional mental health services. Therefore, Baseline (Year 1) + Population (Year 1) + Blueprint (Year 1) = Baseline (Year 2)
[23] One off project money resulting from phasing under spend of Blueprint funds
[24] At the commencement of the plan

	2004	2005	2006	2007	2008	2009	2010
Regional Population (000s)	1482.4	1505.4	1526.7	1547.4	1567.9	1588.3	1608.5
Baseline Funding ($Millions)	$265.18	$296.26	$314.39	$326.84	$339.27	$351.77	$364.45
Gap from Blueprint	36.60%	30.25%	27.02%	25.14%	23.31%	21.51%	19.70%

Table 3: Effect of Assumed Funding Increase on Regional Gap From Blueprint[25]

Our regional gap from Blueprint in 2004/05 amounts to $112 million. By 2010/11 our regional gap from Blueprint will have reduced to approximately $77 million, based on this set of assumptions. Mental health and addiction services are labour intensive. One way of quantifying the gap is to treat it purely as people. If the gap is treated purely as staff (FTEs) then that gap amounts to a shortfall of approximately 1040 staff. This compares to a gap on the same basis at the start of 2005 of approximately 1300 staff.

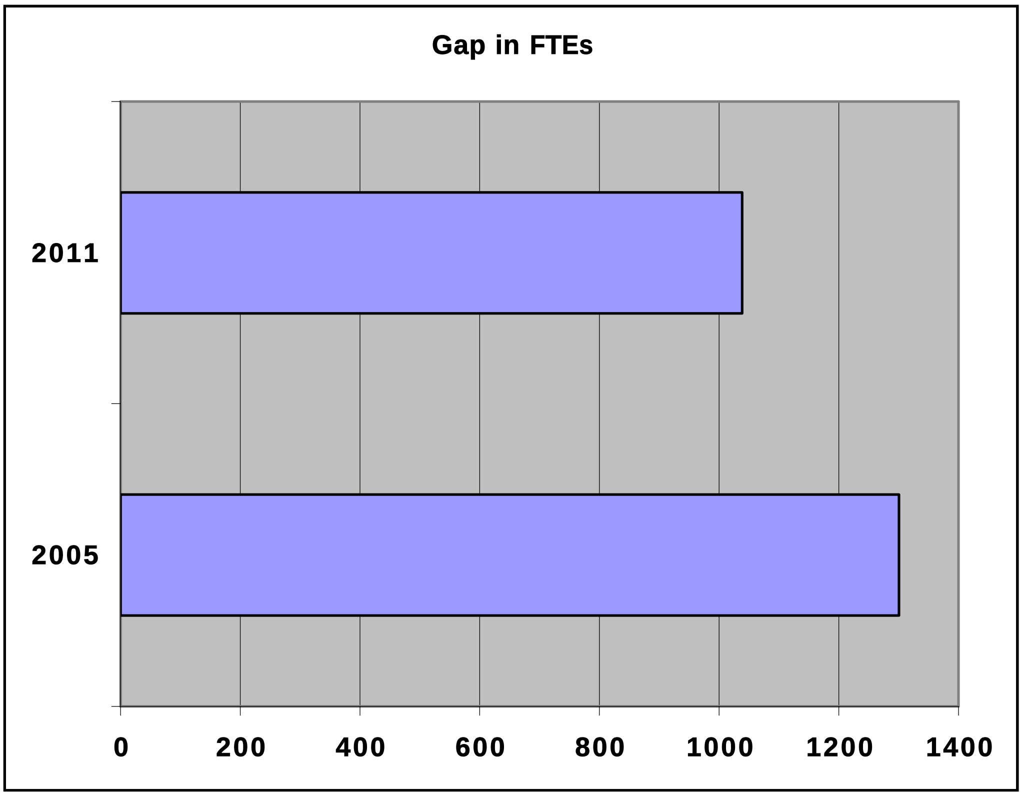


Figure 7: Narrowing of Blueprint Gap Demonstrated Solely in FTEs

[25] The assumptions are of necessity at a very high level, and do not include factors such as the difference in price between different FTEs in a service mix.

Priority effects on Funding

The change in comparative priority between the work streams shows that the application of funding priorities is shifting the balance positively towards those services that are prioritised. While the percentage amounts may not look large, clearly there is a large amount of funding tied to the sustaining of current services. Additional Blueprint funding over the course of this plan accounts for approximately 3% of the total mental health funding in the region.

	05/06 start	% of total	10/11 finish	% of total	Change in priority
Child Youth	28.43	9.60%	38.37	10.17%	0.58%
Older	9.92	3.35%	13.47	3.57%	0.22%
AOD	23.46	7.92%	30.93	8.20%	0.28%
Adult	234.29	79.08%	280.16	74.28%	-4.80%

Table 4: Change in Relative Priority

The effect of a priority shift will of necessity be quite small, and measuring the shift is of most value in showing our priorities are matched by our funding intent. The preceding table demonstrates that the funding is shifting in line with our stated priorities. The primary work stream has not been included, as it comes from a base of zero; therefore any increase is a total increase in priority. The use of the marginal funding increase (the Blueprint funding) is therefore making a change in priorities, as well as an impact on the gap to Blueprint.

10.4. Glossary

Baseline Funding – the amount of operational (not capital) funding available at the commencement of a period, usually a financial year.

Benchmark – a measure of resource, such as available staff or beds, with an implication that it is a baseline or adequate level, a level suitable for comparison purposes.

Blueprint funding – funding allocated and committed by the government to address the resource gap between current mental health service provision, and the benchmarks established within the Mental Health Commission Blueprint.

CAMHS – Child and adolescent mental health services. Children and young people are specified within the national mental health framework as aged between 0 and 19 years of age inclusive.

Capacity – funding an available level of resource (inputs) such as beds or FTEs. Contrasts with fee for service, where the amount of service delivered is funded.

Consultation – Obtaining opinions and views of people affected by potential or proposed changes or developments, in order to consider those views in the decision making process.

DHBs – District Health Boards.

District Annual Plan – the planning document prepared by District Health Boards each year, which sets out their intentions for the coming year. When agreed between the DHB and government, it becomes the key accountability document, whereby government can determine whether the DHB is doing its job.

Economy of Scale – it is cheaper to serve large numbers of people through one process than small numbers of people through many distinct processes. For example, a provider has certain overhead costs such as management, information technology, office costs etc. Those costs will usually make up a larger proportion of a small provider's overall costs, than those of a large provider. Effectively, a lesser proportion of money is thus available for service delivery, where it is spread across many providers.

Equity – an equal level of resourcing, when certain factors are taken into account. The factors are a matter for discussion and agreement, and might include the incidence of mental illness, deprivation, rural/urban, or indeed none at all. The PBFF is a mechanism for arriving at an equitable distribution of health funding between DHBs.

FFT – a centrally determined annual adjustment of DHB funding to address health cost inflation (price increases)

Flexi funding – a regional term used to describe extended packages of care, and similar flexible funding approaches that do not fit within the existing service specifications of the Nationwide Service Framework

Forensic Mental Health Services – mental health services for those people with experience of mental illness or addiction who are also involved in some way with the criminal justice system, for example in prison or on remand.

Full Time Equivalent (FTE) – a measure of staff availability, equalling a person (working full time) or several persons (part-time) totalling 40 hours a week.

GAMHS – General Adult Mental Health Services

Gap – the difference between available resources and that proposed by a benchmark, such as the Blueprint.

Hinengaro – Emotional well-being, mental health

Intra-district equity – equity of resourcing between DHB services in one region, such as the Northern region.

Intra-regional equity – equity of resourcing between regions, such as the Northern and Southern regions. While there are differences between DHBs in the Northern region, the largest gap in equity is between the Northern region and the Central and Southern regions.

NGO – Non-governmental organisation. A term which is often narrowly used to describe a not for profit service provider or advocacy organisation.

Oranga – Wellness

PHO – A Primary health organisation. The Ministry of Health defines primary health care as “essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country’s health system, and is the first level of contact with the health system.”

Population Based Funding Formula (PBFF) – The PBFF is an aggregate formula that determines the share of funding to be allocated to different areas of the country, based on the population living in each area. The PBFF does not determine the overall level of funding. The overall level of funding is determined by the Budget process, and is based on the Government’s spending priorities.

The PBFF model is designed to fairly distribute available funding between DHBs according to the relative needs of their populations and the cost of providing health and disability support services to meet those needs. The PBFF will give each DHB the same opportunity, in terms of resources, to respond to the needs of its population.

Recovery – Living well in the presence or absence of mental illness and the losses than can be associated with it.

Tangata motuhake – Means special people. It is a term adopted by and used for people with experience of mental illness.

Tangata Whaiora – People seeking wellness, mental health service users

Whanau – Family, extended family, and or other networks of natural support