

Central Region District Health Boards

Regional Mental Health Strategic Plan

**Central Region Mental Health and Addiction
Network
July 2002 – June 2004**

He Karakia Whakawatea

Whakataka te hau ki te uru
Whakataka te hau ki te tonga
Kia makinakina ki uta
Kia mataarataara ki tai
E hi ake an te Ataakura
He tio, he huka, he hau huu
Tihei Mauri Ora!

Mihi

E nga mata-a-waka o te motu, tena koutou

E nga mana, e nga reo, e nga maunga tapu,

E nga pataka o nga taonga tuku iho,

Tena koutou, tena koutou, tena koutou katoa

Foreword

In this new environment of DHB collaboration and community involvement, it is exciting to present this regionally developed strategic plan. The focus of this document is on the improvement and expansion of mental health services in the Central region. It is a reflection of the willingness of the member DHBs to work with their communities and to share expertise and resources to better meet the mental health needs of our populations.

Key to the development of the strategic plan is the establishment of the Central Region Mental Health and Addiction Network, otherwise known as CRMHAN. This network is a joint enterprise of the six Central region DHBs and has ensured effective engagement with, and input from all sectors of the mental health community. It is made up of representatives from DHB mental health funders, DHB Local Advisory Groups, consumers/tangata whai ora, families, maori and pacific people, DHB and Non Government Organisation providers, and clinicians from both the mental health and primary care sectors.

The production of this strategic plan is the first major piece of work undertaken by CRMHAN and a big thank you must go to the members of that group for the hard work and dedication they have put into producing it. The Central region CEOs are very supportive of CRMHAN and are pleased to present the outcomes of their work, which was based on the key Treaty of Waitangi principles of partnership, protection and participation.

This strategic plan contains an ambitious list of projects and initiatives that have a strong recovery focus. CRMHAN's attention will now turn to putting these projects into action so that we can realise the benefits to our communities. The DHBs of the Central region are demonstrating their commitment by putting in the resources and efforts required to achieve these goals. We feel confident that CRMHAN will be successful in making this plan a reality.

Margot Mains
Chief Executive Officer
Capital and Coast District Health Board

(Central region CEO responsible for Mental Health)

Acknowledgements

The Central region DHBs are grateful to the many consumers/tangata whai ora, family members, clinicians, providers and other community groups who had input into this document through the different avenues open to them.

Thank you to Mr Hare Arapere of Ngati Raukawa for kindly providing us with the Mihi and Karakia.

We would like to acknowledge the input provided by Paul McLennan and Paul Hirini in the early stages of the planning process.

Finally, special thanks goes to Christine Elliot for her constructive critique and advice throughout the development of this document.

All of the above input was of significant benefit to CRMHAN.

Table of Contents

Acknowledgements	4
Table of Contents	5
1 Executive Summary	7
1.1 Background.....	7
1.2 Central Region Mental Health and Addiction Network	7
1.3 Current Situation in Central Region.....	7
1.4 Vision for Future Mental Health Services.....	8
1.5 Priority Areas	9
1.6 Putting the Plan into Action	9
2 About this document	11
2.1 Purpose of the plan.....	11
2.2 Scope of the Plan.....	11
2.3 Planning Process	12
2.4 Structure of this document.....	13
3 Introduction.....	14
3.1 Strategic Context.....	14
3.1.1 Policy Context	14
3.1.1.1 Treaty of Waitangi.....	14
3.1.1.2 Legislation.....	15
3.1.1.3 New Zealand Health Strategy.....	15
3.1.1.4 Mental Health Strategies.....	16
3.1.2 Organisational Context	21
3.1.2.1 Ministry of Health.....	21
3.1.2.2 Mental Health Commission.....	21
3.1.2.3 District Health Boards	21
3.1.2.4 Non Government Organisations	22
3.1.2.5 Central Region Technical Advisory Services (TAS).....	22
3.2 Central Region Mental Health and Addiction Network	23
4 Current Situation.....	26
4.1 Profile of the Central Region.....	26
4.1.1 Central Region Total Population.....	26
4.1.2 Central Region Ethnic Composition.....	27
4.1.3 Central Region Age and Gender Structure	28
4.1.4 Central Region Population Projections.....	28
4.1.5 Central Region Deprivation Profile	30
4.1.6 Prevalence of Mental Illness.....	30
4.1.7 The implications for the Central Region mental health services	32
4.2 Current Central Region Service Funding.....	33

4.3 *Current Access Levels to Mental Health Services* 34

4.4 *Current Performance Against Blueprint* 35

4.5 *Mental Health Workforce* 36

4.6 *Regional Services*..... 37

 4.6.1 A note about the Mental Health Line – Access and Information Service

1 Executive Summary

1.1 Background

This plan has been developed by Central Region Mental Health and Addiction Network as the first step in a consultation and planning process with the ultimate goal of providing strategic direction for the funding and provision of Mental Health services in the Central region.

The plan was developed within the context of increased collaboration between the key stakeholders including the Ministry of Health, Mental Health Commission, District Health Boards, non-governmental organisations, and mental health service consumers and their families. The New Zealand Health Strategy (December 2000), National Mental Health Strategy (1994 and 1997), and the Blueprint for Mental Health Services in New Zealand provide a policy context for this work.

1.2 Central Region Mental Health and Addiction Network

In response to recent changes to the New Zealand public health system, and in line with the expectations of the Ministry of Health and the Mental Health Commission, six District Health Boards in the Central Region have established the Central Region Mental Health and Addiction Network. The six District Health Boards are:

- Hawke's Bay DHB
- MidCentral DHB
- Whanganui DHB
- Wairarapa DHB
- Hutt Valley DHB
- Capital and Coast DHB

The regional network is the key vehicle for achieving the collaborative approach that enables District Health Boards to plan for local service delivery and planning within a regional context. The Portfolio Managers from each District Health Board draw on the experience and expertise of a broad range of stakeholders represented in the Network, including mental health clinicians, consumers, family members, Maori and Pacific people, primary care providers and other non-governmental provider organisations. This broader group meets on a quarterly basis to discuss the issues of strategic relevance to mental health services in the region, such as:

- Workforce development
- Quality Improvement
- National, Regional and Local service delivery

1.3 Current Situation in Central Region

Central Region is a large and diverse geographical area in which six District Health Boards are responsible for planning, funding and provision of health services to a total population of almost 800,000 people.

About one hundred providers, both DHB and NGO based, provide a variety of services in the Region. The DHB based mental health workforce of the region numbers around 1,220 full time equivalents. This number is projected to increase to 1,350 by fiscal year 2003/04.

The total funding for these services was \$141 million in the fiscal year 2000/01, as a result of a sustained funding growth of around 10% per annum over the last 10-12 years. This funding growth has now reached a plateau and is expected to be significantly lower over the next couple of years (at less than 2%). About \$102 million is spent on Crown provider services and \$41 million (29%) on NGO services. Some \$15.5 million (10.8%) is spent on Maori specific services, and \$1.4 million (0.9%) on Pacific peoples specific services.

Throughout the development of this document the planning team has encountered difficulties in obtaining a complete and precise picture of the current spending on mental health services for each individual DHB population. Further technical work is in progress to obtain this information.

In relation to the current status of mental health services in the region, the consultation and planning process has identified a number of issues that need to be addressed. The key issues seem to be around:

- Access to services
- Fragmentation of service provision
- Lack of standardisation and consistency
- Workforce issues, including cultural competence and recovery focus
- Slow progress of and barriers to inter-sectoral work
- Lack of relevant and reliable information and analysis
- Capability and process issues around audit and monitoring of service providers
- Lack of consumer run services
- Limited capacity and capability of Maori mental health services

1.4 Vision for Future Mental Health Services

In undertaking this work, the Network has sought to demonstrate its commitment to the development of a shared vision for holistic mental health services across the region. Integral to this vision is development of Mental Health services that are easily accessible, coordinated and responsive, and at the same time integrated, open, and consumer and recovery focused. Crucial to the achievement of this vision is strong inter-sectoral approach and development of an effective, competent and confident mental health workforce.

CRMHAN's vision statement, 'Recovery as a Right', aims to reflect all of the above in a clear and concise way that is easily understood and remembered.

1.5 Priority Areas

The region has experienced rapid volume growth over the last few years, and now needs to ensure that the quality side is being addressed. The NZ Mental Health Strategy is to achieve “More and Better” mental health services. The Network believes that priority should now be focused on “better” rather than more.

The region’s additional Blueprint funding allocation is very small – less than 2% increase in total funding. Before investing further in more services DHBs need to take stock and evaluate those services that are currently funded. We believe the most gain from this relatively small sum will be achieved by using a significant portion of it to facilitate quality improvement and evaluations of effectiveness of current services.

The following priorities were arrived at based on the analysis of the current provision of mental health services in the region as compared to the targets set out in the Blueprint document, and informed by the consultation process with the Network members.

Service Development and Delivery Priorities:

- Maori participation in all service planning and delivery.
- Consumer participation in all service planning and delivery.
- Workforce development, retention and recruitment.
- Quality improvement.
- Outcome Measurement.
- Implementation of the recommendations contained in the ‘Framework for Forensic Services 2001’.
- Development of a consumer run case management service.
- Development of a consumer run audit team/service.
- Review and enhancement of Alcohol and Drug services, including A&D Councils, to further promote integration with other mental health services.
- Increased capacity and capability of Maori mental health services to provide services for Maori by Maori.
- Increased capacity and capability of mental health services to provide appropriate, flexible services for clients with complex needs.

It is anticipated that investment towards improving outcomes in the above areas will also serve to benefit other aspects of mental health and addiction provision. The nature of some of the initiatives developed for priority areas for 2002/03 and 2003/04 are designed to also have generic benefits for the sector as a whole. Initiatives that lead to better service coordination and staff support for priority areas will also provide experience and knowledge that can be used when similar initiatives are developed for other areas of provision, making the process more efficient and effective in future.

1.6 Putting the Plan into Action

To address the above priorities, the planning team has identified a number of specific projects and initiatives that are detailed in Appendix A of this document.

Some of these projects will require specific additional funding to be allocated to them while others will be managed within existing funding arrangements. The regional projects are aimed at service development and quality improvement and will be coordinated by a Service Development Group within Central Regions Technical Advisory Service (TAS). CRMHAN will provide the strategic guidance and oversight to the projects and will monitor progress toward completion.

In addition to the projects and initiatives that will be managed and funded regionally, each of the six District Health Boards will receive a limited amount of additional Blueprint funding for purchasing new and enhanced mental health services in their local areas and regionally.

2 About this document

2.1 Purpose of the plan

The Central Regional Mental Health Strategic Plan is focused on the provision of services to the 3% of the population with severe mental illness. It is intended to support the development of more and better specialist mental health services as set out in the New Zealand Mental Health Strategy documents – Looking Forward (Ministry of Health, 1994) and Moving Forward (Ministry of Health, 1997) and operationalised in the Mental Health Commission’s Blueprint for Mental Health Services in New Zealand.

This plan outlines the strategic direction for the development of mental health services in the Central Region over the next five years that is consistent with the Blueprint guidelines. It also outlines purchasing priorities for mental health and addiction services in the Central Region. The plan is primarily intended for use by the six Central region DHBs. Appendix E provides a brief overview of these organisations and their mental health goals.

2.2 Scope of the Plan

The Plan provides:

- A record of the region’s approach to regional collaboration.
- A record of the plans agreed, through regional collaboration on:
 - Mental health service funding, access and provision.
 - Quality, workforce, infrastructure and sector development.
- Support to DHBs in developing the District Annual Plans, including the Mental Health Service Plan.
- Means for the Ministry of Health and others to check that the District Annual Plans of the DHBs from each region contain mutually consistent intentions for the funding and provision of services.
- Means for the Ministry to determine the allocation of “Blueprint” funding to individual DHBs.
- Information to Ministers, the Ministry of Health and the Mental Health Commission on planned expansion and improvement of services.

2.3 Planning Process

This plan was developed in consultation with the stakeholders represented in the Central Region Mental Health and Addiction Network (CRMHAN). Appendix C gives a list of CRMHAN members. Key inputs into this document include:

- Interviews with stakeholder members of the Network.
- Survey of the Network members (in consultation with any groups they may represent on the Network).
- Analysis of mental health service contracts in the Central region.
- Analysis of Blueprint funding requirements as advised by the Ministry of Health.
- Analysis of regional population demographics.
- An estimate of the expected demand for mental health services within the Central region based on published prevalence data.

Limited time was available to develop the strategy and, as a consequence, consultation was of a tightly focused nature. Appendix D gives a summary of the initial consultation with stakeholders. Additional future consultation is planned to help refine the strategy and improve its ability to meet the needs of specific interests in the sector. In particular, further consultation is required with Maori and Pacific peoples throughout the region.

Central Region DHBs envisage this strategic plan as dynamic in nature. It is expected to develop and change over time as interventions take effect, relationships are established and new information is sourced and analysed. As DHBs evolve it will become clearer where cross-over or duplication of services exist, which will allow a more informed approach to coordinating and enhancing services to mental health consumers at both local and regional levels. Over the next two years, the Central Region Mental Health and Addiction Network (CRMHAN) will work with the Ministry of Health, Mental Health Commission, DHBs and other regions to identify opportunities for improving outcomes targeted by the strategic plan.

It is also anticipated that the strategic plan will be modified over time as the quality and quantity of information available about mental health in the region improves. The key assumption here is that the New Zealand Health Information Service's MHINC project (Mental Health Information National Collection) will lead to significant improvements in the range of statistical data available to mental health. It has a number of potential DHB uses such as management of inter-DHB patient flows. A national epidemiology study, funded by the Ministry of Health and the NZ Health Research Council is expected to produce detailed data by 2003 about the patterns of mental illness, which is likely to be beneficial to Central Region strategic plan development.

2.4 Structure of this document

The main part of the document provides an overview of the policy, funding and organisational context within which this plan has been developed. It details current demographic profiles and levels of mental health service provision and funding in the region and implications of these findings. Finally, it outlines the key strategic recommendations with priorities for future spending on Mental Health services in order to achieve the 'Blueprint targets'.

Further detailed information about the proposed strategic projects and initiatives, as well as a framework for putting these recommendations into action are provided in appendices A and B.

3 Introduction

3.1 Strategic Context

This chapter provides an overview of the relevant legislation, policies and national strategies that combine to provide a high-level context for the development and implementation of this Regional Plan. It also describes the current organisational landscape that affects the planning, funding and delivery of mental health services in this region and nationally.

3.1.1 Policy Context

3.1.1.1 Treaty of Waitangi

Both the Government and the Central region DHBs recognise the Treaty of Waitangi as a founding document and acknowledge the special relationship between Maori and the Crown under the Treaty. Central region DHBs are committed to fulfilling their obligations under the Treaty.

Fundamental to the Treaty relationship and the implementation of Treaty principles is a common understanding that Maori will have an important role in developing and implementing health strategies for Maori. The Crown and Maori will relate to each other in good faith, with mutual respect, cooperation and trust. This is reaffirmed in the Maori Health Strategy: He Korowai Oranga¹ and the draft National Maori Mental Health Strategy².

The Central Regional Mental Health and Addiction Network is committed to:

- The principles of partnership, participation and protection.
- The improvement of health outcomes for Maori; and
- The reduction of disparities between Maori and non-Maori.

We will honour this commitment by encouraging and facilitating:

- A holistic approach for all service developments.
- Participation of tangata whai ora, whanau, hapu and iwi as an essential component of all planning and service developments and the development and implementation of culturally safe planning, practice and service provision.
- The acceptance of culturally based values and beliefs and the integration of these into service provision.
- Access to Tohunga, kaumatua and traditional medicine practitioners.
- Recognition of the principle of tino rangatiratanga as an essential component of service provision for providers, tangata whai ora, whanau, hapu and iwi.
- Recognition of cultural need by all providers involved in service delivery to Maori.
- Collaboration between service providers, tangata whaiora, whanau and hapu.

¹ Ministry of Health. (2001). He Korowai Oranga. Maori Health Strategy Discussion Document. Wellington: Author.

² Ministry of Health. (2001). Towards a National Maori Mental Health Strategy. Draft discussion document.

3.1.1.2 Legislation

The provision of mental health and addiction services is subject to the statutory requirements contained in the New Zealand Public Health and Disability Act 2000, the Mental Health (Compulsory Assessment and Treatment) Act 1992, Public Finance Act 1989 and the Criminal Justice Act 1985.

The Health and Disability Services (Safety) Act 2001 will come into force on 1 July 2002. The Act includes The National Mental Health Sector Standard – NZS 8143:2001, and the restraint minimisation standards – NZS 8141:2001. As a result, all licensed mental health providers will be required to be audited by Designated Auditing Agencies (DAA) against the National Mental Health Sector Standard.

3.1.1.3 New Zealand Health Strategy

The New Zealand Health Strategy (December 2000) provides an overarching framework for approaching Government's priority areas for health and establishes the working environment for DHBs. The strategy aims to ensure that health services are directed at areas that will ensure the greatest benefit for the population. The emphasis of the strategy is on tackling inequalities in health.

Three of the NZ Health Strategy's population health objectives apply directly to the development of mental health services:

- Improve the health status of people with severe mental illness
- Minimise harm caused by alcohol and illicit and other drug use to both individuals and the community
- Reduce the rate of suicides and suicide attempts

Improving mental health service responsiveness is one of five service priorities identified in the New Zealand Health Strategy. Underpinning this is the Government's commitment to implementing the Mental Health Commission's Blueprint, which sets out the implementation of the Ministry of Health's national mental health strategic objectives as identified through Looking Forward (Ministry of Health, 1994) and Moving Forward (Ministry of Health, 1997).

In line with the priorities in the NZ Health Strategy the regional plan places emphasis on ensuring accessible and appropriate services for Maori and Pacific peoples.

3.1.1.4 Mental Health Strategies

NZ Mental Health Strategy and Plan

In 1994, the Government launched the strategic directions for mental health services - *Looking Forward*. This strategy indicated a major shift in direction from services dominated by psychiatric hospitals towards community mental health services and teams.

The strategy contains two key goals:

- To decrease the prevalence of mental illness and mental health problems within the community.
- To increase the health status of and reduce the impact of mental disorders on consumers, their families, caregivers, and the general community.

Seven strategic directions are specified:

- More mental health services.
- More and better services for Maori.
- Better mental health services.
- Balancing personal rights with protection of the public.
- Developing and implementing the national drug policy.
- Developing the mental health services infrastructure.
- Strengthening promotion and prevention.

In order to ensure the implementation of *Looking Forward*, and also in response to the later Mason Inquiry (see 'Mason Report' below), the Ministry of Health (MOH) published *Moving Forward: The National Mental Health Plan for More and Better Services* in 1997. The wider scope of *Moving Forward* allowed for the inclusion of mental health promotion, prevention and primary health care activities. In addition, it identified the principles that were to underpin any service development, the population to be served and how services may be delivered.

These two key documents discuss the setting of access benchmarks for people with mental health problems. Based on prevalence data that shows that 20% of the population have a diagnosable mental health disorder (including alcohol and drug disorders) at any one time, the intention of *Moving Forward* is to ensure that there are enough specialist mental health services to meet the needs of the 3% of the population who have severe mental health disorders.

Figure 1 summarises the prevalence data for New Zealand.

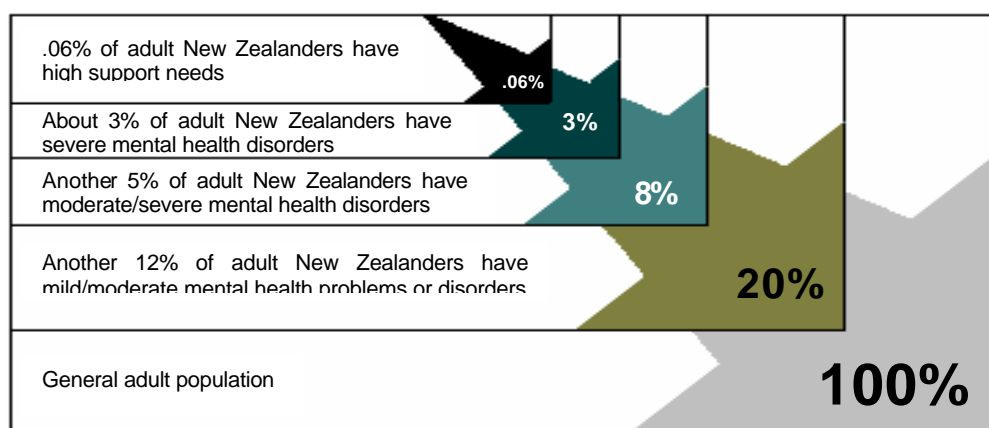


Figure 1: Estimates prevalence of mental health problems amongst adult New Zealanders (Moving Forward, 1997)

Mason Report

Two years after the release of *Looking Forward*, a government inquiry was undertaken into the availability and delivery of Mental Health services in New Zealand, and the findings were documented in a report referred to as the *Mason Report* (Inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of Certain Mental Health services). The major findings of that inquiry concluded amongst other things:

- The sector was under funded.
- Lack of co-ordination between and across services.
- Poor service delivery to Maori.
- Lack of services for children and youth.
- Major workforce issues particularly recruitment, retention and training.
- The importance of undertaking a public awareness campaign.

Blueprint for Mental Health Services

In 1998, the Mental Health Commission released the *Blueprint for Mental Health Services in New Zealand*. The Blueprint is a national mental health service development plan that sets out the qualitative and quantitative changes needed to realise the three percent access objective and other qualitative objectives.

The *Blueprint* builds on the *National Mental Health Strategy* by making more explicit the need for services to:

- Use evidence-based approaches, which treat the person with respect.
- Give people hope of recovery.
- Work in ways that reduce discrimination against people with mental illness, which is a major barrier to recovery.

The *Blueprint* serves two functions:

- It gives guidance to District Health Boards and the rest of the sector on how mental health services need to be for full realisation of the *National Mental Health Strategy*.
- It provides a basis for the assessment of mental health service progress towards full implementation of the strategy, and enables the Mental Health Commission to fulfil its statutory responsibilities to report on progress. The key mechanism for this is the setting of detailed resource guidelines for achieving the 3% access target e.g. 15 acute in-patient beds per 100,000 total population.

It should be noted however, that the resource guidelines were developed for national services, and at smallest, regional. They were not designed to identify the resource guidelines for individual DHBs, particularly the smaller ones, so some interpretation is required when looking at the figures.

NZ Maori Mental Health Strategy

The Ministry of Health has released a draft *Towards a National Maori Mental Health Strategy* discussion document. The final strategy, Te Puawaitanga, is due for release in April 2002. Its purpose is to provide a nationally consistent framework for the planning and delivery of services for tangata whai ora and their whanau by DHBs. The discussion document proposes five goals:

- Provide comprehensive clinical, cultural and support services to at least 3% of Maori with the greatest mental health needs, and to their whanau, within any six-month period.
- Ensure active participation in the planning and delivery of mental health services that reflects Maori models and Maori measures of mental health outcome realities.
- Ensure that 50% of Maori adults accessing services will have a choice of a mainstream or a Kaupapa Maori community mental health service.
- Increase the number of Maori mental health workers (including clinicians) by 50%.
- Maximise opportunities for intra and inter-sectoral cooperation.

It should be noted that the Ministry of Health is currently working towards access benchmarks and associated resource guidelines for Maori. The *Blueprint* suggests that the target for access to specialist mental health services for Maori should be twice that of the general population (i.e. 6%).

Other Key Policy Documents

The objectives and recommendations of a number of other key Ministry of Health documents have been utilised in developing the recommendations in the Regional Plan and provide the national policy framework for specific sections. Key documents include:

- **New Zealand Health Strategy DHB Toolkits**

DHBs are required to report annually on progress towards the priority areas for population health identified in the NZ Health Strategy. To help DHBs address these population health objectives, the Ministry of Health has agreed to develop a set of toolkits that will identify the types of actions different organisations need to take to address the priority population health objectives. The toolkits provide guidance on the best ways to achieve health gains for specific population groups, set performance indicators and provide data. There are three toolkits that are specifically relevant to mental health:

- The Mental Health Toolkit - specifically addresses the health objective of improving the health status of people with severe mental illness.
- The Alcohol and Drug Toolkit - specifically addresses the health objective of minimising the harm caused by alcohol, illicit and other drug use to both individuals and the community.
- The Suicide Prevention Toolkit - specifically addresses the health objective of reducing the rate of suicides and suicide attempts.

- **National Mental Health Sector Standard (2001)**

The National Mental Health Sector Standard applies to all New Zealand mental health service providers and every provider has been sent a copy. The Standard should be used to inform consumers/tangata whai ora, their families, service providers and the New Zealand community as to what to expect from a mental health service. Implementation of the Standard was July 2000 for hospital services and December 2000 for non-governmental organisations (NGOs).

- **Service Coverage Document**

The Service Coverage Document outlines the range and nature of mental health services that are to be provided to defined groups of people.

The Ministry of Health expects DHBs to use the Service Coverage Document when planning for mental health services in their area, as it is part of the contractual relationship between the Ministry of Health and DHBs.

- **Nationwide Mental Health Framework**

The Nationwide Mental Health Framework provides definitions, service descriptions and prices for mental health services. It also outlines the general requirements common to all mental health service providers. Detailed requirements concerning each set of mental health services are contained in the service descriptions.

The Ministry of Health expects DHBs to use the Framework when contracting for mental health services in their area.

- A National Strategic Framework for Alcohol and Drug Services 2001.
- Services for People with Mental Illness in the Justice system –Framework for Forensic Mental Health Services 2001.
- Tuutahitia Te Wero: Meeting the Challenges - Mental Health Workforce Development Plan 2000-2005.
- New Futures: A Strategic Framework for Specialist Mental Health Services for Children and Young People in NZ 1998.
- In Our Hands: New Zealand Youth Suicide Prevention Strategy 1998.
- Involving Families Guidance Notes – Guidance for involving families and whanau of mental health consumers/tangata whai ora in care, assessment and treatment processes.
- Kia Tu Kia Puawai.

Kia Tu Kia Puawai is a strategy for mental wellbeing and mental health promotion, which focuses on the strength of community and self development in improving the mental health status of Maori. It plans to integrate a mental health focus into existing services to Maori.

Other Strategies And The Interface With Primary Care

The Primary Health Care Strategy (Ministry of Health, February 2001), Suicide Prevention Strategy, New Zealand Disability Strategy, Pacific Health and Disability Action Plan (Ministry of Health, February 2002) and the Child and Youth Strategy all set out priorities and objectives, which have some bearing on this plan. Of particular relevance are the national goals of suicide reduction and prevention, which have implications for specialist mental health services and for improved co-ordination with primary health care providers.

An increased focus on establishing protocols for closer relations between specialist mental health services and primary care providers is needed to improve management of mental illnesses (including mood disorders such as anxiety and depression) in the community, and to facilitate timely and appropriate access to specialist mental health services. Specialist mental health services may play an important role in educating primary care professionals in recognition and management of mental illness and addiction, with an increasing need to strengthen their consultation and liaison functions.

3.1.2 Organisational Context

3.1.2.1 Ministry of Health

The Ministry of Health is the Government's principal agent and advisor on health and disability, including mental health. It develops policy advice for the Government on health and disability issues, administers health regulations and legislation, funds health and disability support services, plans and maintains nationwide frameworks and specifications of services, monitors sector performance and provides information to the wider health and disability sector and the public.

The Mental Health Directorate is an organisational unit within the Ministry of Health, which has specific responsibility for the planning and funding of mental health services. The planning guidelines and funding allocations developed by the Ministry's Mental Health Directorate were used extensively in the development of this Regional Plan.

3.1.2.2 Mental Health Commission

In 1996, a government inquiry was undertaken into the availability and delivery of mental health services in New Zealand. The findings were documented in a report referred to now as the Mason Report³. As a result of this report the Mental Health Commission was established to monitor the implementation of the National Mental Health Strategy, reduce discrimination against people with mental illness, and strengthen the mental health workforce.

In 1998 the Mental Health Commission released the Blueprint for Mental Health Services in New Zealand⁴. It sets out guidelines for community staffing and inpatient and residential beds required to provide mental health services, promoting a recovery approach. Progress towards implementing the Blueprint has been recently reviewed by the Mental Health Commission⁵, which is responsible for monitoring its implementation.

3.1.2.3 District Health Boards

Recent changes to New Zealand's public health system have resulted in the country being divided into twenty one District Health Boards (DHBs), which have grouped themselves into four broad regions: North, Midland, Central and South. DHBs are responsible for the health of their local populations and ensuring the needs of individuals and communities are represented at the local level.

³ Mason K, Johnston J, Crowe J. (1996) Inquiry under section 47 of the Health and Disability Act 1993 in respect of Certain Mental Health Services; Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley.

⁴ Mental Health Commission (1998) Blueprint for Mental Health Services: How things need to be.

⁵ Mental Health Commission (2001) Report on Progress 1998-2000; Towards Implementing the Blueprint for Mental Health Services.

The responsibility for planning and funding of most public health services has already been devolved to the DHBs. Eventually each DHB will assume responsibility for the funding and planning of almost all health services in their region, and for direct provision of some services (eg. inpatient mental health services).

The key objective of DHBs is to improve, promote and protect the physical and mental health of their resident populations, and to promote independence and participation in society of people with disabilities. Within mental health services, this responsibility can be exercised by minimising community burden and reducing personal disability and distress associated with mental illness or addiction.

The following six District Health Boards are working together as the “Central” region:

- Hawke’s Bay DHB
- MidCentral DHB
- Whanganui DHB
- Wairarapa DHB
- Hutt Valley DHB
- Capital and Coast DHB

3.1.2.4 Non Government Organisations

Non-government organisations (NGOs) are essential components of effective post-institutional mental health service delivery and development. They offer a broad range of primary and secondary mental health services, including residential care, community support, employment services, consumer and family support services.

NGOs provide a key link between statutory health services and the communities in which they are delivered. They account for 28% of the funding allocated to mental health. They have their own national network, *Platform*, the New Zealand Association of Support Services and Community Development in Mental Health.

3.1.2.5 Central Region Technical Advisory Services (TAS)

Central Region Technical Advisory Service (TAS) is a shared support agency that was established by the six DHBs in the Central region in order to inform local and regional funding and planning decisions from 2001/2002. TAS is a stand-alone unit, established as a limited liability company under equal joint ownership by the six DHBs.

The purpose of the Central Region TAS is to support the effective functioning of DHBs so they can meet the objectives of the New Zealand Health Strategy and the New Zealand Public Health and Disability Act 2000. TAS supports DHBs with applied analysis, service planning, and external service audit functions.

Applied analysis includes activities such as: health needs assessment, population health statistics and epidemiology, interpretation of health information, pricing of health services, effectiveness and cost-effectiveness of health services, and analytical input into the prioritisation process.

Service planning covers service-specific advice on design of health services within each DHB area and region-wide. It uses comparative analysis and service knowledge to provide advice to the DHBs on the content, volume, price and quality of health services that will be provided locally and regionally.

Audit and evaluation covers all those activities that enable DHBs to monitor contract performance of health providers as well as quality of their work and patient/community outcomes. It is based on day-to-day surveillance of health information received from providers as well as on scheduled and ad hoc audits of specific services.

In summary, TAS is an expert advisory service, which combines information management and analytical capabilities with health service experience and project management skills to provide the best health service advice to the DHBs. TAS has been providing administrative, analytical and planning support to the Central Region Mental Health and Addiction Network since its inception in June 2001.

3.2 Central Region Mental Health and Addiction Network

The Central Region Mental Health and Addiction Network is a key vehicle and enabler of joint planning, funding and service development of Central Region District Health Boards.

The Mental Health Commission's guidance to DHBs (August 2000) recommends the establishment of regional Mental Health Networks to identify mental health needs and funding priorities, and to undertake planning and promote quality improvement. In line with this, the Central Region DHBs established the 'Central Region Mental Health and Addiction Network' (referred to as 'CRMHAN'). The project to establish the Network was commenced in July 2000 with the official launch and inaugural AGM taking place in August 2001. The overall purpose of the Network is to ensure that effective services are available across the region.

CRMHAN has the following specific objectives:

- Establishment of a collective approach to regional strategic mental health service planning, that develops a regional approach and enables DHBs to plan for local service delivery and planning within a regional context.
- Establishment of those regional mechanisms that will contribute to developing and maintaining quality improvement, audit, review and benchmarking.
- Establishment of a regional mental health workforce plan.
- Establishment of multi-agency and inter-sectoral partnerships.

These objectives are consistent with those of the Mental Health Commission and the Regional Chief Executive Officers Forum.

The CEOs of the member DHBs provide the governance for the regional network, with authority for decision-making coming through the Regional CEO Forum. The Regional General Managers Funding and Planning Group, of the member DHBs, provide the link between the Regional CEO Forum and CRMHAN.

The General Managers Funding and Planning Group ensures that CRMHAN is operating appropriately and according to priorities and timeframes, assists CRMHAN in resolving significant issues, and provides recommendations to the Regional CEO Forum on the adoption of regional plans, and subsequent regional contracting initiatives.

The CRMHAN consists of two principal component groups:

- **The Executive Group**, made up of the Mental Health portfolio managers or some equivalent as nominated by the member DHBs, and the Service Advisor Mental Health (Central Region TAS). This group is primarily accountable for the functioning, and expected deliverables, of the Network to the GM Forum. It is also responsible for the Regional Plan for Mental Health, as well as audits, purchasing, quality, pricing and costing and aligning all development with national strategies.
- **The Stakeholder Group**, made up of representatives of the Local Mental Health Advisory Groups as well as representatives from stakeholders including consumers, family members, Kaupapa Maori Services, and clinicians. The Stakeholder group is primarily accountable for providing advice and support through the planning process. They meet quarterly and are responsible for consultation with wider stakeholders in the region, input into network meetings by way of updates, expertise, service information, participation in workgroups, meeting targets for tasks, advocacy/ championing network activities and assisting in change management.

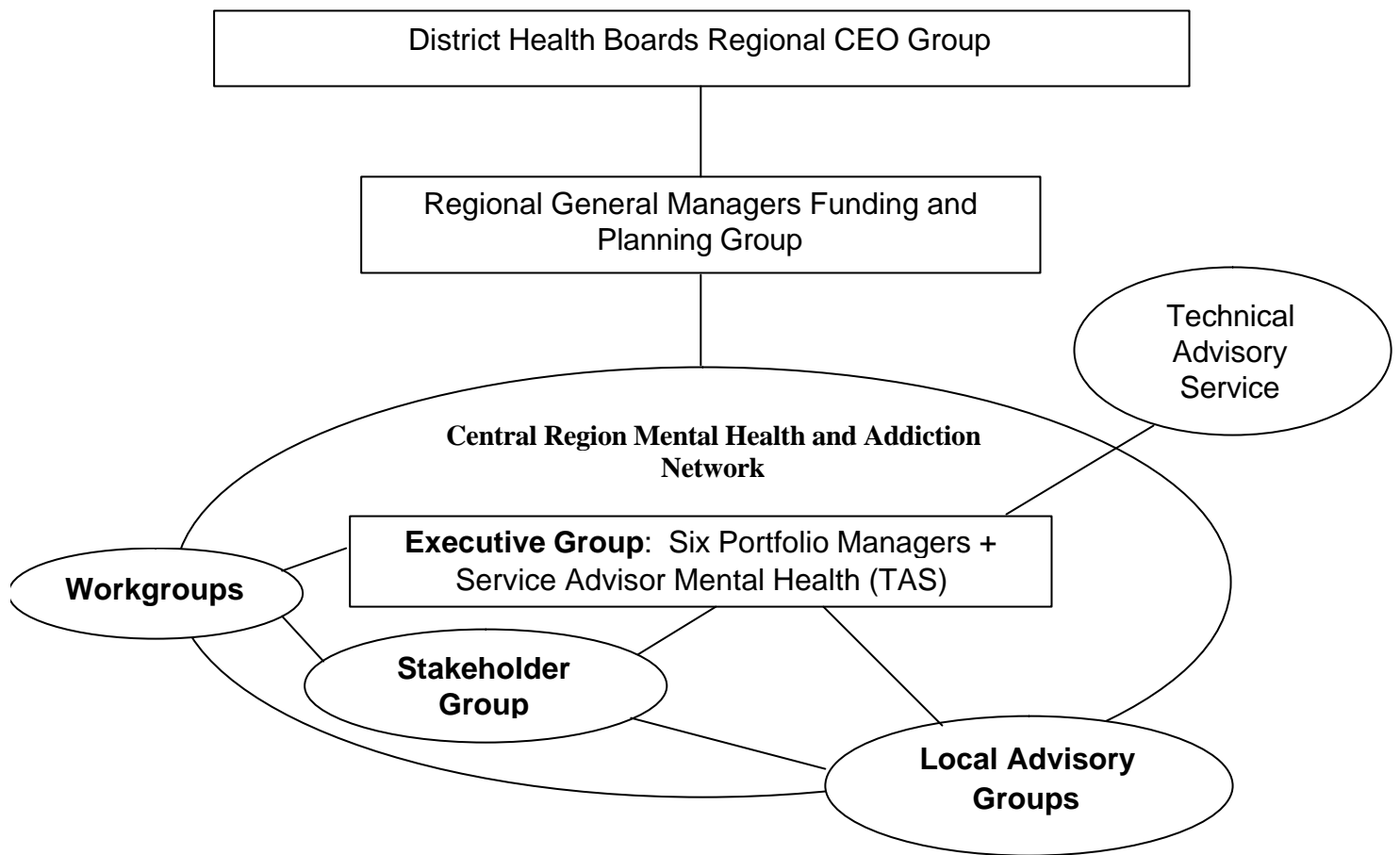
Workgroups will also be established at different times to address specific tasks within the plan. The use of workgroups within the Central Region Mental Health and Addiction Network allows the Executive Group to access additional expertise from within the central region as well as giving others within the mental health community the opportunity to be involved. The suggested workgroups for year 2001/2002 are:

Workforce development.

Forensic services.

Addiction/Alcohol and Drug services.

Central Region Mental Health and Addiction Network Organisational Chart



There will be a minimum of four meetings of the full CRMHAN per year. An annual meeting in August will review performance, identify new trends and current problems and plan for the coming year.

Each year the CRMHAN will announce the establishment or continuation of work groups within the forum.

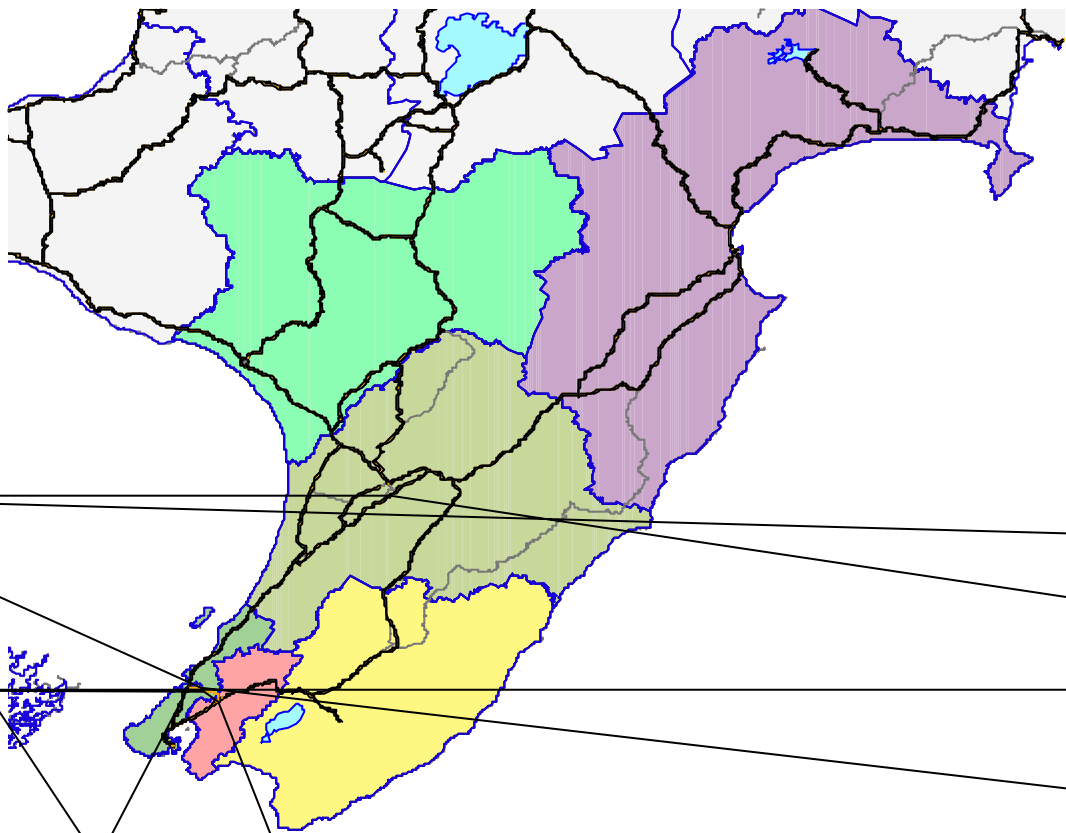


Table 1: Projected DHB Populations for 2001

DHB	2001	Proportion	Territorial Authority 'City' Population
Hawke's Bay	146150	18.3%	37%
MidCentral	161010	20.2%	46%
Whanganui	66340	8.3%	0%
Capital and Coast	250660	31.5%	86%
Hutt	134810	16.9%	100%
Wairarapa	37960	4.8%	0%
Central Region	796930	100.0%	60%

Table 1

Source: MOH Health Needs Assessment CD Ver.2 (All projections in this document are Medium Level Projections based on 1996 Census Data).

4.1.2 Central Region Ethnic Composition

- The Central region has an ethnic mix which is consistent with that of the country as a whole.
 - Maori make up 15% of the Central region's population compared with 14% for New Zealand as a whole.
 - Pacific peoples account for 4.1% of the region's total population compared with 4.7% of the national population.
- Asian people living in the Central region make up 3.8% of the population but make up 4.4% of the national population.

Figure 3 shows the Central Region Maori and non-Maori populations by age group.

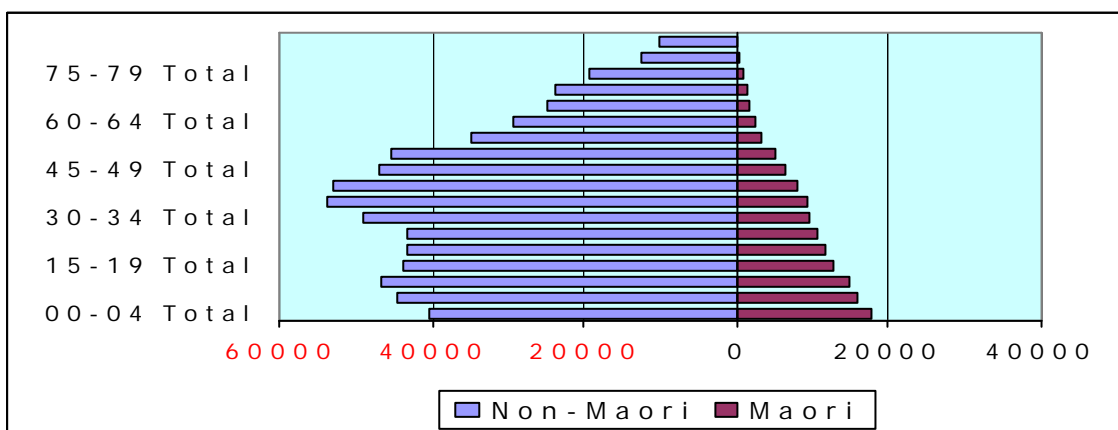


Figure 3

Source: MOH Health Needs Assessment CD Ver.2

The national pattern of shorter life expectancy for Maori is replicated in the Central Region.

4.1.3 Central Region Age and Gender Structure

In the Central region, females outnumber males (404,500 versus 391,000), as they do in New Zealand as a whole. The Central Region Age Structures by Gender and Ethnicity mirrors the national distribution of these population breakdowns⁶.

- Twenty three percent of the population is under 15 years of age, which is the same as for New Zealand as a whole.
- People aged 65 years or over make up 12% of the Central region's population, which is also the same as for New Zealand as a whole.
- The proportion of the population in the working age range is also the same as for New Zealand overall.

Figure 4 gives the Central Region Age and Gender Structure.

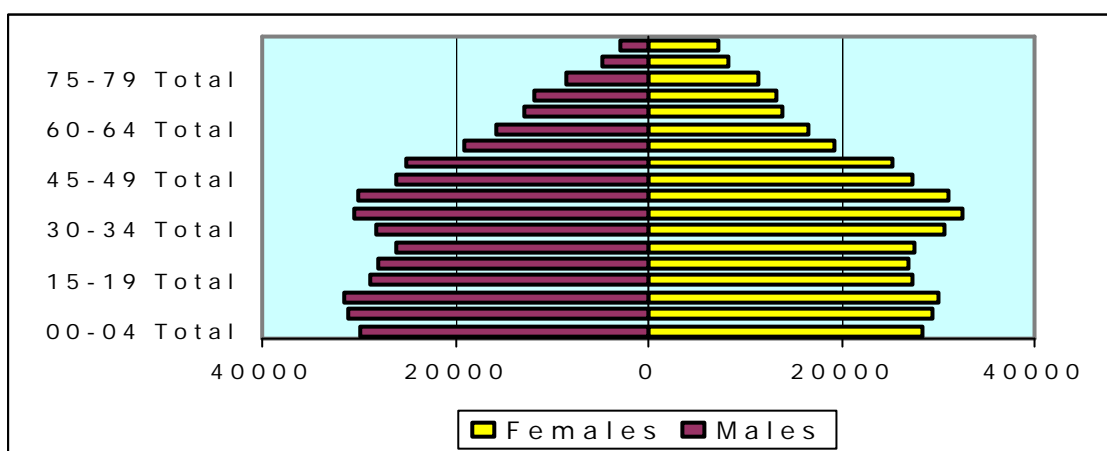


Figure 4

Source: MOH Health Needs Assessment CD Ver.2

The Central Region's Age and Gender structure mirrors the national distribution of this demographic breakdown. Females and Males make up 50.8% and 49.8% respectively of the Central region population.

4.1.4 Central Region Population Projections.

The entire region is expected to grow 1.2% in the next 5 years, while Maori and Pacific peoples population is expected to grow to 7.1% and 9% respectively.

- The NZ population is projected to increase by 2% over the decade 1996 to 2006.
- The most substantial changes are increases in the number of 45 – 64 year olds (by 26%), and in the number of people aged 75 years and over (23)%.
- The number of under 5 year olds is expected to decrease by 13%

⁶ The difference of Central and National Age Structure by Gender proportions had a mean of 0.000 and a std.dev. of 0.0007. Likewise, the difference of Central and National Age Structure by Ethnicity had a mean of 0.000 and std.dev of 0.0012.

Figure 5 shows the Central Region Ethnicity Projections:

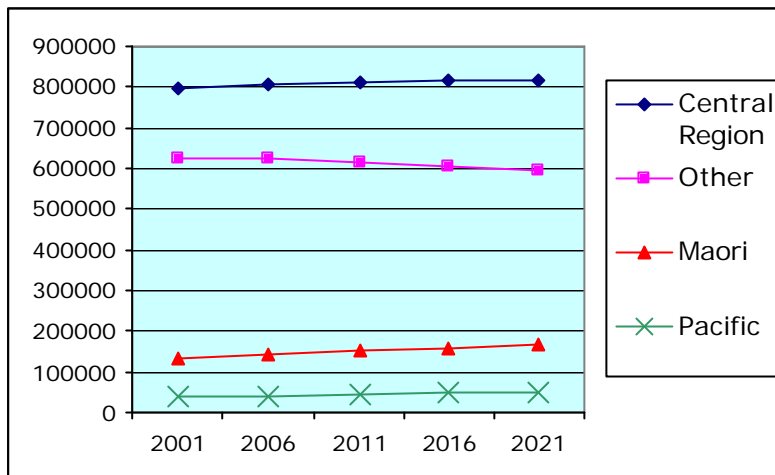


Figure 5

The graphical label 'Other' refers to all ethnicities not categorised as Maori or Pacific peoples.

Figure 6 shows the Central Region Age Cohort Projections:

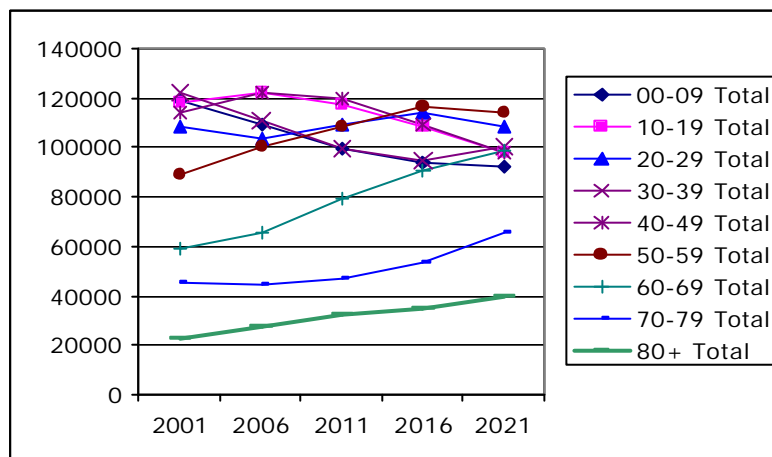


Figure 6

Source: MON Health Needs Assessment CD Ver.2

For the next 5 years, all age groupings under and including the 30-39 year group are projected to decline in size (with the exception of the 10-19 year cohort). Their decline ranges from -4.9% to -8.9% . Conversely, all age groupings above and including the 40-49 year cohort are projected to experience growth. The one exception to this trend is the 70-79 year, with a decline of 0.9% . The 80+ year cohort has been projected to experience 19.4% growth while the other groupings' growth ranges from 7.0% to 13.1% .

4.1.5 Central Region Deprivation Profile

The N.Z Deprivation Index 96 combines nine variables with different aspects of deprivation to give an overall relative score. An index value of '1' represents low deprivation, while '10' is high deprivation. Figure 7 shows the numbers of people under each of these scores, in the Central Region.

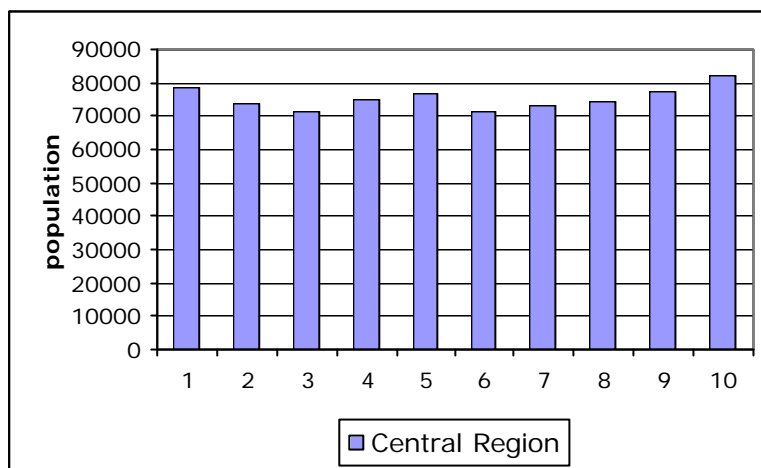


Figure 7

Source: Skelly, C. Et al. "Degrees of Deprivation in New Zealand"
David Bateman Ltd, Auckland, 2000

The Central Region's deprivation profile is a little more unevenly distributed than the NZ profile, with higher numbers at both extremes, and at the mid point of the deprivation chart. Each DHB has pockets of significant deprivation.

The third of the population in the most affluent areas have few material barriers to accessing health services.

The middle third of the region population sit in the middle of the index, and may find it more difficult to access services.

The most deprived third of the population not only have a much higher incidence of mental illness, but may potentially have the most difficulty in accessing services due to financial barriers and social isolation. This effect is exacerbated in rural areas.

4.1.6 Prevalence of Mental Illness

Understanding the prevalence of individuals with mental health conditions in the community is critical aspect of service provision. Disease prevalence is defined as the measure of disease occurrence within a population over a given period. The 1989 Christchurch Psychiatric Epidemiology study remains New Zealand's most recent and comprehensive field study of the prevalence of mental health conditions in the community.

A national survey has been planned by the Mental Health Research and Development Strategy (administered by the HRC on behalf of the Ministry of Health). The national survey intends to "provide better information on the current prevalence of mental health problems in New Zealand to improve planning, purchasing and delivery of mental health services". 12,500 subjects, across the country will be surveyed with over sampling in Maori and Pacific people groups in order to obtain valid statistical estimates. The data collection for this survey will be occurring in 2003.

The report "Mental Health in New Zealand from a Public Health Perspective" (1997) for the Ministry of Health⁷, created by a range of New Zealand mental health experts, is a unique resource in this area. It presents a full analysis of current N.Z mental health epidemiological issues.

Bushnell and Collings (1994) provide a N.Z 'best estimate' of six-month prevalence of all disorders and a severity of disorder rating table. The values have been developed from the Christchurch Psychiatric Epidemiological Study and international studies.

Applying the proportions contained in this study to the Central Region's population of 796,930 people, we have estimated the following numbers of people with various degrees of mental illness:

Central Region Severity Population Estimates:

Disorder groups	'best estimate'	Severity Level 1	Severity Level 2	Severity Level 3
Group A	4,782	2,869	1,434	478
Group B	219,953	43,991	109,976	65,986
Group C	239,079	23,908	47,816	167,355

Group A had an estimated six-month prevalence of 0.6 percent and included only schizophrenia/ schizophreniform illnesses and mania.

Group B affected 27.6 percent of people and included depression, substance use, anxiety disorders, antisocial personality disorders, eating disorders, pathological gambling and cognitive disorders.

Group C comprised those disorders that would come under the category of 'mental health problems' and included such disorders as stress disorders and those with significant behavioural or emotional difficulties, although these may never develop to be a diagnosed psychiatric disorder. (Group C had an estimated six-month prevalence of 30 percent).

The disorder groupings have been split into 3 levels of severity:

Severity Level 1 (severe) indicates that at the least weekly professional contact is needed.

Severity Level 2 (moderate) indicates that professional contact is necessary less than weekly, but more than occasionally.

⁷ Ellis, P. & Collings, S. "Mental Health in New Zealand from a Public Health Perspective" Ministry of Health Online Publication, 1997.

Severity Level 3 (mild) indicates that primarily non-professional community/social agency support is needed with only occasional professional consultation. (These severity of disorder estimates were based on overseas models (Hoeper et al 1979; Andrews 1994) which were extended and applied to New Zealand data).

The utilisation of mental health services is not determined by the prevalence of the disease within the community. The 'rate of presentation' to health services however does not necessarily follow the prevalence of the disease within the community because there are numerous other factors that can influence this.

4.1.7 The implications for the Central region mental health services

Deprivation is a strong predictor of demand for mental health services. However because of the potential to lose detail in a regional deprivation analysis, deprivation analysis is best conducted at an individual DHB level.

As said above, those at a higher level of deprivation will generally find it more difficult to access health services in general. Barriers to access include lack of transport, telecommunications, as well as income.

Therefore, DHBs will have a larger impact on the mental health of their populations by directing a significant part of their resources to improving the health status of this most deprived group. To achieve the best health gains we need to work with other sectors such as justice, housing, employment and education, to improve the general socio-economic conditions people live in, and to help prevent the development of mental illness.

Rural/ Urban Split:

The demarcation of areas as either 'urban' or 'rural' is somewhat subjective. Here is an approximate Rural-Urban population split based upon the populations in the rural and urban Census Area Units within each DHB.

DHB Area	Percent Urban	Percent Rural
Wairarapa	51%	49%
Whanganui	62%	38%
Hutt	100%	0%
Capital & Coast	98%	2%
Hawke's Bay	84%	16%
Mid Central	47%	53%
Central Region	81%	19%

Source: MOH Health Needs Assessment CD Ver.2 (All population in this document are Medium Level Projections based on 1996 Census Data).

Provision of mental health services in rural areas poses a potential problem for most Central region DHBs. Rural consumers face greater risks of social and geographic isolation. Costs in terms of time, communication and mobility may be greater than that for urban consumers. Also, the health professionals that provide these services may be less able to undertake ongoing education to maintain and improve their skills.

Provision of mental health services in urban areas may be able to take advantage of the economies of scale and peer support that is difficult to achieve in rural locations.

Central region needs to work strategically to develop better local and Primary Care based mental health services to meet the need of rural populations. This includes supporting workforce and quality development.

Projections:

Age Projections

Like the rest of NZ, the Central region is becoming 'older'. Therefore there will be a greater demand for services for mental illnesses that are more common in old age (eg Depression, Anxiety, etc). The frequency and severity of these conditions are exacerbated by a general deterioration in health that often occurs in older people. We will need mental health services and mental health professionals that are able to manage the complex nature of these illnesses.

Ethnicity projections:

As well as an aging population, the Central region has Maori and Pacific populations that are projected to grow significantly in the future, particularly in the 0–19 age group. Given this, we can expect there will be an increase in the demand for mental health services for this age group also.

We therefore need to focus service provision on the specific and expanding needs of these ethnic groups, particularly in the area of child and youth services, and alcohol and drug services. Services will also need to be delivered in culturally appropriate manners and settings.

Summary:

The diversity encompassed within this region presents significant challenges for agencies with responsibility for service provision at a regional level. In addition to the physical and resource demands associated with travel for both consumers and providers, extra effort must be made in the planning and delivery of regional level services to ensure that they reflect the specific characteristics of the often quite different communities contained within DHB boundaries.

4.2 Current Central region Service Funding

Funding for Central region mental health services has increased significantly in recent years averaging around 10% growth per annum. Between 1998/99 and 2000/01 funding⁸ for Central region mental health services grew by 20% from \$119.5M to \$141M.

In contrast, funding growth for the next two years will be significantly lower, at less than 2%.

In 2000/01 the Central region spent \$101.7M on Crown provider services and \$41.3M on NGO services (29%).

⁸ Excludes funding for pharmaceuticals and the destigmatisation campaign.

Table 2 shows the portion of this funding spent on Maori and Pacific peoples services.

	Specific Maori Services		Specific Pacific peoples Services	
	\$\$	% of Regional Funding	\$\$	% of Regional Funding
Crown Providers	6.5M	6.4%	0.6M	0.6%
NGOs	9.0M	21.8%	0.7M	1.8%
Total	15.5M	10.8%	1.4M	0.9%

Table 2

4.3 Current Access Levels to Mental Health Services

Table 3 below shows current levels of access for Central region DHBs compared to regional and national averages. The NZ Mental Health Strategy target is 3%.

DHB of residence	2001 Population	Total number of unique clients seen by agency, recorded in MHINC	Percentage of Population
Hawke's Bay	146150	2149	1.5%
MidCentral	161010	2709	1.7%
Whanganui	66340	1511	2.3%
Capital and Coast	250660	4194	1.7%
Hutt Valley	134810	2393	1.8%
Wairarapa	37960	594	1.6%
Region			
Central	796930	13550	1.7%
North	1371330	18150	1.3%
Midland	762540	13556	1.8%
South	928540	18797	2.0%
NZ Total	3859340	64053	1.6%

Table 3

The figures represented in Table 3 above are based on the MHINC reports for August 2001. As not all NGO providers are supplying data to MHINC, these figures would represent an estimate between the number of clients seen by DHB provider arm services and the total number of all clients seen by all agencies.

4.4 Current Performance Against Blueprint

The Ministry of Health has provided regions with documents detailing their performance against established Blueprint targets for 2001/02. The following table summarises the position of the Central Region.

Table 4 shows the 'Blueprint' positions for Central Region:

	2001/02 Volumes	2001/02 Spend (\$M)	Position Relative to Blueprint Funding (100%)
All Blueprint Services Combined		141	75%
Blueprint Services by Service Type			
Inpatient – Beds/Care Packages	301	45	89%
Community Mental Health Teams – FTE/Care Packages	568	51	77%
Residential Beds	595	19	81%
Community Support – FTE/Care Packages	213	12	53%
Consumer – FTE/Programmes	22	1	42%
A & D Residential – Beds	86	2	86%
A & D Community – FTE/Care Packages	103	8	76%
Methadone – places	772	2	64%
Blueprint Services by Target Population			
Adult Services – Beds or Care Packages	911	54	103%
Adult Services – FTEs	705	53	73%
Adult Methadone Places	772	2	64%
Children and Young Persons Services – Beds or Care Packages	27	3	57%
Children and Young Persons Services – FTEs	138	12	64%
Forensic Services – Beds or Care Packages	40	9	76%
Forensic Services – FTEs	25	2	140%
Specialist Services – Beds or Care Packages	-	-	0%
Specialist Services – FTEs	25	3	25%
Non Blueprint Services ⁹	-	1.8	

Table 4

⁹ Training, Workforce Development, Quality Control and Access Fees.

The table above shows Ministry of Health estimates of current service provision relative to Blueprint for the whole Central region. Central region mental health portfolio managers and TAS have been unable to reconcile the Ministry's figures with local contract details. However the table does provide a rough indication of the relative order of disparities between current service provision and Blueprint target volumes.

Table 4 indicates that specialist services are the least developed, followed by consumer provided programmes, and community support services. Child and youth are the least well-served population group.

4.5 Mental Health Workforce

Total average FTEs employed in DHB provided mental health and addiction services in 2001 was:

	Inpatient	Community	Total FTEs	% Of Regional FTEs	% Of Regional Population
Hawke's Bay	69.0	119.0	188.0	15%	18%
MidCentral	75.2	125.0	200.2	16%	19%
Whanganui	118.1	69.9	188.0	15%	9%
Wairarapa	15.2	28.0	43.2	4%	5%
Hutt Valley	40.9	87.1	128.0	10%	17%
Capital and Coast	224.9	229.4	474.3	39%	31%
Total	563.3	658.4	1221.7	100%	100%

Table 5

NB: When interpreting the above table we need to take in to account that some DHBs, such as Capital and Coast and Whanganui, provide regional services to the populations of other DHBs in the Central region.

Future staffing projections for DHB provider arms in the Central Region are:

Average FTEs			
	2001/02	2002/03	2003/04
Hawke's Bay	190.6	190.6	189.6
MidCentral	204.0	204.0	204.0
Whanganui	199.8	199.8	199.7
Wairarapa	46.8	47.2	47.2
Hutt Valley	147.2	149.8	149.8
Capital and Coast	523.0	556.6	556.6
	1311.4	1348.0	1346.9

Table 6

There is no available information on the number of FTEs employed in NGO services. This limits our ability to get a complete picture of the Central Region workforce. Latest indications show that there has been a large increase in the number of FTEs employed by NGO's, however, issues regarding career paths, competencies and ongoing workforce development for this group still need addressing.

4.6 Regional Services

The following services are provided on a regional basis:

- Clinical Rehab/Sub Acute/Extended Care
- Long Term Secure Forensic
- Specialist Dual Diagnosis
- Community Clinical Rehabilitation
- Child and Youth Community Service
- Eating Disorder Service
- Specialist Psychotherapy
- Community Forensic
- Refugee Mental Health Service
- Specialist Maternal Mental Health Service
- Dual Diagnosis with Intellectual Disability
- Child and Youth Intensive Clinical Support
- Residential Rehabilitation Levels 1 – 4
- Child and Youth Community Residential
- Child and Youth Community Alcohol and Drug Residential
- Other Residential Support/Home Support
- Community Support Work
- Supported Landlord Service
- Work Rehab/Employment and Educational Support
- Activity Based Rehab/Day Activity and Living Skills
- Adult Planned respite
- Advocacy/Peer Support Services
- Alcohol and Drug Residential Treatment Service
- Community Alcohol and Drug Service
- Workforce Development

Appendix G shows the service type and description, alongside the provider and beneficiary DHB area, of the regional service.

The model for delivery of these services is that a lead DHB is contracted to provide a service to either part or all of the Central region (and beyond in some instances). That lead DHB then enters into a Memorandum of Understanding (MOU) with the DHBs it is delivering the service to, which outlines the delivery model, access levels, prioritisation criteria etc.

Throughout the consultation process there has been concern regarding the ability of regional services to deliver on their wider regional function.

To determine the nature and extent of the problems facing regional service delivery, the Regional Network, using Central TAS, plan to carry out a review of current regional contracts to assist in identifying the issues. It is envisaged that a work plan to address improved regional service delivery will come out of that review.

4.6.1 A note about the Mental Health Line – Access and Information Service

Mental Health lines have been successfully operating overseas for some time and have been suggested for development in New Zealand for a number of years. In 2000/2001 the then Central Region Health Funding Authority Locality Team brought together a group of interested stakeholders to undertake a scoping study looking at the development of a 0800 line. From the work undertaken by that group a pilot health line has been established in the Waikato, Hutt Valley and Capital and Coast DHB regions.

The aims of the health line are as follows:

- To streamline access to mental health services and ensure that the service consumers receive is appropriate and timely
- To assist in delivering an efficient, effective mental health service in the pilot districts; complementing existing services, providing an optimum service for consumers and improving the information flow between services.
- Right care, right place, first time.

Delivery of the health line commenced on Monday 6 May 2002 although the service was funded from 1 April 2002. The pilot is for a two-year period and evaluation of the service is ongoing throughout the pilot. Details regarding evaluation criteria and selection of an evaluation team are yet to be finalised. The lead District Health Board for this pilot contract is Capital and Coast.

4.6.2 A note about the Mental Health Crisis Services Review

Following the Mental Health Commission's review of mental health crisis services¹⁰, a working group has been established to progress recommendations set out in the review, including initiating a national forum of interested stakeholders to consider and agree upon the following objectives:

- Ensure a focus on reducing variability in access to crisis services
- Seek agreement on key training standards
- Have a nationally defined description of crisis services suitable to translate into the National Service Framework

At the time of writing this plan it is expected that the forum will take place during October 2002. Central region will participate in the work of this forum (Dr Peter McGeorge is a member of the working group and will be the key link for CRMHAN).

¹⁰ *Open All Hours? – A Review of Crisis Mental Health Services*. Mental Health Commission, November 2001.

5 Future Service Provision

5.1 CRMHAN Vision Statement

“RECOVERY AS A RIGHT”

5.2 Objectives for Future Service Provision

- Develop services that are easily accessible, co-ordinated and responsive to target population needs.
- Develop closer relations and partnerships with target populations and consumer groups to enable service responsiveness.
- Have an integrated approach that works with all sectors impacting on the lives of mental health consumers.
- Promote an effective, qualified, competent and confident mental health workforce.
- Promote an integrated, consumer focused, recovery model.
- Consolidate and build on progress made in service provision by improving effectiveness and efficiency through cooperation and co-ordination between Central Region DHBs.
- Have culturally safe, appropriate and responsive services.

5.3 Funding for new services

The Government has allocated additional funding for mental health to achieve improvement in mental health services and to make substantial progress towards the implementation of the Mental Health Commission’s Blueprint. The total amount of this additional funding is \$34.2 million over two years (2002/03 and 2003/04).

The Ministry of Health’s Mental Health Directorate had the responsibility of distributing additional Blueprint funds across the four regions (North, Midland, Central, South) encompassing 21 District Health Boards. The Ministry has allocated the following amounts of new Blueprint funding to the Central Region:

2002/03	\$1.6M
2003/04	\$1.3M

This regional allocation was based on the Ministry’s view of the current funding position of each region relative to full Blueprint target. The formula the MOH used for the Blueprint allocation also took into consideration moving the four regions to equity under Population Based Funding Formula.

Our planning team has undertaken similar analysis of current DHB funding positions relative to the Blueprint target and has been unable to reconcile the Ministry’s blueprint volumes and dollar amounts with our own. This raised considerable concern about the validity of the Ministry’s funding allocations to each region.

In addition to this, the Ministry's chosen approach of providing comparative DHB funding tables led DHBs to make comparisons between their prices and volumes. This has highlighted discrepancies in prices paid and raised issues that could potentially distract DHBs from focusing their energies on other significant service improvement initiatives.

Given the above funding limitations and based on the results of the initial consultation, it is CRMHAN's view that our immediate focus should be on improving the existing mental health services in the region and creating a foundation for the development of new services in the long term. In other words, greater emphasis should be placed on removing barriers to accessing regional services and making those services work better in a co-ordinated, evidence based and consumer focused fashion.

There is strong support across the region for a period of consolidation. The region has experienced rapid volume growth over the last few years, and now needs to ensure that the quality side is being addressed. The NZ Mental Health Strategy is to achieve "More and Better" mental health services. We all believe that priority now should be focused on "better" rather than more.

There are shortages of mental health personnel in all areas against current contracted volumes both nationally and regionally. It would be very difficult, if not impossible, to fill an increased number of positions in clinical services in the near future as well as fill current vacancies.

The region's additional Blueprint funding allocation is very small – under 2% increase in total funding. Before investing further in more services DHBs need to take stock and evaluate those we have now. We believe the most gain from this relatively small sum will be achieved by using a significant portion of it to facilitate quality improvement and evaluations of effectiveness of current services.

Therefore, most of the funding allocation proposed in this plan targets those projects and initiatives that will result in better services that are well understood and properly managed rather than more services of uncertain value and effectiveness.

5.4 Needs assessment and prioritisation process used to determine the allocation of funding

Prioritising funding and service provision for mental health and addiction is a challenging task. The real needs of consumers and service providers must be matched and balanced against the strictly limited public resources available, and the demands of short-term needs considered in relation to the potential benefits of supporting long-term goals.

Mindful of the need to utilise additional funding so as to maximise progress towards full realisation of the Blueprint, the Network has considered, as far as possible, both the quantitative and the qualitative developments required by the Blueprint. The Network has sought to prioritise its funding allocation so as to achieve the greatest possible gains towards Blueprint ideals.

The process used to determine the funding allocation proposed in this plan comprised the following steps:

- a) Consideration of current positions relative to Blueprint, from information supplied by the Ministry of Health, and local health needs assessments reports.
- b) Consideration of wider Network/stakeholder views as indicated by survey forms and focus group meetings.
- c) Consideration of other initiatives or developments currently planned, and which funding has already been allocated, but is not yet operational.
- d) Consideration of the funding available, and other resource limitations.

Current positions relative to Blueprint

At present there is very limited accurate information available about the relative sizes of gaps in service quality and quantity, between services, access for the population groups needing services, and between districts. We have some information about service volumes, but the linkage between purchase units and Blueprint service lines is not clear in a number of areas. We do not yet have a complete picture of services that may be accessed by residents of each DHB within the region. The Network is addressing this. A complete service stocktake and contract analysis is underway but cannot be completed in time to inform funding decisions for 2002/03.

In future years we also expect to be able to use MHINC data to inform funding decisions, particularly with respect to possible variations in access.

The Blueprint service volume tables provided by the Ministry give no indication of service quality. While there are widespread concerns about mental health service quality, and a number of issues based audits have been carried out in recent years, there are no tables of qualitative achievement relative to Blueprint to complement the quantitative information.

Consideration was given to service volume gaps as indicated by the table shown on page 28/29, although, as indicated in the previous section, there are doubts as to the accuracy of some of these figures. Although access to regional specialist services is of concern, it is unlikely that the region is as badly served by specialist services as indicated. It may be that the volumes for some specialist services have been included elsewhere.

Local health needs assessment and consultation

Individual DHB health needs assessment reports have addressed mental health to varying extents. All DHBs have considered local service needs, gaps and other service provision issues in their strategic planning processes and consulted widely with their local populations. This has provided a base for mental health funding allocation and prioritisation at local level, but the information gained is not in a form that enables clear regional comparison and prioritisation across DHBs. Although there are some common issues, including access to regional services, that will be addressed regionally.

Network and Stakeholder views

Network members gave highest priority to addressing workforce deficits (retention, recruitment, training for recovery, cultural competence and responsiveness). They also favoured system changes to enable mental health services to be less fragmented, better co-ordinated and holistic (see Appendix D). Overall they gave priority to addressing qualitative issues (including workforce development) over service volume growth. Workforce development was identified as the highest priority, followed by consumer service development, complex needs service development and overall service quality.

Other initiatives planned or imminent

There are new child and youth mental health services that are expected to come on stream during the latter part of 2001/02 and 2002/03. These will add considerably to the range and volume of child and youth mental health services available in the region. Details of these are given in Appendix F.

Forensic service developments are being overseen nationally. The Ministry of Health has retained funding for forensic services. The new service developments include residential step-down services to be established in the Central region. These will add to the range of services available and should relieve some of the pressures on other adult services.

Funding and other resource considerations

Only a small amount of additional funding is available in each of the next two years. It was realised that this would not be sufficient to make any significant difference to service gaps overall. It was estimated that if the whole sum available were allocated to additional services the region would move from 75% of Blueprint to 76%, a negligible increase overall. However it is possible to use some of the funding to address a few specific very high priority gaps, including development of consumer run services and investigation of ways to improve access to regional specialist services.

Conversely, the additional funding available represents a large amount in the context of service improvement. It was felt that using some or most of the funding for service improvement projects could create an increase in service quality much greater than 1%.

A further consideration is the current shortage of qualified mental health workforce, particularly psychiatrists, and child and youth mental health professionals of all kinds. Lack of qualified mental health service personnel limits the extent to which it is possible to increase service volumes over the next two years.

Proposed funding allocation

Given the considerations above, the Network proposes, for 2002/03, a 35:65 split of funding between region-wide initiatives and local initiatives. The regional projects and initiatives are to be developed and overseen by the Network, and are expected to provide assistance and service gain across all six DHBs.

Central region's preferred method of determining individual DHB Blueprint allocations was to base it on their current position relative to Blueprint targets. However, TAS was unable to complete the analysis required to ascertain DHB's current position relative to Blueprint targets within the timeframe required by the MoH. Central region has therefore chosen to use the interim Population Based Funding Formula (PBFF) to determine the allocation of Blueprint funding to each DHB (see Table 7 below). The Blueprint funding split for 2003/04 will be based on DHB's current position relative to Blueprint targets. Some extra weighting may be given to those DHB's that were disadvantaged by using the PBFF split for 2002/03.

The local projects will be determined by local DHB funding divisions in accordance with their local needs and priorities, as indicated in their strategic and annual plans.

DHB Blueprint allocation based on Interim Population Based Funding Formula

DHB	PBFF Share of National Funding	Relative PBFF Shares within Central	Allocation for Individual DHB Purchases	Allocation for Regional Projects	Total Additional Blueprint Funding 2002/03
Capital & Coast	5.84%	28.21%	\$ 293,411	157,990.34	451,400.97
Hutt Valley	3.35%	16.18%	\$ 168,309	90,628.02	258,937.20
Wairarapa	1.10%	5.31%	\$ 55,266	29,758.45	85,024.15
MidCentral	4.31%	20.82%	\$ 216,541	116,599.03	333,140.10
Whanganui	1.95%	9.42%	\$ 97,971	52,753.62	150,724.64
Hawkes Bay	4.15%	20.05%	\$ 208,502	112,270.53	320,772.95
Total Region	20.70%	100.00%	\$ 1,040,000	\$ 560,000	1,600,000.00

Table 7

Regional projects include a mix of quality improvement and new service initiatives, as indicated in Appendix A.

Details regarding how the six DHB's plan to spend their local Blueprint funding is contained in section 5.6 of this document.

5.5 Regional Projects and Initiatives

Based on the analysis of the current and future environment and the key issues for mental health services in Central region, the planning team have identified a number of regional projects and initiatives. All of these projects and initiatives are aimed at enhancing and improving the scope and quality of mental health services in line with the Network's vision and the national strategies and legal imperatives.

The projects are broadly divided into several subject areas and are not necessarily constrained or limited to these headings but are seen as inter-related components of a broader strategy. Some of the projects have a more specific time frame and budget allocation whereas the others are seen as the ongoing effort and concern of the Network.

This chapter describes key strategic priorities from the perspective of Central Region Mental Health and Addictions Network and outlines regional projects and initiatives designed to address these priorities. Further details of project timeframes and budget allocations are provided in Appendix A of this document. The way in which these projects will be implemented at a practical level is described in Appendix B.

5.5.1 Workforce Development

In common with other regions, mental health services in the Central region face significant workforce issues. The key issues identified by CRMHAN to date are:

- Insufficient workforce numbers
- Deficits in skills and knowledge of current staff
- Development of the Maori and Pacific peoples workforce
- Reorientation to a Recovery approach
- Access to training
- Workforce development for primary mental health services

Workforce numbers

Recruitment and retention is an ongoing struggle for many services as there are national shortages of mental health professionals across all categories. Provider arms of the Central region DHBs employ around 1225 FTE staff in their mental health services, not including locums and other arrangements to cover vacant positions. All report some vacancies. Mental health services provided by the three smaller DHBs (Hawke's Bay, Whanganui, and Wairarapa) have the greatest recruitment and retention difficulty, relative to their staff establishment numbers. Staff shortages and vacancies create difficulties in maintaining service volumes and coverage. At the present time there is no information available about numbers and vacancies within NGO services.

Skill and knowledge deficits among current staff and services

Many older staff in mental health services were trained in institutional settings, in clinical skills and approaches that are at odds with the community based mental health system of today. There have been huge shifts in mental health best practice over the last 15 or so years. Service users are more likely to have a mix

of conditions and cultural issues, including alcohol and drug problems as well as mental illness. Staff are expected to manage and provide effective therapies in the community for a wide range of people who previously would have been treated as inpatients. All services are required to be culturally responsive, and to provide cultural assessments. There is a need for upskilling in both clinical skills and cultural knowledge.

A specific training need for the immediate future, in order to implement the recommendations of the forensic services review, is to upskill community mental health team (CMHT) staff to be able to handle individuals who have a wide range of complex and challenging co-morbidities and behaviours.

Within the Central region, the need for training in dealing with multiple and challenging conditions, is even more important given the approaching closure of Kimberley and the expected increase in calls on mental health services to provide services for people whose condition or behaviour is complicated by intellectual disability.

In addition, all staff should update and refresh their knowledge and skills on an ongoing basis.

Development of the Maori and Pacific peoples workforce

Too few Maori and Pacific people are employed in mental health services. They are under-represented relative to both total population numbers and the numbers of Maori and Pacific people who are service users. Those that do work in mental health tend to be most often found among those with lower levels of qualifications. There are no Pacific psychiatrists and very few who are Maori. Special efforts are needed to boost recruitment of Maori and Pacific staff, to provide them with strong cultural and clinical support, and to provide effective career pathways for them.

Reorientation to a Recovery approach

Consumer empowerment and the principles of recovery now required of all mental health services comprise a conceptual revolution for many people. The mental health recovery approach has only recently (since 1998) been promoted in New Zealand and the implications for service culture and practice are only now beginning to be understood fairly widely. Although many now understand the principles, there is still a long way to go before they are practised widely on a day-to-day basis.

Access to training

Across the region there appear to be difficulties in accessing training opportunities, particularly for staff of small organisations/services and those outside the main centres. Small services have difficulty releasing staff to attend training, and if in a more remote area, face additional travel time. Generally services prefer to have training brought to them rather than have staff travel away to be trained.

Primary mental health care

There are increasing requirements for primary health providers (General Practitioners and Practice Nurses) to provide assessment and

treatment/management of: risk of suicide, depression, anxiety disorders, and alcohol and drug problems. In addition General Practices are being asked to support specialist services through establishment of shared care schemes for people with more severe disorders. There are also particular needs to increase General Practitioner involvement in methadone programmes.

CRMHAN approach

CRMHAN has established a regional workforce development project team. The first task of this group is to complete a stocktake of the region's mental health workforce, and training provided/available to the region's mental health employees. This stocktake of workforce and training will build on information that can be gleaned now from existing DHB provider arm plans, and will include all NGOs. The aim is to have a snapshot of numbers, qualifications, and ethnicities of the current mental health workforce, together with vacancies and skill/competency gaps. This information will then be used, together with individual DHB mental health workforce plans, to identify the highest priority issues that should be addressed at regional level, and to develop a regional mental health workforce plan.

CRMHAN expects to complete its workforce and training stocktake and regional workforce plan by March 2003, in time to inform plans and funding decisions for 2003/04. The plan will be used to inform advice to DHBNZ and to the CTA about priorities for use of the mental health workforce development funding they hold, within the Central region.

5.5.2 Quality Improvement

One of the Government's key objectives for regional mental health networks is for them to promote and take responsibility for mental health quality improvement across the region. The Mental Health Commission guidelines for regional networks proposed regional and local mental health quality improvement committees encompassing clinical competence, peer review, and region-wide quality systems development.

Quality assurance and quality improvement are key goals for the Network. We recognise that much of the "better" envisaged in Looking Forward, and the Blueprint still needs to be actioned. This requires shifts in attitudes, knowledge, skills, and service culture. It takes time and requires strong leadership and advocacy. Addressing quality also requires partnership with a strong consumer movement, and is very closely linked with workforce development. The regional network can foster quality improvement through identification and promotion of examples of good quality, providing forums for sharing of ideas and experiences, and generally raising expectations.

Service monitoring and audit is important, but is not our only tool. It will however be a key facet of a comprehensive Quality Improvement programme/framework, including cultural issues, which we will develop during 2002/2003.

The *National Mental Health Sector Standard* underpins the quality and performance expectations for mental health services. Under the *NZ Public Health*

and Disability Act 2000, DHBs have a responsibility to monitor the delivery and performance of services. Each DHB should have in place a provider audit programme to help facilitate this. It is important that audits specifically address issues regarding the responsiveness of services to Maori.

Central region TAS, in conjunction with representatives of the six regional DHBs, is constructing a regional audit framework for all devolved provider contracts. At present these contracts cover Mental Health, Maori Health and Personal Health services.

This audit programme will focus primarily on issues associated with contractual compliance, however this should evolve more in the direction of service quality and strategic development as the Ministry develops overarching sector risk and quality frameworks.

The audit framework incorporates a regular monitoring programme of providers and the capacity to undertake 'special' audits as and when the need arises.

In addition to the regional auditing framework Central region TAS has proposed a regional survey of all providers to examine a range of issues and help gauge the regions capacity to meet proposed service standards and projected service demands.

The combination of the audit programme and baseline survey should enable DHBs to work collaboratively with providers to continuously improve service quality within the Central region.

5.5.3 Forensic Services

As part of the Ministry of Health's Nationwide Forensic Implementation Project, Central region, through CRMHAN, has established a Forensic work group to lead the implementation of the recommendations from the 'Framework for Forensic Mental Health Services 2001'.

The focus of the workgroup will be:

- Development of a regional implementation plan.
- Translation of national resource guidelines into regional resource requirements that reflect regional need.
- Agree detailed service specifications.
- Review pricing and funding for services.
- Agree service provision plans with providers.

The regional implementation plan will outline how the region intends to address:

- Capacity and service enhancement in Regional Forensic Services including Beds and FTEs, Kaupapa Maori, Prison and Court services.
- Capability enhancement of existing Community Mental Health teams to reflect the capacity to assess, manage and audit high risk persons in community care in conjunction with Regional Forensic Services.

5.5.4 Alcohol and Drug Services

The Central Region Mental Health and Addiction Network have identified Alcohol and Drug services as one of its three main work areas for 2002/03 and 2003/04. The Network's A & D work stream will be taking an issues based approach to regional A & D services.

Areas currently identified as requiring input are:

- Develop framework for credentialed clinicians and the role of A & D Councils. This includes a review of budget holding arrangements for residential services by the central region.
- Regional services - review of access, sustainability and service configuration of selected services.
- Service gaps - identification and options to address service gaps. The output from this work will feed into future regional strategic plans and Blueprint funding.
- Workforce issues - includes development as well as specific training such as the management of consumers with complex needs. This will be done in conjunction with the workforce work stream and the DHBNZ mental health workforce project.

5.5.5 Maori Mental Health

Currently, mental illness and mental health problems are the major health concern for Maori (Durie, 1997¹¹; Ministry of Health, 2001). Increasing psychiatric admissions and re-admissions for Maori since the 1970s, a continued pattern of high substance abuse and an increasing Maori youth suicide rate since the 1980s require an earnest and urgent response to unmet need among Maori. Late presentation for mental health treatment and different patterns of access to services (eg, via law enforcement or welfare agencies) signal that primary, early intervention and mental health services need to be more accessible and responsive to meeting the needs of the tangata whenua (Ministry of Health, 2001).

The conventional mental health system has not met the needs of Maori, who have long advocated for traditional concepts of health and healing to be applied to mental health models and practice. Maori experts are best placed to advise on and develop culturally responsive strategies and services for tangata whai ora Maori. National initiatives to develop and enhance the Maori mental health workforce (e.g. the Te Rau Puawai scholarship programme at Massey University) are promising steps toward achieving a more responsive service to tangata whai ora Maori.

The national contractual requirement of service responsiveness to Maori necessitates Maori participation at both strategic and operational levels. Genuine Maori participation at all levels would be an acknowledgement of DHB commitment to the Treaty of Waitangi and an expression of the principles of partnership and Maori participation, as well as facilitating the protection and improvement of Maori mental health status. This strategic plan endorses a

¹¹ Durie, M.H. (1997). Puahou: A Five Point Plan for Improving Maori Mental Health.

planned and co-ordinated approach to improve the responsiveness and effectiveness of mental health services to Maori throughout the Central region.

The initiatives currently being discussed and developed through the Regional Network:

- Implementing the Maori Mental Health Plan (Te Puawaitanga) throughout our services and aligning all initiatives to the plan.
- Investigate establishing a regional Maori expert group.
- Supporting the development and implementation of Maori specific outcome measures.
- Improving collaboration between Central region Maori health providers.
- Developing collaborative relationships with external organisations e.g. Te Puni Kokiri, Massey University, Wellington School of Medicine and Health Sciences.
- Working with Maori providers to ensure they receive adequate clinical supervision, peer support, training, access to evidence based guidelines and assistance in developing quality assurance and information systems.
- Development of a project looking at moving hospital based Maori mental health teams to Iwi based or Iwi supported services.

5.5.6 Services for Pacific Peoples

The prevalence of mental illness amongst Pacific peoples¹² is not clear because the only reliable data available are based on inpatient admissions. The Ministry of Health, in conjunction with the New Zealand Health Information Service and the Health Research Council, has commissioned an epidemiological survey for mental health in 2002. The results will provide clear information on the prevalence rates of certain mental illnesses in the population by age group and by ethnicity.

It is known that many people experiencing mental health problems in Pacific communities never access mainstream services. The development of links between Pacific communities and mental health services is therefore vital. In addition, a tool to measure mental health outcomes for Pacific peoples is currently being trialled, and a cultural assessment tool is being developed.

Currently, services for Pacific People in the Central region are only available through Capital and Coast and Hutt Valley DHBs. While Pacific Island populations in the four other DHB areas are small, we believe it is important to provide people with the choice of accessing culturally appropriate services.

The following initiatives are being discussed and developed to support improved service provision to Pacific People throughout Central region:

- Establishment of a regional expert group.
- Infrastructure and governance training and support for Pacific Island providers.

¹² Attention needs to be given to the ethnic diversity of Pacific peoples. That is, mental health responses will vary across Pacific groups.

- Workforce development and training.
- Reconfiguration of local services into regional services.
- Advocate for national project to develop Pacific Island specific outcome measures.

5.5.7 Consumer Services

As services are increasingly recognising the value and importance of consumer involvement in all aspects of mental health service planning, development and delivery, we need to be constantly re-assessing the way in which we support and encourage consumer participation.

Through the Central Region Mental Health and Addiction Network, Central region DHBs are looking at the following initiatives:

- Support moves towards the full implementation of Standard 9 of the National Mental Health Standard (NZS 8143:2001) by all services in the Central region.
- Make it a requirement that on all planning groups (including Central Region Mental Health and Addiction Network), consumers and/or consumer organisations are represented in numbers that allow them to participate safely and effectively, and that they are recompensed for their time and expenses where they are not already in paid employment.
- Work with consumers to identify training needs and involve consumers in the development and delivery of that training.
- Strengthen relationships between DHB Consumer Advisors and local consumer run groups and services.
- Encourage 'Central Potential'¹³ to support the infrastructure development of consumer run groups and services in local areas.
- Commence project for the development of a consumer run case management service.
- Commence project looking at the development of a consumer run audit service.

5.5.8 Family Services

Central Region DHBs recognise the importance of family involvement in clients care and wish to develop and promote policies that encourage and support families to participate in our mental health services from planning through to service provision. Strategies to achieve this include:

- Monitoring the implementation of the 'Involving Families Guidelines' throughout Central Region services.
- Making it a requirement that planning groups include at least one family member (including the Central Region Mental Health and Addiction Network).

¹³ 'Central Potential' is a networking service for people with experience of mental illness, who live in the following districts: Hawke's Bay, MidCentral, Wanganui, Wairarapa, Kapiti, Porirua, Hutt Valley, Wellington and Tairāwhiti.

- Assisting families to expand their knowledge and understanding of the mental health system and mental illness.

5.5.9 Child and Youth Services

Table 8: Central region DHBs reported community CAMHS FTEs in 2000/01

	Contract FTEs	Delivered FTEs
Hawke's Bay	21.1	15.4
Mid Central	23.0	20.5
Whanganui	12.0	9.2
Wairarapa	5.6	4.3
Hutt Valley	18.4	19.6
Capital and Coast	22.7	27.0
Total	102.8	96.0

Table 8 shows that Child and Youth services in the Central Region are established in all DHBs. There has been further growth in FTEs particularly in the CCDHB and HVDHB and the development of specialist services such as the Rangatahi/Adolescent Inpatient unit referred to below. CCDHB and HVDHB have built up to a point where the services are able to provide leadership for the region. However while teams are in place there is a need for improved coordination between the services and the recruitment of further FTEs to meet contractual requirements. This is particularly true of Child and Adolescent Psychiatrists but there are also particular needs to develop more services for Maori and Pacific children and youth, and to ensure CAMHS include A & D.

A major project currently under way in the Central region is the development of an Acute Youth Inpatient Unit. This 10-bed unit is due to open on 1st July 2002 and will serve the entire Central region as well as the Tairāwhiti district. It is sited at Te Whare O Rangatuhi on the Porirua Hospital Campus and is operated by Capital and Coast DHB Mental Health Services.

To support this Acute Inpatient Unit the Ministry of Health also funded the development and delivery of Child and Youth Acute Packages of Care in each district. The majority of these packages of care were due to commence on 1st July 2001, however it is apparent from the stakeholder feedback that some DHBs are struggling to achieve this.

The Network has identified the need to support DHBs in their development and delivery of these packages of care as a priority for this year.

Another project the Network will be monitoring is the CYFS pilot currently underway in Hutt Valley, Capital and Coast and Wairarapa DHBs. The service aims to provide long-term intensive individualised case management, using a multi-systemic therapy model, for a small number of children and young people who are in the care of Child, Youth and Family Services and who have multiple deep-seated mental health problems.

5.5.10 Rural Mental Health Services

As mental health services are predominantly provided from large urban locations, areas with smaller populations, such as rural communities, generally do not feel they get adequate access to the services they require. While most rural areas in the Central region have access to some local service, most clients requiring mental health care have to travel to the main centres to receive this.

It is understood that a large number of rural people seeking mental health interventions do so through their local General Practitioner (GP). This is problematic in itself, as the client has to pay to see their GP, so is often reluctant to do so, and the GP often has little experience of managing clients with mental health illnesses, and little knowledge of available mental health services and how to access them.

After hours crisis response is another difficult issue for rural populations. Response times may be slower than desirable due to the crisis team having to travel from their urban base. If the urban location they are coming from is also relatively small, there may be no backup and the base may be left with no crisis response team during such a call out.

It is difficult to quantify the level of unmet need in rural populations as the only data collected represents a record of service delivery and does not account for those who have not accessed services.

CRMHAN would like to support at least one district within Central to develop a pilot project on behalf of the region, focussing on improved service delivery to rural populations. It is anticipated that a number of recommendations for improving rural mental health services would come out of this project that should be included in our 2003/04 work plan.

The use of Telemedicine for rural service delivery is discussed under section 5.5.14.

5.5.11 Outcome Measurements

Recent monitoring and evaluation efforts have been based mainly on the examination of financial and personnel inputs, whereas quality improvement has tended to be equated with implementation of The National Mental Health Standard and auditing of services. Little evaluation relating to service effectiveness has taken place. A move to an output and outcome-based sector is envisaged for the medium term and is supported by a mental health research and development strategy. The introduction of clinical outcome measurements into routine clinical practice at national level (eg, HONOS, HONOSCA and LSP tools) will assist in the monitoring of service effectiveness, as will further development of population-specific outcome tools (eg, Hua Oranga¹⁴ and other Maori mental health outcome tools).

¹⁴ Kingi, K. and Durie, M.H. (2000). Schedules and Guidelines for the Application of "Hua Oranga" A Māori Measure of Mental Health Outcome. A report prepared for the Ministry of Health. Palmerston North: Te Pumanawa Hauora, Te- Putahi-a-Toi, Massey University.

While there is some debate occurring throughout the mental health sector regarding which outcome measurement tools are the most appropriate, we support developing a service culture based on outcome measurement.

Initiatives currently being considered are to:

- Develop a framework for incorporating good outcome measures into funding and planning work and service contracts with providers.
- Work with the Intermediate Level Training project¹⁵ to develop a training package for Central region providers on HONOS, HONOSCA and Hua Oranga (Maori specific outcome measures).
- Work with Central region providers to encourage the use of outcome measurement tools in their daily practice.

When developing any of the above initiatives, CRMHAN will take into account the work of the current Classifications and Outcomes Study (CAOS) that a number of DHB mental health services are participating in. The 'Policy Advice to Ministry of Health on Outcomes in Mental Health', prepared by the Mental Health Advocacy Coalition will also be a guiding document. The long-term goal is to have outcome measures linked into the MHINC database.

5.5.12 Nationwide Mental Health Service Framework

Central Region is committed to participating in and supporting the national work currently underway on reviewing the National Mental Health Service Framework. Areas of improvement Central region would like to see are:

- Inclusions of outcome measurements.
- Removal of the 65 year age barrier on some service specifications.
- Improved reporting requirements.

5.5.13 MHINC (Mental Health Information National Collection)

MHINC is a relatively new tool available to DHBs and is not yet being used to its full potential. Central region see this as a valuable resource and wish to improve our understanding of its capabilities and possible uses, especially in the area of service planning.

We plan to do the following:

- Participate in the identification and resolution of any MHINC issues through the DHBNZ MHINC group.
- Provide training on MHINC reports for mental health Portfolio Managers and other relevant staff.
- Have Central Region TAS produce regular reports and updates for the DHBs to encourage better utilisation of the MHINC data.

¹⁵ Intermediate Level Training project is a DHBNZ workforce development initiative

- Improve data quality and compliance – especially ethnicity and diagnostic recording.
- Provide support and encouragement to the NGO sector to link to MHINC.

5.5.14 Telemedicine

Telemedicine has been available in the six Central region DHBs since June 1999. It is currently used to varying levels within each DHB but generally under-utilised in all. Evidence from programmes operating here and overseas show that telemedicine can be an effective tool for clinical supervision, peer support, assessments and training across our region and beyond. Rural communities in particular would benefit from improved access to Telemedicine. Given we are moving to more regional based services, the video conferencing equipment we have is a valuable mental health resource and the Network is currently looking at the following ways of promoting its use:

- Undertake a review of current usage around the region.
- Develop policies and protocols for use in clinical practice.
- Provide training to staff so they are happy using the equipment routinely.
- Identify clinical staff who can become champions for promoting the use of telemedicine.
- Extend telemedicine sites to rural areas.
- Lead by example e.g. use the technology for some regional meetings.

5.5.15 Central Region Response to a Crisis

CRMHAN Stakeholders have requested that a workgroup be set up to look at how the Central Region could provide support to a mental health service when in crisis. This would include both NGO and DHB provided services.

Areas to be considered by this group could include:

- How a service notifies the region that they are in crisis and in what service area they require assistance eg inpatient, crisis team, community etc.
- What type of staff skills are required eg management, clinical, support, admin etc.
- What services have spare capacity and for how long, in the required areas that could release staff to assist.
- Who could provide de-briefing for staff involved in the crisis.
- How staff salaries are managed. This would include considering differences between DHB's Collective Employment Contracts and staff allowances.
- Co-ordination of and communication with staff sent to assist.
- Transport requirements and availability of one service to release vehicles to another.
- Accommodation requirements.

5.5.16 Information Flows and Improvements in Information Management

Effective sharing of clinical, demographic, and administrative information is a key to successful running of services at a regional level, and is an important enabler of all service development initiatives including workforce development, quality improvement and outcome measurement. Our existing systems and business rules do not adequately support this regional approach and we are faced with a number of technological, cultural and funding issues in relation to improvements in information management.

A concerted and well funded long term effort will be required to overcome these barriers and implement systems and processes that can fully support the regional service provision, as well as evidence-based funding and planning at a regional level. Funding for this was not available from the additional Blueprint allocation and it is currently unclear where it will come from. This is limiting the Network's ability to propose any specific projects and initiatives in this important area of work. In addition to this, many of the required improvements are heavily dependent on the progress of recently announced national strategy for information management and technology in health (also known as 'WAVE Report').

With these limitations in mind, we can suggest the following action plan:

- Analyse WAVE report and shortlist those recommendations and national projects that are likely to have the greatest impact on Mental Health. Stay informed on the progress of these projects and work proactively with the Ministry of Health to provide DHB input and advice to these projects.
- Continue with the implementation of MHINC and start using the data collected in this system (see paragraph 5.4.13 above).
- Do a stocktake of NGO computer systems, current capabilities and future plans and combine with similar stocktake of DHB owned providers.
- Work with the group of DHB Chief Information Officer and Information Systems Managers on any possible standardisation and alignment of systems used for Mental Health patient management at a DHB level.
- Participate in the proposed regional project for the development of a 'standard data model' for DHB and regional decision-making (project proposal from Central Region TAS is currently being evaluated by the six DHBs).

5.5.17 Resource Management

Quantity and security of funding are of major concern to service providers across the sector. Given the limitations this places on both quality and quantity of service provision, CRMHAN wish to ensure that available resources are used to the greatest effect, and the opportunities to secure new resources are identified and pursued.

Good management of existing resources will be supported through:

- Ensuring that Government funding tagged for mental health is not diverted to other areas.

- Strategic investment in research, evaluation and monitoring of consumer needs, service provider performance and trialling of new initiatives.
- Improving communication between stakeholders at local, regional and national levels.
- Reviewing opportunities for service rationalisation and integration.
- Support for workforce development and training at a regional level.
- Identifying and pursuing strategies for cross-sectoral and inter-regional partnerships and joint ventures.

5.5.18 Intersectoral linkages and Partnership Opportunities

Intersectoral linkages are part of mental health policy. The aim of such linkages at a national level is to improve access to appropriate and affordable housing, education and employment to assist recovery from mental illness and full participation in society, and there are a range of existing agreements for intersectoral co-ordination and co-operation that clarify the roles of health in relationship to other sectors.

Pursuing similar initiatives at local and regional levels within the Central region with Government agencies, territorial authorities and non-government organisations is considered to offer great potential for improving mental health and addiction service objectives.

Maximum improvement in mental health outcomes requires intersectoral action, and cannot be achieved by the health sector alone.

Advocacy of mental health interests, collaboration with other interests, development of cross-sectoral partnerships, and joint ventures presents a path to increased mental health and is an important component of the National Mental Health Strategy, recognised at national level, in recent times through new mental health and housing initiatives.

5.5.19 Research and Evaluation

Central region DHBs are committed to the pursuit of sound research and evaluation. Investment in these areas is vital to support local and regional planning, evidence-based decision making, quality improvement, performance monitoring, consumer responsiveness and the efficient and effective use of resources.

A national initiative has been implemented in the form of the New Zealand Mental Health Research and Development Strategy (MHRDS), which is funded by the Ministry of Health, administered by the Health Research Council of New Zealand and supported by the Mental Health Commission. The overall objective of the MHRDS is to use research and development to identify ways that will improve the planning, purchasing and delivery of mental health services in New Zealand, that is consistent with the Treaty of Waitangi and with the needs of consumers, family, whanau and other stakeholders. Central region DHBs intend to contribute to this

project where and when possible, and to ensure that relevant outcomes are applied to their own activities.

The Ministry has advised its medium term intent is to move towards a more balanced approach to evaluating the implementation of the mental health strategy by output and outcome measures as well as inputs.

The Mental Health Research and Development Strategy Steering Group has commissioned the development of Maori, Pacific and consumer based outcome measures that DHBs may wish to test and apply in future (eg, Kingi and Durie, 2000). Until these New Zealand-specific measurement tools are available, the Ministry recommends the HoNOS/HoNOSCA and Life Skills Profile be used in the first instance. Central Region DHBs intend to follow this recommendation, and work with the Ministry where appropriate to ensure the outcome measures developed are meaningful and workable for both parties.

It is also considered important for the Central region to pursue its own research and evaluation initiatives to ensure that local and regional planning, purchasing and delivery reflects the characteristics of the region, are well targeted to the needs of specific populations and to encourage and support providers to undertake evaluations of their own services. National level research and evaluation is an insufficient tool for local and regional planning. Central region investment in these areas will help target resources and improve the effectiveness of interventions over time.

In this context it will be important to establish links with academic and research organisations such as the Wellington School of Medicine and Health Sciences. This should have a positive impact on the workforce development project as well.

5.6 New Services in Local DHB areas

In addition to the regional projects and initiatives detailed in section 5.5 above, Central region DHBs also intend purchasing the following new and/or additional services in their local areas. Please note however that the individual DHB service allocations are indicative only, pending further analysis and discussions with Local Advisory Groups.

Capital and Coast DHB Blueprint Allocation for Local Service Purchasing

Youth A&D Service	Purchase Units not yet decided	\$ 75,000.00
Maori and Pacific Services	Purchase Units not yet decided	\$128,411.00
Community & Primary Based Services	Purchase Units not yet decided	<u>\$ 90,000.00</u>
		\$293,411.00

Hutt Valley DHB Blueprint Allocation for Local Service Purchasing

Primary Care initiatives	Purchase Units not yet decided	\$ 43,309.00
Older people initiatives	Purchase Units not yet decided	\$100,000.00
Workforce Development	Purchase Units not yet decided	\$ 10,000.00
MH LINKS Newsletter	Purchase Units not yet decided	<u>\$ 15,000.00</u>
		\$168,309.00

Wairarapa DHB Blueprint Allocation for Local Service Purchasing

Community A&D Service	MHCS01C	\$ 55,266.00
-----------------------	---------	--------------

MidCentral DHB Blueprint Allocation for Local Service Purchasing

Methadone Treatment Enhanced Packages of Care	MHCS29.2	\$ 36,000.00
Consumer Training	MHCS06A	\$ 50,000.00
Community Support Workers	No Purchase Units available	\$ 10,000.00
A&D (Consumer)	MHCR09.2	\$ 50,000.00
	No Purchase Units available	<u>\$ 70,541.00</u>
		\$216,541.00

Whanganui DHB Blueprint Allocation for Local Service Purchasing

A&D Packages of Care	MHCS06A7	\$ 97,971.00
----------------------	----------	--------------

Hawke's Bay DHB Blueprint Allocation for Local Service Purchasing

Clinical Rehabilitation Service	MHCS06A7	\$141,295.00
Adult Crisis Respite	MHRE02	<u>\$ 67,207.00</u>
		\$208,502.00

List of Appendices

Appendix A. Schedule of Regional Projects and Initiatives

Appendix B. Operationalising the Regional Plan

Appendix C. List of Central Region Mental Health and Addiction Network Members

Appendix D. Outcome of Initial Stakeholder Consultation

Appendix E. Profile of Individual DHBs

Appendix F. Central Region Child and Youth Service Developments

Appendix A: Schedule of Regional Projects and Initiatives

NB: As this is a strategic document, no actual costings have been done for any of the listed projects in Appendix A. The funding allocation is indicative only. Detailed scoping, costing and prioritisation of projects will be carried out once approval for the Regional Mental Health Strategic Plan has been obtained.

Work Area	Goals/Output	Strategies/Specific Projects and Initiatives	Indicative Timeframe Y1 = 02/03, Y2 = 03/04, Y3 = 04/05 (Years 2 and 3 are subject to Blueprint funding availability).	Blueprint Budget Allocation
Workforce 5.5.1	Sufficient MH workforce with the skills competencies knowledge and attitudes to meet the services specifications.	Link with DHBNZ project to review existing workforce skills and deficits within Central region. Development of regional workforce development plan that overarches district plans + links to national/regional initiatives. Implementation of the regional workforce plan.	Y1 Y1 Y2	100K – for all Y1 developments.
Quality 5.5.2	Central region mental health services are delivered consistently to a recognised quality standard	Development and implementation of a regional quality framework across all services (DHB and NGO). Includes implementation of MH standards measurements and implementation of Maori MH measures Development of Treaty responsiveness framework Development of regional audit plan Implementation of monitoring and support programmes	Y1 Y1 Y1 Y2	100K – for all Y1 developments 100K – for all Y2 developments
Forensic Services 5.5.3	To implement the recommendations contained in the 'Framework for Forensic services 2001'	Development of a regional implementation plan, which includes an impact assessment Translation of national resource guidelines into regional resource requirements that reflect regional need	Y1 Y1	Funding requirements for these initiatives yet to be determined. Funding for new

Work Area	Goals/Output	Strategies/Specific Projects and Initiatives	Indicative Timeframe Y1 = 02/03, Y2 = 03/04, Y3 = 04/05 (Years 2 and 3 are subject to Blueprint funding availability).	Blueprint Budget Allocation
Forensic services 5.5.3 (continued)		<p>Agree detailed service specifications</p> <p>Review pricing and funding for services</p> <p>Agree service provision plans with providers</p>	<p>Y1</p> <p>Y1</p> <p>Y1</p>	<p>Beds and FTEs has been top sliced from national Blueprint funding prior to regional allocation</p>
Alcohol and Drug Services 5.5.4	<p>Effective and comprehensive A & D services that operate as an essential integral part of overall mental health services</p> <p>Effective and comprehensive A & D services that operate as an essential integral part of overall mental health services. (Continued)</p>	<p>Develop framework for credentialed clinicians and the role of A & D Councils. This includes a review of budget holding arrangements for residential services by the central region.</p> <p>Regional services - review of access, sustainability and service configuration of selected services.</p> <p>Service gaps - identification and options to address service gaps. The output from this work will feed into future regional strategic plans and Blueprint funding.</p> <p>Workforce issues - includes development as well as specific training such as the management of consumers with complex needs. This will be done in conjunction with the workforce work stream and the DHBNZ mental health workforce project.</p>	<p>Y1</p> <p>Y1</p> <p>Y2</p> <p>Y2</p>	<p>Funding options to be considered (but largely seen as covered by existing base funding)</p>
Maori Mental Health, Kaupapa Maori and mainstream services 5.5.5	<p>Increase capacity and capability of the sector to provide services to Maori by Maori.</p> <p>Work with Maori providers to ensure they receive adequate clinical supervision, peer support, training, access to</p>	<p>Implement the Maori Mental Health Plan, Te Puawaitanga, throughout our services and align all initiatives to the plan.</p> <p>Investigate the establishment of a regional Maori expert group.</p> <p>Develop an implementation framework for movement of Maori services to Iwi based or Iwi supported community services.</p>	<p>Y1 and Y2</p> <p>Y1</p> <p>Y1</p>	<p>100K –for all Y1 developments.</p>

Work Area	Goals/Output	Strategies/Specific Projects and Initiatives	Indicative Timeframe Y1 = 02/03, Y2 = 03/04, Y3 = 04/05 (Years 2 and 3 are subject to Blueprint funding availability).	Blueprint Budget Allocation
Maori Mental Health, Kaupapa Maori and mainstream services 5.5.5 (continued)	evidence based guidelines and assistance in developing quality assurance and information systems.	Develop change management plan for above and establish infrastructures. Investigate use and implementation of Maori specific outcome measurement tool. Work nationally to develop Audit and Quality framework for Maori mental health services based on outcome measures. Improve collaboration between Central region Maori health providers. Develop collaborative relationships with external experts, eg. Te Puni Kokiri, Massey University Local implementation efforts supported by Mental Health Service Development Group.	Y2 Y2 Y3 Ongoing Ongoing Ongoing	200K – for all Y2 developments. 200K – for all Y3 developments.
Regional Pacific Peoples Development 5.5.6	Improve access, scope, capacity and capability of Pacific peoples Services.	Establishment of a regional expert group. Infrastructure and governance training and support. Workforce development and training (part of workforce plan). Advocate for and support national project to develop Pacific peoples specific outcome measures. Reconfiguration of local services into regional services. Work nationally to develop Audit and Quality framework for Pacific peoples mental health services based on outcome measures.	Y1 Y1 Ongoing Y1 Y2 Y3	100K – for all Y1 developments. Funding allocation yet to be decided.
Consumer Services 5.5.7	Consumer Driven Case Management Services.	Feasibility study. Training programme, development and establishment/	Y1 Y2	100K 200K

Work Area	Goals/Output	Strategies/Specific Projects and Initiatives	Indicative Timeframe Y1 = 02/03, Y2 = 03/04, Y3 = 04/05 (Years 2 and 3 are subject to Blueprint funding availability).	Blueprint Budget Allocation
Consumer Services 5.5.7 (Continued).	<p>Consumer run Audit Service (to ensure consumer participation at all levels of audit, monitoring and evaluation of services).</p> <p>Consumer participation.</p> <p>Workforce Development</p> <p>Improve consumer capability</p>	<p>implementation.</p> <p>Pilot (limited programme), research and evaluation.</p> <p>Develop audit framework.</p> <p>Identify consumer skills/competencies.</p> <p>Training programme.</p> <p>Implement audit service.</p> <p>Support moves towards the full implementation of Standard 9 of the National Mental Health Standard (NZS 8143:2001) by all services in the Central region.</p> <p>Make it a requirement that on all planning groups (including Central Region Mental Health and Addiction Network), consumers and/or consumer organisations are represented in numbers that allow them to participate safely and effectively, and that they are recompensed for their time and expenses where they are not already in paid employment.</p> <p>Work with consumers to identify training needs and involve consumers in the development and delivery of that training (part of work force development plan).</p> <p>Strengthen relationships between DHB Consumer Advisors and local consumer run groups and services.</p> <p>Encourage 'Central Potential' to support the infrastructure development of consumer run groups and services in local DHB areas.</p>	<p>Y3</p> <p>Y1</p> <p>Y2</p> <p>Y2</p> <p>Y3</p> <p>Y1</p> <p>Y1</p> <p>Ongoing</p> <p>Ongoing</p> <p>Y1+ ongoing</p>	<p>200K</p> <p>100K</p> <p>100K - for all Y2 developments.</p> <p>Funding allocation yet to be decided.</p>
Complex Needs	Increase capacity and capability of sector to provide appropriate,	Provide appropriate training for staff to increase their capability of working with more complex needs clients.	Y1	250K – for all Y1 and Y2 developments.

Work Area	Goals/Output	Strategies/Specific Projects and Initiatives	Indicative Timeframe Y1 = 02/03, Y2 = 03/04, Y3 = 04/05 (Years 2 and 3 are subject to Blueprint funding availability).	Blueprint Budget Allocation
As referred to in section 5.5.1 under heading: Skill and knowledge deficits among current staff and services.	flexible services for complex needs clients.	Develop models of integrated service delivery for people with complex clinical needs. Expand model to include social integration needs.	Y1 Y2	
Stocktake of Regional Specialist Services As referred to in section 4.5	Improve access to regional services including specialty.	Review of existing services and issues facing access and delivery. Provide framework for improving regional service delivery including the use of telemedicine.	Y1 Y2	\$100K – for all Y1 and Y2 developments.
Family Services 5.5.8	To create an environment within Central region services that supports and encourages Family/Whanau participation at all levels. Assist families to expand knowledge and understanding of the mental health system and mental illness.	Monitoring the implementation of the ‘Involving Families Guidelines’ throughout Central region services. Making it a requirement that planning groups include at least one family member (including the Central Region Mental Health and Addiction Network). Review existing patient information material and its current use and distribution. Consider improvements and standardisation as required. Consult with families/whanau through the Network on their needs and ideas in this area. Link with national ‘Like Minds, Like Mine’ campaign and other relevant groups working in this area eg Schizophrenia	Y1 and Y2 Y1 Y1 + ongoing Y1 Y1	

Work Area	Goals/Output	Strategies/Specific Projects and Initiatives	Indicative Timeframe Y1 = 02/03, Y2 = 03/04, Y3 = 04/05 (Years 2 and 3 are subject to Blueprint funding availability).	Blueprint Budget Allocation
		Fellowship and KITES.		
Child and Youth Services 5.5.9	Improve child and youth acute services. Improve intersectoral collaboration.	Establish (or build on existing) Child and Youth expert group to support DHBs in their development and delivery of the child and youth services, including the acute packages of care. Engage with relevant agencies eg Ministry's of Social Development and Education, Department of Child Youth and Family Services (CYFS), Te Puni Kokiri etc and initiate discussions on action orientated intersectoral projects (including common funding options). Monitor the CYFS/CAFS pilot (Intensive Clinical Support Service) currently operating in Hutt Valley, Capital and Coast and Wairarapa DHBs, and build on that model if successful.	Y1 Y2	
Rural Mental Health Services 5.5.10	Improve rural mental health service delivery and access in the Central region.	Support one Central region district to develop a pilot project, looking at ways of improving rural mental health service delivery.	Y1	
Outcome Measures 5.5.11	Improve Central region provider knowledge and use of outcome measurement tools. Develop evidenced based planning framework using effective outcome measures.	Carry out impact assessment on implementation of outcome measures in Central region. Work with the Intermediate Level Training project to develop a training package for Central region providers on HONOS, HONOSCA, LSP and Hua Oranga (Maori specific outcome measures). Work with Central region providers to encourage the use of outcome measurement tools in their daily practice.	Y1 Y1 Y1 and Y2	

Work Area	Goals/Output	Strategies/Specific Projects and Initiatives	Indicative Timeframe Y1 = 02/03, Y2 = 03/04, Y3 = 04/05 (Years 2 and 3 are subject to Blueprint funding availability).	Blueprint Budget Allocation
	Outcome measures linked to MHINC.	Develop a framework for incorporating good outcome measures into funding and planning work and service contracts with providers. Work with MOH and NZHIS to have outcome measurement reporting incorporated in to MHINC database.	Y2 Y3	
National Mental Health Service Framework 5.5.12	To have more meaningful and outcome focussed service specifications and reporting requirements to which all providers are contracted.	Support the national project currently under way on reviewing the National Mental Health Service Framework. Advocate for: Inclusions of outcome measurements Removal of the 65 year age barrier on some service specifications – impact assessments would need to occur before this could happen Improved reporting requirements.	Y1	
MHINC (Mental Health Information National Collection) 5.5.13	To have MHINC become an effective and reliable tool for use in service planning, evaluation, management and delivery of mental health services.	Participate in the identification and resolution of any MHINC issues through the DHBNZ MHINC group. Provide training on MHINC for mental health Portfolio Managers and other relevant staff. Have TAS produce regular reports and updates for the DHBs to encourage better utilisation of the MHINC data. Improve data quality and compliance. Provide support and encouragement to the NGO sector to link to MHINC.	Y1 Y1 Y1 Y1 Y1	
Telemedicine 5.5.14	Make better use of existing investment in telemedicine and find new and innovative ways of using telemedicine in future planning and delivery of mental health services.	Undertake a review of current usage around the region. Identify clinical staff who can become champions for promoting the use of telemedicine.	Y1 Y1 Y1	

Work Area	Goals/Output	Strategies/Specific Projects and Initiatives	Indicative Timeframe Y1 = 02/03, Y2 = 03/04, Y3 = 04/05 (Years 2 and 3 are subject to Blueprint funding availability).	Blueprint Budget Allocation
		<p>Link with national telemedicine workforce group. Extend telemedicine sites to rural areas.</p> <p>Lead by example e.g. use the technology for some regional meetings.</p>	<p>Y2and3</p> <p>Ongoing</p>	200K ??
Central Region Response to a crisis 5.5.15	Establish effective ways of supporting Central region services when in crisis.	Establish workgroup within CRMHAN to do initial investigation in to how this can best be achieved.	Y1	
Information Management 5.5.16	Effective regional sharing of clinical, social, demographic and administrative information between all mental health providers.	<p>Analyse WAVE report and shortlist those recommendations and national projects that are likely to have the greatest impact on Mental Health. Stay informed on the progress of these projects and work proactively with the Ministry of Health to provide DHB input and advice to these projects.</p> <p>Continue with the implementation of MHINC and start using the data collected in this system (see MHINC section above).</p> <p>Do a stocktake of NGO computer systems, current capabilities and future plans and combine with similar stocktake of DHB owned providers (Consider including GP's computer systems in this stocktake).</p> <p>Work with the group of DHB Chief Information Officer and Information Systems Managers on any possible standardisation and alignment of systems used for Mental Health patient management at a DHB level.</p> <p>Participate in the proposed regional project for the development of a 'standard data model' for DHB and regional decision-making (project proposal from Central Region TAS is currently been evaluated by the six DHBs).</p>	<p>Y1</p> <p>Y1 and Y2</p> <p>Y2</p> <p>Y1 and Y2</p> <p>Y1</p>	
Resource	Make the best use of mental	Strategic investment in research, evaluation and monitoring	Ongoing	

Work Area	Goals/Output	Strategies/Specific Projects and Initiatives	Indicative Timeframe Y1 = 02/03, Y2 = 03/04, Y3 = 04/05 (Years 2 and 3 are s ubject to Blueprint funding availability).	Blueprint Budget Allocation
Management 5.5.17	health funding and maximise government investment to date	<p>of consumer needs, service provider performance and trialling of new initiatives.</p> <p>Reviewing local regional opportunities for service rationalisation and integration.</p> <p>Identifying and pursuing strategies for cross-sectoral and inter-regional partnerships and joint ventures.</p>		

Appendix B: Operationalising the Regional Plan

The planning team has identified a number of specific projects and initiatives that are presented in this document. The purpose of this appendix is to briefly describe how these ideas can be translated into action, ie. how they can be successfully implemented.

Most of the planned projects and initiatives have the following characteristics:

1. They are “regional” in terms of scope and coverage as they span across the six DHBs, as well as a number of Mental Health providers and consumer groups.
2. Their main objective can be described in broad terms of “service development” as they strive to improve and enhance the scope and quality of mental health services in the Central Region by developing new and improved models of service delivery, building and strengthening mental health workforce in the region, improving the information base and information flows and encouraging a shift towards outcome-focused, recovery-based and client-centred solutions.

The key to the successful implementation of regional projects and initiatives will be to establish a “Mental Health Service Development Group” as an operational unit within Central Region Technical Advisory Service (TAS). The purpose of the group will be to support the development of mental health services in the region by interpreting policy in the local context, using and promulgating best practice and evidence-based approach in planning, funding and delivery of services, and by working with individuals, teams, organisations and networks in the region.

The Group will have a small core staff and extensive network of associates and advisors covering the full range of knowledge and expertise required (including psychiatry, nursing, psychology, occupational therapy, social work, consumer, Maori, Pacific peoples etc), as well as user, carer and independent sector perspectives. This networking will be achieved with and through the Central Region Mental Health and Addictions Network - CRMHAN. The Network will have a governance and steering function, while Service Development Group becomes its 'operational arm' by focussing on implementation of the projects and initiatives set out in the Regional Mental Health Plan. For example, current work streams within the Network could become 'Steering Groups' overseeing progress of the individual projects and initiatives that the Development Group is working on.

Key characteristics of the Service Development Group are:

- Policy and practice knowledge (understanding of national policy balanced with practical day-to-day service delivery agenda and local context).
- Sound set of values and principles (focussed on needs of consumers, families, communities).
- Part of local and regional system (regarded as integral part of the system, 'owned' by the stakeholders and seen to help their local efforts in continuing to improve, modernise, change and adapt their services).
- Supports and promotes local solutions and builds local capacity and capability.
- User and carer involvement and capacity building in service planning, design and delivery.
- Collection and dissemination of knowledge and information from research and practice using a variety of methods.
- Knowledge and experience of organisational development and the management of change.
- Ability and experience to build and sustain partnerships, alliances and networks through which their work is both designed and delivered.
- Experience in service research and evaluation.
- Ability to work with and through others to develop a wider body or network of experience, knowledge and skills to draw on.

In terms of the actual work, the Group should focus on supporting the local and regional process of implementation, using a wide range of interventions, delivered in a range of styles, sensitive to the local and regional context. This includes work on the strategic projects and initiatives identified by the Regional Network, but also practical on site support to overcoming barriers to change.

The range of activities might include (but is not limited to):

- Working with local implementation teams (led by DHB Funding and Planning Teams, and Mental Health Service Managers and Clinicians).
- Service evaluation.
- Training and education.
- Leadership development.
- Networks and forums.
- Knowledge repository.
- Projects.
- Events (eg. conferences, seminars and workshops).

The first major task for the Group will be to develop detailed project scopes (or action plans) for each of the projects and initiatives that were identified in this Regional Plan. These project scopes should then be ratified by the Regional Network (CRMHAN), and their deliverables, timeframes and budgets signed off through the previously agreed regional decision-making process.

Establishing a “Mental Health Service Development Group” as part of Central Region TAS is consistent with the purpose and objectives of TAS as a shared support agency and would bring the following benefits:

- Building on the existing relationships and support services that TAS currently provides to the Regional Network;
- Utilising the existing infrastructure and facilities of TAS, including information systems, knowledge management, project management and information delivery (eg. Web site);
- Single point of project co-ordination with clear lines of responsibility and accountability to the Regional Network and to the six shareholding DHBs.
- Developing a common pool of information and expertise that can be shared among the six DHBs and with other Network participants, including provider and consumer organisations;

Appendix C: List of Central Region Mental Health and Addiction Network Members

DHB Portfolio Managers (Executive Group)

Nicola Ehau	Hawke's Bay DHB (Chair person)
Danny Wu	Hutt Valley DHB
Rose Wall	Capital and Coast DHB (up to May 2002)
Kate Beresford	Capital and Coast DHB (from May 2002)
Joanne Hayes	MidCentral DHB
Joy Cooper	Wairarapa DHB
Tracey Schiebli	Whanganui DHB
Fiona Fowles	TAS

Local Advisory Group representatives

Susie Crooks	Hawke's Bay DHB
Sue Etuale	Wairarapa DHB
Lucy Laphen	Hutt Valley DHB (Up to May 2002)
Sharessa Langley	MidCentral DHB
Peter McGeorge	Capital and Coast DHB
Mike Ward	Whanganui DHB

Stakeholder representatives

Elva Edwards	
Tim Harding	(Co-chair of CRMHAN)
Julia Hennessy	
Nick Judson	
Vito Malo	
Carole Maraku	
Eseta Nonu-Reid	
Hugh Norris	
Helen Rodenburg	
John Tovey	

The above members represent the following areas of expertise:

Consumers, Family members, Maori, Pacific peoples, Psychiatrists, Mental Health Managers, Non-government Organisations, Alcohol and Drug, General Practitioners, Child and Youth, Forensic, Clinicians, funders.

Appendix D: Outcome of Initial Consultation with Stakeholders

Stakeholders identified a range of positive things about mental health services provided in the Central Region. These include

- Wide range of established services available
- Lots of skill and enthusiasm
- Good cooperation between services
- A growing sense of regional community
- Strong NGO sector
- GPs receive good support
- Community development approaches and community support models that look beyond clinical solutions.
- Initiating improvements in the cultural responsiveness of services (Maori and PI)
- Developing consumer networks
- Continuum of care and relationships across providers
- Well-trained, reliable key workers assisting in preventative approaches
- Free eating disorders clinic and alcohol and drug counselling
- Mental Health Services Stakeholder Forum provides important venue for stakeholders
- Implementation of the Like Minds Project to reduce stigma and discrimination
- Availability of crisis team with short response time
- Psychiatrists and staff acknowledging Maori protocols
- Willingness of the six DHBs to work together

There was also a variety of things that needed to be improved, including:

- Providing more timely access to services
- Closing key gaps in the workforce (eg lack of psychiatrists in Hawke's Bay, Wairarapa, more employment of consumers in mental health services)
- Providing consistency in funding and benchmarking across all services
- Providing a framework for service provision that reduce fragmentation (eg too many small, specialised services)
- Establishing processes for dealing with sub-standard providers
- Reducing pressure on acute services (particularly in-patient beds) by stemming demand and/or increasing capacity.
- Need to build systems and expectations that support service providers and give them the confidence to do their job and to take calculated risks.
- Quality audits
- Equity
- Willingness to change things that are not working
- More holistic approach to mental health – recognising employment, housing, social inclusion as essential for recovery.
- More consumer run services
- Changing attitudes of staff towards recovery focus.
- Better planning for the MCH region, which is disadvantaged by the regional model basing services in the Greater Wellington region
- Cultural competence and sensitivity to women's needs

- Mentoring and supervision of mental health staff to reduce turnover
- Services for people with borderline personality disorders
- Involvement of whanau in healing process
- Youth focused policy development

Stakeholders identified a number of opportunities for mental health services in the Central Region including:

- Ensuring support is provided to those areas that demonstrate excellence, skill and innovation.
- Regional co-ordination allows skills and expertise to benefit the region as a whole
- Developing more primary care services
- Developing more integrated care
- Utilising academic networks to help research and evaluate new models.
- Platform is able to organise networking
- SCS steering group
- Local employers
- Ability of consumers to provide peer support models
- Strengthening Families model

Stakeholders identified a number of risks associated with current provision of mental health services in the region:

- Low number of psychiatrists
- Inadequate levels of early intervention/prevention
- Lack of good basic services such as general adult and child services.
- Lack of analysis of current information
- Lack of audits
- Skill and knowledge base limited in some areas
- Community based expertise not always recognised
- Inadequate funding of some services
- Limited access to regional services
- Focus on DHB provider arms to the exclusion of other services
- Poor decision making due to political interference and/or fiscally driven decisions
- Too much pressure on key staff leading to burn-out.
- Lack of co-ordinated, simple pathways through services leading to fragmentation and inefficient use of skills and resources.
- Services that feel “at risk” act defensively
- Reliance on clinical solutions for social problems
- Children and young persons being excluded from services at an early age, resulting in more intensive intervention requirements later
- Cross-cultural miscommunication
- People with less serious conditions slipping through the cracks

Other general comments provided by stakeholders included:

- Political and public expectations are seen as unrealistic in some instances and add to the pressures faced by providers
- The community is not confident about the quality of current mental health services and staff share that concern

- Systems errors are a common underlying problem – feedback and incident reporting by staff and families should be encouraged
- Staff should be able to speak more openly about personal experiences with mental illness
- The Probation Service has a national offender warning register for high risk clients but there is no local document
- More liaison is required between mental health and Maori providers
- Need for whanau rooms with sufficient seating
- Poor staff remuneration

Appendix E: Profile of individual District Health Boards

Capital & Coast DHB Profile – Mental Health Services:

1. Capital & Coast District and population profile

Capital & Coast DHB serves its local resident population of approximately 235,000 people and provides regional services to approximately 850,000¹⁶ in the Central Region.

The Capital and Coast District is made up of three main geographic areas, Wellington, Porirua, and most of the Kapiti Coast. The population of each area is made up of different communities with distinct characteristics that influence their health needs.

Population Analysis of Wellington, Porirua and Kapiti

Area	Māori	Pacific Peoples	Others	Total
Wellington	9,820	5,884	140,417	156,121
Porirua	8,520	9,460	25,643	43,623
Kapiti ¹⁷	2,241	126	29,011	31,378
Total	20,581	15,470	195,071	231,122

Numbers based on 2000 projections from 1996 Census

Parts of Kapiti within Capital & Coast DHB boundary

The proportion of Maori in Capital & Coast, at around 11%, is lower than in the total New Zealand population (15%). Pacific Peoples make up 8% compared with 5% nationally. The Maori and Pacific populations have more children per adult and very few older people. The “other” population peaks in the 30-40 age group, and has a significant number of people over 65.

Demographic characteristics of our population (age, sex, and ethnicity) together with a number of socioeconomic and environmental influences determine many of the mental health needs for the region.

High health need has been linked with deprivation, which is measured by factors such as income, and access to telephone and transport services.

A brief outline of each of the three areas focusing on deprivation, age and ethnicity follows.

Wellington City

Most of Wellington City is well off and enjoys good health; however, there are pockets in central, south and east Wellington where people are relatively poor and in poor health. There are significant numbers of Māori and Pacific populations in these deprived areas.

¹⁶ Note CCDHB is responsible for providing a range of specialist mental health services to the regions population

¹⁷ Parts of Kapiti within Capital & Coast DHB boundary

Kapiti

Kapiti Coast has fewer working-age people and older people; with a significant number of Māori, but very few Pacific people. In general, Kapiti people are moderately well off, healthy and are located in the middle deprivation categories.

This rating may be misleading for many of Kapiti residents, as there are areas of poverty; plus older people living in small homes or retirement villages are not necessarily hard up.

Porirua

Porirua area represents two extremes.

Residents around the Pauatahanui Inlet (north of Porirua city) are well off, with good health and access to resources. The high health status of this group is often overlooked in the average for Porirua.

By contrast, people living in Porirua city and Cannons Creek are poor, with high health needs and an increasing rate of health problems related to crowded housing.

Expected changes

The Capital & Coast population is growing slowly overall, at 1% per year. The Maori and Pacific populations are both growing faster, at 2% per year. These increases are very close to those expected for New Zealand as a whole.

That slow overall growth masks a significant ageing of the Capital & Coast population. In the next five years, the 50 – 65 age group will increase by 26%, and the 80 – 85 age group by 46%. The number of children under 10 is expected to decline, except among Maori and Pacific Peoples. And even in those two groups there will be fewer children under five.

2. Mental Health services in the District

Capital Coast Health is the largest Mental Health Service provider in the Capital & Coast DHB Region. They provide specialist secondary and tertiary mental health services for adults, children, adolescents and families. Included in this range of services is the Specialist Maori Mental Health service that has a focus inclusive of child, adolescent and family, adult and day programs.

Inpatient services are delivered from units at Porirua and Wellington and comprise of the following:

Service	Beds	
Acute Beds (ICU and General)	35	
Clinical Rehabilitation & Extended Care ¹⁸	52	
Long Term and Medium Term Forensic ¹⁹		25
Child Youth (operational 1/7/02)	10	

¹⁸ This is inclusive of beds for patients referred from other DHBs in the region

¹⁹ The forensic service is both a local and regional service

Total Inpatient Beds:

122

Service Coordination and a range of community based assessment, crisis, treatment, consult/ liaison and training services are delivered to tangata whaiora/ consumers in the Wellington, Porirua and Kapiti areas, Greater Wellington (including Hutt Valley) and throughout the Central region.

There are a range of local community based services provided to Wellington, Porirua and Kapiti including:

- Crisis intervention (CATT)
- Adult CMHT
- Alcohol and Drug (CADS)
- Child, Adolescent and Family
- Maori and Pacific Peoples Mental Health

There are also a range of Specialist Community Mental Health Services provided to Wellington, Porirua, Greater Wellington (including Kapiti and Hutt Valley) and Central Health region HHSs including:

- Early Intervention
- Dual Diagnosis (alcohol and drug and psychiatric disorder)
- Dual Diagnosis (intellectual disability and psychiatric disorder)
- Maternal Mental Health
- Personality Psychotherapy Services
- Opioid substitution
- Psychiatric Liaison (Wellington only)
- Forensic Community Services

Expansion within the Mental Health sector has been significant over the past five years with a growth of approximately 25%. Overall Mental Health services have already moved in the direction of an integrated network of services. This has included an emphasis on community care and a wide range of choice of services delivered by different and diverse agencies. CCDHB has a non-government sector that provides services for people with conditions ranging from psychotic to alcohol and drug disorders.

In the CCDHB we have a number of Maori Providers who deliver Kaupapa Maori Mental Health Services, Alcohol and Drug Services and Child and Youth Services. These incorporate Community Based Services, Activity Rehabilitation and Day Activity, and Community Residential Beds. Nga Oranga (wholistic) models are adopted for delivery of Alcohol & Drug and Child and Youth Services. In addition there are several Pacific providers who deliver residential mental health services, community support services and community alcohol and drug services.

The CCDHB Region has a significant number of Community Residential Beds provided by a number of organisations, many of who also offer Community Support Work Services. Consumer Run Day Services, incorporating a drop-in centre for service users, are also available.

The Primary Care sector is expanding their services to persons with a mental illness. A number of Capital & Coast District Health Board/Primary Care Organisation jointly

led projects are currently underway. These include Mental Health Assessments, Substance (Drug & Alcohol) Use Assessment and Pre-referral Assessments for Child and Youth.

The CCDHB Region also has a large support network of other funded and voluntary services provided outside the District Health Board jurisdiction and these form a vital part of the service continuum.

3. Identified Issues and Service gaps

The Mental Health of our community impacts in many ways upon its General Health. The scope of mental health problems is very broad. The number of people for example, at any point in time, coping with some degree of distress due to mental health issues is approximately 20%. It is predicted that by 2020 depression will be the most prevalent disease worldwide basis. Depression and anxiety disorders are already among the most frequent diagnoses in General Practice. The incidence of Youth suicide while having reduced nationwide is still increasing in the CCDHB area. The numbers of people with psychotic disorders and alcohol and drug disorders continue to provide challenges for our services. (This is becoming a particular issue amongst Maori and Pacific youth). Of the total population with mental health problems our greatest concern is for the 3% suffering severe mental illness.

Further work is needed to establish specific local needs for mental health care. To date, the focus has been on the 3% people with severe mental illness and services are designed to ensure this group can access treatment and rehabilitation. We need to understand however the mental health needs of other people so that an increasing focus can be given to providing mental health services in primary healthcare sector. In the future particular emphasis will be given to early detection and intervention and public health approaches, which focus on mental health promotion and the prevention of serious mental disorders.

Hawke's Bay District Health Board Profile – Mental Health Services

1. Hawke's Bay district and population profile

The region extends from Waikaremoana in the north, to the Takapau Plains in the south. The Chatham Islands lie some 800 kilometres to the east of New Zealand. There are five local authorities and one Hawke's Bay Regional Council.

There are two Iwi Authorities in the region. Ngati Kahungungu Iwi Incorporated in the Hawke's Bay and Te Runanga o Te Wharekauri Rekohu on the Chatham Islands.

The population of the Hawke's Bay District Health Board is approximately 146,000. Just over 700 people reside in the Chatham Island's

Territorial Authority	Local	Estimated Population June 2000 (%)	Estimated population change since 1998(%)
Hastings District		68,100	(0.1)
Napier City		54,300	(0.4)
Central Hawke's Bay		13,000	(0.8)
Wairoa		9,740	(1.0)
Chatham Islands County		740	(1.3)
TOTAL		145,880	

Table 1: *Estimated populations*

Within Hawke's Bay 79% of the population live in the urban areas of Napier and Hastings. The remainder live in rural towns and country areas of Central Hawke's Bay and Wairoa, some in very isolated settlements.

The population is characterised by;

- A relatively high proportion of under 15 or over 65 years, with 29% of the Wairoa population under 15 years. 48% of the Maori Population through out Hawke's Bay are aged under 14yrs.
- A relatively large Maori population accounting for 22% of the population compared with 15% in the Central Region as a whole. Wairoa has 55% Maori and on the Chatham Island's Maori account for 57% of the population. Based on medium population projections, the Maori population of Hawke's Bay will increase to 45,000 by 2021. This represents an increase to 35%. The over 55 years group will grow by 52%.
- An increasing number of older people reside in Hawke's Bay. There was a 6% increase in the 60 and over group, between 1991 and 1996, while the age group 50-59 years increased 14% in the same period. This compares with an overall population increase in Hawke's Bay of only 3.3% between 1991 and 1996
- The rural nature of the population presents special problems with accessing health care. For example, 10% of the population lives more than one hour away from the Regional facility at Hawke's Bay Hospital

- The socio-economic status of Hawke's Bay remains less favourable than that of the Central Region as a whole, however, there is considerable variation within the district.
- Maori make up 12% of all people unemployed in the Hawke's Bay and 52% of all people on income support. Only 9% of the Maori Population employed earn more than \$30,000 per annum and 20% of Maori households do not have a private motorcar.
- The population of Hawke's Bay is in slight decline, with an estimated loss of 0.3% population between 1999 and 2000. Over the same period of time the North Island had an estimated growth rate of 0.7%.
- The apparent population shift from the region is particularly amongst the younger age groups, exacerbating the significant shortages of sufficiently skilled labour.
- The average life expectancy at birth of a person residing in Hawke's Bay is 76.2 years (as at 1997). This is the 6th lowest life expectancy of any region in NZ. Maori life expectancy at birth was significantly shorter in the region in 1996; 64.5 years for males and 70.5 for females, compared with 74.8 and 80.3 years respectively for non-Maori.

2. Mental Health services in the District

The following services are currently provided in the Hawke's Bay district.

Hawke's Bay District Health Board Health Care Services is the largest mental health service provider in the district approximately 75% of services are delivered from this provider. Services include:

- Inpatient services for acute and sub-acute care
- Step down rehabilitation service
- Level 1-4 supported accommodation
- Community mental health continuing care teams
- Rehabilitation day programmes
- Needs assessment and service co-ordination service
- Access/ triage and psychiatric emergency service
- Children and family / whanau service with kaupapa Maori component
- Kaupapa Māori adult community team
- Drug and alcohol services with kaupapa Māori team
- Consumer/tangata whai ora advisor
- Pacific island advisor
- Eating disorder specialist
- Maternal mental health specialist
- Crises respite services
- Carer respite
- Home based care
- Acute packages of care for children and young people

HBDHB has access to two extended care/clinical rehabilitation beds on buy beds from Capital and Coast Health. Utilisation rates for Inpatient beds are high. There

are some proposed changes to this configuration to better align services to the continuum of care for consumers.

Services provided by Non Government Organisations include:

- Level 3-4 supported homes
- Support for community services (SCS)
- Ngā oranga o te rae (Māori model of community support) children and young people and drug and alcohol
- Kaupapa Māori day programmes
- Children and young people day programmes
- Consumer/tangata whai ora operated services (advocacy and support)
- Kaupapa Maori tangata whai ora network development (ngā ihi o te ra)
- Shared care pilot (in conjunction with Healthcare Services)

3. Identified Issues and Service Gaps

Service Utilisation

Utilisation of all services is high, and the demand to increase the coverage of existing services is increasing.

Utilisation of inpatient beds in the mental health Unit has remained high for the past two years. As well as this occupancy in level three and four beds has also been high. In contrast level one and two bed occupancy has been low. The movement towards the development of support for community services has only been a year in development in Hawke's Bay however there are early signs that once fully operational these services will offer valuable support in maintaining consumers in the community.

Community Mental Health Teams for adults are fully utilised however there are still some under utilisation in child and youth services across the both HCS and NGO providers.

The Mental Health Sector struggles with workforce issues including recruitment and retention of skilled Mental Health staff. These are challenges that the Central Regional Mental Health and Addictions Network will be working to address in the next 2-5 years these will work alongside of national plans.

Health Care Services HBDHB are currently poorly configured to meet the current challenges of the district. Clear boundaries for treatment and support are required to reduce duplication of service delivery to individuals.

Kaupapa Maori treatment teams are not able to deliver services that are integrated with Kaupapa Maori non treatment teams due to over utilisation of resources as well as some perceived separateness from NGO providers.

Consumer services have been established however there has been very little growth or scope for development in the past two years.

Complex needs consumers are not well catered for (reflected across the region).

MidCentral DHB Profile – Mental Health Services

MidCentral District

The MidCentral district stretches across the North Island from west to the east coast and is bisected by the Tararua and Ruahine ranges. MidCentral comprises the following territorial local authority districts:

- Horowhenua district
- Manawatu district
- Palmerston North City
- Tararua district
- The Otaki ward of Kapiti coast district

Four Iwi have Manawhenua status within the region: Muaupoko; Ngati Kahungunu; Ngati Raukawa; and Rangitane.

Ngati Raukawa and Muaupoko iwi are located on the western side of the ranges and Ngati Kahungunu iwi is located on the eastern side of Ruahine ranges. Rangitane iwi covers both side of the ranges from Manawatu district across to Pahiatua and Dannevirke areas.

1. MidCentral Population Profile

MidCentral has a total population of approximately 161,030 as based on the 1996 Census data. Over the next ten years the population is expected to grow. It is expected that there will be population growth in the number of older people, however significant growth is expected in our total Maori population (from 17% to 20%) – and the proportion of older Maori (those aged over 55 years) is expected to increase by nearly 55%.

MidCentral has 28% of its population living outside of a major urban or secondary urban area; a slightly larger than average percentage are Maori, and a slightly larger than average percentage are Older people (aged 65 +). MidCentral has a growing Pacific peoples population and a significant migrant (including Asian) population. The expected changes in our population can be seen in the graph below.

2. Mental Health Services in the District

Services are consistent with the Service Coverage Schedule and aim to reach the 3% of the population with a severe Mental Health condition.

MidCentral Health is the largest Mental Health Service provider in the district. Services provided include:

Acute Beds	20
Intensive Care Inpatients Beds	4
Sub-acute beds	12
Alcohol and Drug Medical detox Beds	2
<i>Total Inpatient Beds</i>	<i>38</i>

MidCentral Mental Health on-buys 2 extended care/clinical rehabilitation beds from Capital and Coast Health. In addition it has access to up to 6 beds at Good Health Wanganui for intensive rehabilitation.

These services are complimented by Community Alcohol and Drug Services, Child Adolescent and Youth Community Services, Community Mental Health Teams, Kaupapa Maori Mental Health Services, Maternal Mental Health, Forensic Liaison and Prison Services, Specialist Eating Disorders Services, and Methadone Treatment. Home based support service coordination and residential coordination services are also incorporated into the MidCentral Health Services. Forensic Liaison and Prison Services are provided in this district by the regional service of Capital and Coast Health.

MidCentral has one large Non Government Organisations, MASH Trust, and several smaller residential providers. MASH Trust is the largest community Mental Health residential service in the district. MASH also administers the Luck Venue a drop in centre that offers day activities for consumers, and a Community Support Workers Service for the Manawatu and Horowhenua.

There are five Maori Providers that provide Mental Health and Kaupapa Maori Alcohol and Drug services in the district. They are located in Dannevirke, Horowhenua/Manawatu and Palmerston North city.

There are a total of 117 level 2,3,4 residential beds in the district. Additionally there are 6 regional beds for dual diagnosis A&D and 1 Adult respite bed.

GP and practice nurse training has commenced for the provision of general health services to specifically targeted Mental Health consumers.

MidCentral is fortunate in that it not only has an established Local Advisory Group but it also has a larger stakeholder group that has been operating for some years. Membership is 45 plus.

3. Identified Issues and Service Gaps

Alcohol and Drug

This is an ongoing issue for MidCentral, social detoxification, dual diagnosis, methadone treatment, early intervention, and child and youth A&D services are areas that require attention.

Child and Youth

Youth suicide prevention is a key issue for MidCentral.

Access to Child Adolescent and Family services is difficult and the demand for community based Child Adolescent and Youth services is increasing.

Psychogeriatric Services

MidCentral like other districts is not excluded from the effects of an aging population. Increased demand on age-related mental health services is expected to continue to grow. Furthermore aging mental health consumers may also be affected by the aging process and require a dual approach to care and treatment. Health service planners will need to be cognisant of this fact. At present service provision in this area is aligned with services for the Elderly rather than Mental Health.

Rural Services

Access to services remains a challenge for MidCentral, a service provider providing services in a geographically spread area. There is increased demand for community based and/or mobile mental health services/teams to rural areas.

Primary Care

There is increasing demand for Primary Care providers to provide a number of assessment and treatment services to those with a diagnosis of mild to moderate and moderate mental illness and at risk patients with mental health problems. Further development is ongoing, although some work has commenced with a Primary Care Liaison position provided by MidCentral Health.

Clients with Complex Needs

This is an area that requires further ongoing development. There are a host of other areas that have not been identified including but not limited to.

- ID/MH and ID/Challenging behaviours.
- Elderly MH/High physical needs
- Head injury/MH
- A&D/MH eg: Korsakoffs
- Personality disorders
- Psychotherapy services not purchased in this region
- Roll out of the Forensic Framework

There are a number of options available for addressing clients with complex needs, which need to be investigated.

Maori Mental Health

MidCentral does not have a Kaupapa Maori Mental Health residential service. The establishment of which will provide an option to Maori with mental illness who would prefer a Kaupapa Maori setting over mainstream. This needs attention in the coming years.

Wairarapa DHB Profile – Mental Health Services:

1. Wairarapa District and population profile

The Wairarapa district is situated in the southeast corner of the North Island, between the Rimutaka hill and Mount Bruce. On the Eastern side it is bounded by the Tararua range, and on the west by the Pacific Ocean. The district covers 601000 hectares. The main town, Masterton is an hour and half by road from Wellington and Palmerston North.

The district has 38,200 residents, about half of whom live within the Masterton urban area. 22,600 people live in the Masterton district, 6,850 in the Carterton district and 8,740 in the South Wairarapa district (including the towns of Greytown, Featherston and Martinborough). About one fifth of the population (around 7,600) live outside the five towns. Some of this group are resident in quite remote rural areas with very limited services such as Ngawi, Riversdale and Castlepoint. Transport is an issue. There is limited public transport available and no public transport to Masterton Hospital. Around 11.5% of households are without cars.

16% of the Wairarapa population is Maori, slightly above the New Zealand average of 15%.

The Wairarapa population overall is declining, and expected to reduce by 1.9% over the next decade. However the numbers of Maori and Pacific people (around 2% at present) are growing and will form an increasing proportion of the total. The numbers of Maori are projected to increase by around 11% over the next decade.

Life expectancy of Wairarapa residents is one year less than the New Zealand average for all groups. Wairarapa people overall, suffer more deprivation than New Zealand as a whole. Wairarapa people, on average, have lower levels of education, are more likely to be in lower socio-economic groups, have lower average incomes, and higher benefit usage. Wairarapa Maori have an unemployment rate three to four times higher than that of non-Maori.

Incomes are lower and there is greater income inequality between Maori and non-Maori in the Wairarapa than for New Zealand as a whole.

Wairarapa figures are poor compared with New Zealand averages for most health indicators.

Maori have the highest health needs of all ethnic groups in the Wairarapa. The growing and aging Maori population indicates that Maori health needs will grow in the future and resources will need to be redistributed and re-oriented to provide more for Maori. For tamariki and rangatahi the available data indicates high needs in relation to infant mortality, smoking, alcohol and drug problems, and sexual and reproductive health issues.

Health needs assessment work to date includes very little information about mental health. While there are no measures available for mental health status per se, there are indications of problems and serious health needs in a number of mental

health related areas. Hospital data shows a high rate of admissions for self-harm, indicating suicidal intentions. Numbers of completed suicides are also of concern. There is anecdotal evidence of high levels of alcohol and drug abuse, with binge drinking being a serious issue, particularly among young people. There are relatively high numbers of people accessing methadone treatment services indicating high levels of opioid addiction.

There are strong community concerns about high levels of interpersonal violence, and the violent crime data indicates this is a serious issue for the Wairarapa.

2. Mental Health services in the District

The Wairarapa DHB allocates \$4.5 million per annum, approximately 11% of its total funding, to mental health services. This does not include all services provided within the district. Some are funded by other DHBs, such as those provided by Richmond Fellowship.

The Wairarapa DHB is the largest Mental Health Service provider in the district, and receiving \$3.5 million per annum in funding. This funds a total mental health staff establishment of around 47 FTEs across all disciplines.

Wairarapa DHB provided services include:

Alcohol & Drug services - Community Detoxification and Methadone Maintenance; Child, Adolescent & Family services - Maori Mental Health staff and Respite Care; Acute Inpatient services; and Adult Community Mental Health services - 24-hour Mobile Crisis intervention, Maori Mental Health staff, Service Coordination with Needs Assessments and access to Community Residential and Support services; and Access to Regional Specialist Services.

Children, Adolescents and Families Services include:

- Community/outpatient based specialist assessment and treatment including medication;
- Case management;
- Psychological assessment and interventions;
- Individual and family therapy;
- Group therapy;
- 24-hour mobile crisis assessment and intervention;
- Maori Mental Health/cultural input;
- Consultation, liaison and education;
- Needs assessments, service coordination and access to Respite care; and
- Access to regional specialist services.

Adults Services include:

- Primary and secondary care for service users on methadone treatment;
- Alcohol and drug treatment and therapy;
- Social mobile community detoxification;
- Community/outpatient based specialist assessment and treatment including medication.
- Acute inpatient assessment and treatment.
- Case management.

- Psychological intervention/psychotherapy.
- Individual therapy/counselling and group therapy.
- 24-hour mobile crisis assessment and intervention.
- Brief and assertive follow-up care.
- Maori Mental Health/cultural input.
- Support needs assessments, service coordination, and access to Residential care, Respite care, Home-based Support, SFI and CSW.
- Access to service user advocacy and representation.
- Consultation, liaison and education.
- Access to family/carer support; and
- Access to regional specialist services.

Non Government Organisation provided services include:

- Maori Community Support work
- Maori A&D Youth Programme
- Social Detox Treatment – non residential
- Day Activity/Rehab programmes
- Consumer drop-in centre
- Crisis Respite for older people
- Crisis Respite for adults
- Community Residential Levels – 2, 3 and 4
- Planned Respite
- Support in the Community Services
- Like Minds programme

Capital & Coast District Health Board provide a Regional Specialist Forensic Community Service comprising community follow-up of Forensic patients as well as prison and court liaison.

3. Identified Issues and Service gaps

- Wide range of services available locally although still some gaps.
- Strong and active local Mental Health Forum with inter-sectoral membership
- Poor community knowledge of mental health services – what is available, and how to access services
- Low levels of confidence and lack of trust in local mental health services
- Particularly inadequate utilisation of services by Maori, youth, men, and older people
- Many services are new and still in initial establishment phase, particularly those for Maori
- Mental health issues frequently overlooked by other primary, secondary and social services – lack of holistic approaches
- Many who are referred to, and treated in, secondary services should be treated in primary care
- Insufficient inter-agency, and inter-service collaboration and partnership
- Widespread fear and ignorance of mental illness – lack of basic understanding and basic information about mental illness, although there is a strong and very active Like Minds programme.

- Underdeveloped mental health workforce – widespread skill deficits, and insufficient workforce numbers
- Workforce training programmes inaccessible to staff working in small services
- Some training programmes of poor quality, not based on strengths models and recovery
- Some training programmes for Maori (use of which is a contract requirement) are not NZQA accredited.
- Lack of training and employment opportunities for service users
- Lack of Treaty structures and processes for mental health service development and delivery for Maori
- Inadequate geographical spread – poor access for those in outlying rural areas, few services provided in outlying areas
- Key service gaps – maternal mental health services, drug and alcohol services for youth, services for older people, services for those with severe and complex needs
- Poor access to and insufficient support from regional specialist services
- Very limited information available regarding service utilisation, access and outcomes

Whanganui DHB Profile – Mental Health Services:

1. Whanganui District and population profile

The Whanganui District Health Board region population is approximately 66,360 and covers the area from Bulls in the south to Waitotara in the north west, and east and north east to South Ruapehu, Waiouru and the Rangitikei District. Rural areas in the region, including minor urban centres, are home to approximately 28,500 people, or 43% of the area's population.

It is the characteristics of this population (age, sex, ethnicity, rurality) together with a number of socioeconomic and environmental influences that determine in part the mental health needs for the region.

Overall, the Whanganui DHB region presents a more deprived picture compared with the New Zealand average. People have on average lower levels of education, are disproportionately more represented in lower social class groups, have lower than average incomes, and higher unemployment and benefit usage. People in Whanganui are less likely to own their own home, and there are proportionately higher numbers of sole parent households and people living alone. Households in Whanganui are more likely to be without a phone or a car compared with the New Zealand average.

The proportion of Maori in Whanganui, at around 24%, is higher than in the total New Zealand population (15%). Both the number and proportion of Maori in all age groups are projected to increase in the next ten years, in contrast to the total population of Whanganui, which is projected to drop by 3.5%. There is a small (1.5%), but increasing, population of Pacific peoples. Non-Maori in Whanganui have a population age structure with lower proportions in the 15 to 44 age groups, and a significantly greater proportion in the over 65 age group, than non-Maori in New Zealand overall.

2. Mental Health services in the district

Good Health Wanganui is the largest Mental Health Service provider in the Whanganui Region, with 25% of its revenue ringfenced for Mental Health Services. Services comprise of inpatient services as follows:

Acute Beds	16
Clinical Rehabilitation & Extended Care	25
Long Term and Medium Term Forensic	15
Total Inpatient Beds:	56

These services are complemented by Community Mental Health Teams, Community Alcohol and Drug Services, Child and Youth Community Services and Specialist Community Services such as Eating Disorder, Maternal Mental Health and Methadone Treatment. Adult Planned and Crisis Respite is also available as well as Planned Respite for Child and Youth.

Kaupapa Maori Mental Health Services are incorporated throughout the Mental Health Service. Good Health Wanganui also provide Advocacy/Peer Support for Consumers.

Our largest Maori Provider delivers Kaupapa Maori Mental Health Services, Alcohol and Drug Services and Child and Youth Services. This incorporates Community Based Services, Activity Rehabilitation and Day Activity, Community Residential Beds. Nga Oranga (holistic) models are adopted for delivery of Alcohol & Drug and Child and Youth Services.

The Whanganui Region has a total of approximately 50 Level 2 and 3 Community Residential Beds provided by a number of organizations, many of whom also offer Community Support Work Services.

Capital & Coast District Health Board provide a Regional Specialist Forensic Community Service comprising community follow-up of Forensic patients as well as prison and court liaison.

Consumer Run Day Services, incorporating a drop-in centre for service users, are also available.

The Primary Care sector is expanding their services to persons with a mental illness. A number of Good Health Wanganui/Primary Care Organisation jointly led projects are currently underway. These include Mental Health Assessments, Substance (Drug & Alcohol) Use Assessment and Pre-referral Assessments for Child and Youth.

The Whanganui Region also has a large support network of other funded and voluntary services provided outside the District Health Board jurisdiction and these form a vital part of the service continuum.

Wanganui is also fortunate to have a very functional and effective Mental Health Local Advisory Group that has representation from a wide range of service providers, users and other stakeholder groups.

3. Identified Issues and Service gaps

Alcohol & Drug Services

Clients with a profile of combined mental health and alcohol and drug problems are on the increase and present particular challenges for our region.

Access to regional inpatient services for Alcohol and Drug clients' is fraught with difficulty. Current strict referral criteria for regional rehabilitation beds do not address the reality of the complex needs of Mental Health clients. The regional Detoxification Service which has historically operated out of MidCentral Health in Palmerston North is not currently in operation. This particular patient group requires significant medical input and must be supported in a specialised setting.

One of the biggest issues with the current configuration of Alcohol and Drug Services is that they ignore the reality that an increasing proportion of Mental Health clients are presenting at Primary and Secondary Care Services with complex/dual needs.

Child & Youth Services

Youth suicide has been identified as a key health issue for the Whanganui Region.

Access for Whanganui's children and youth to Regional Inpatient Services is virtually non-existent. A new inpatient service is currently being developed in Wellington, however, to date no progress has been made on commencement date of the service or the access criteria that will apply.

Additionally, focusing on Regional Services ignores the precept of the 'family centered approach to wellness'. In most cases care needs to occur in the context of family/whanau.

Psychogeriatric Services

Like the rest of New Zealand, the Whanganui Region has an ageing population, which will produce greater demand for age-related mental health and disability support services to treat, for example, people with dementia and alzheimers disease. Additionally, there is a large group of people in our region who have a mental illness who will increasingly suffer from medical conditions as a result of ageing. Special attention will be given to this fact to ensure that our local services reflect the changing demographic profile of our community.

Rural Services

The main issue for rural areas is access to appropriate services. This encompasses access to clinicians, transport, medicines and support networks. The Whanganui District Health Board has recently undertaken a stocktake of services provided in rural areas to identify gaps in current services. This work will be expanded upon to provide some unique solutions to assist those in rural areas in getting access to appropriate services.

Primary Care

There is an increasing onus on Primary Care Providers to provide assessment, treatment and management of risk of patients with mental health problems such as suicidal behaviour, anxiety, depression, and alcohol and drug problems. Identifying and appropriate referral of this increasingly large and complex patient group is the key for effective delivery of services. This can be assisted with better integration between primary, secondary and community services through improved communication about referral criteria, access to services and networking. Another option is shared care schemes between Primary and Secondary care for persons with ongoing mental health issues.

Clients with Complex Needs

A key in delivering effective mental health services, is recognition that those suffering from mental health problems actually have a much larger range of complex needs that also need addressing in order for recovery to occur. These needs include alcohol and drug problems, problems due to underlying medical conditions and or

ageing, social problems such as lack of appropriate housing, income, and lack of family/whanau support.

A holistic approach is required whereby the 'whole person' is treated within the context of their particular environment. This approach has long been supported by Maori who have advocated for traditional holistic concepts of health and healing to be applied to mental health models and practice. This can be adapted and expanded to encompass an inter-sectorial approach to wellness, which includes case management of a person's wider personal and social situation, to allow them to recover sufficiently so they can participate in society in the longer term.

The 'core group' of clients with particularly complex requirements need to be identified and supported to help them achieve social inclusion.

Hutt Valley DHB Profile – Mental Health Services

1. The Hutt Valley district and population profile

The Hutt Valley district is made up of two Territorial Local Authority Areas (TLAs): Upper Hutt and Lower Hutt.

Population projections (2001) show that the total population for the district is around 135,000. Of these around 98,200 (73%) live in Lower Hutt, and around 36,600 (27%) live in Upper Hutt.

Hutt Valley's ethnic composition

- The Hutt Valley district has a relatively high proportion of non European ethnic groups.
- Maori make up 16% (around 21,000 people) of the Hutt Valley district's population compared with 15% in the Central region as a whole.
- Pacific Islands people living in the Hutt Valley district account for 7% of the area's total population (around 9,500 people) and 25% of the Central Region's total Pacific Islands population.
- Asian people living in the Hutt district region make up 5% of the population and 21% of the Central Region's total Asian population.

Hutt Valley's age and gender structure

- Overall, the age and gender structure of the Hutt Valley district is similar to that of the Central region as a whole.
- Lower Hutt has a higher proportion of children but a lower proportion of youth and the elderly compared with Upper Hutt.
- Twenty four percent of the district's population is under 15 years of age, compared with 23% for the Central region as a whole.
- People aged 65 years or over make up 11% of the district's population, which is the same as for the Central region as a whole.

Hutt Valley's projected population, 1996-2006

- Preliminary data from the 2001 census indicates that the total Hutt Valley district population has reduced slightly since the 1996 Census (less than 1%) and is currently projected to continue to decrease slightly over the next five years.
- While the over 45 year age groups are projected to increase, this is offset by projected reductions in the younger age groups. The 45 to 64 years age group is projected to be 24% of the total population in the Hutt Valley

Deprivation Profile

The Hutt Valley district has a relatively even distribution of deprivation although the most deprived population (Deprivation score 9 & 10) live in the Lower Hutt area.

2. Mental Health services in the District

The majority of services are funded through the Hutt Valley District Health Board. They include specialist secondary mental health and drug and alcohol services for adults, adolescents, children and families. Included in this range of services is the Specialist Maori Mental Health service that also encompasses drug and alcohol services.

A number of services are provided regionally by the Capital & Coast District Health Board. These include forensic services and methadone services.

The Hutt Valley also has a range of Maori and Pacific providers in Mental Health and Drug and Alcohol services. A number of these services are in development and establishment. The Hutt Valley Mental Health Consumer's Network has recently established to advocate for and support consumers in the district.

The range of mental health services provided in the Hutt Valley district are as follows:

Hutt Valley DHB provided services

- Acute Inpatient beds
- Sub-Acute and Long Term Inpatient beds
- Crisis Respite
- Alcohol and Drug – General
- Child and Youth mental health services
- Kaupapa Maori Services
- Community Mental Health Teams
- Mental Health Workforce Development
- Consumer and Carer/Family Support
- Home Based/Community Support

Independent Service Providers (NGO) provided services

- Alcohol and Drug – General
- Alcohol and Drug – Child and Youth specific
- Child and Youth mental health services
- Kaupapa Maori Residential services
- Mental Health Workforce Development
- Day Activity and Rehab Services
- Home Based/Community Support
- Community Residential Beds and Services

Identified Issues and Service gaps

Service quality and the measurement of outcomes have been identified as priority areas for the Hutt Valley. This includes specific training on the use of outcome measures for mainstream and Maori services. A number of tools to assist the improvement of quality such as audit are being developed by the DHB.

Workforce development issues including training, retention and recruitment remain key priorities that also flow across the Central region. The Hutt Valley DHB is seeking to implement local initiatives to complement regional ones. Improving the capability of the workforce to manage people with complex needs remains a high priority.

A number of initiatives in the primary sector are being considered to improve the management of consumers with stable disorders. In addition, there is some scope to provide better treatment services to people with mild to moderate disorders such as anxiety and depression.

There are service gaps in the Hutt Valley for older people including psychogeriatric services. The growth in the proportion of the population in the older age groups is likely to result in greater demand for these services. New services for older people may be funded through Blueprint funding allocated to the Hutt Valley DHB.

Better coordination of services is a common theme across all service areas. This can be improved for mental health services in the Hutt Valley through a common communication channel such as newsletters and networks. A number of networks already operate for various purposes and these will be strengthened through ensuring linkages between them. Newsletters are already produced for specific services and could be merged to provide a more informative and regular platform for ongoing communication.

Appendix F: Central Region Child and Youth Service Developments

Acute Packages of Care

During the last six months of 2000/01 Central region DHBs undertook planning and development work towards establishment of "acute packages of care" services within each district. The purpose was to establish local arrangements for access to short-term residential/respite services to children and young people suffering acute mental illness episodes, who would otherwise need to be admitted to an adult acute hospital bed. The local CAFS are responsible for clinical treatment and oversight for the child/young person receiving the acute care package.

CAFS teams hold the budget for acute care packages. There are contract arrangements between DHB provider arms and local residential and respite service providers for access to services, on an as required basis, for a maximum of 21 days for any individual.

The new services, for which DHB provider arms have been funded in 2001/02, were expected to be operational from 1 July 2001 in 4 of the DHBs, and from 1 November in Hawke's Bay and Wairarapa DHBs. As at 1 March 2002 the new service is not yet operational within any DHB. Contract arrangements have taken longer than expected to finalise. NGOs who are asked to provide the services, are reluctant to commit to having services available on standby for an unknown level of demand, for which they will only be paid for actual days used.

Funding for the Child and Youth Acute Packages of Care is as follows:

District Health Board	Establishment Funding	Establishment Period	Contract Value	Start Date
Capital and Coast	\$123,947.00	1 Mar 01 to 30 Jun 01	\$371,840.25	1 July 01
Hutt Valley	\$ 65,397.00	1 Mar 01 to 30 Jun 01	\$196,191.95	1 July 01
MidCentral	\$ 75,669.00	1 Mar 01 to 30 Jun 01	\$227,007.44	1 July 01
Whanganui	\$ 32,870.00	1 Mar 01 to 30 Jun 01	\$ 98,609.57	1 July 01
Hawke's Bay	\$ 71,560.42	1 Jul 01 to 31 Oct 01	\$214,681.25	1 Nov 01
Wairarapa	\$ 18,831.69	1 Jul 01 to 31 Oct 01	\$ 65,495.07	1 Nov 01
Total 'Ongoing' Regional Funding for CYP Packages of Care			\$1,173,825.53	

Intensive Clinical Support and Wrap Around Service

This is a new service funded within the Wellington region only (covering Wairarapa, Hutt and Capital and Coast districts) for which the Hutt Valley DHB holds the contract. The service is to provide long-term intensive individualised case management, using a multi-systemic therapy model, for the very small number of children and young people who are in the care of Child, Youth and Family Services and have multiple deep-seated mental health problems. The service had a funded establishment period from 27 Feb 01 to 31 March 01 and has been operational from 1 April 2001.

The total establishment funding was one hundred thousand dollars (\$100,000.00). The service is funded as follows:

Volume	Unit	Unit Price	Total Funding
3.0	Clinical FTEs	\$ 80,420.66	\$241,261.98
0.5	Senior Medical FTE	\$170,389.21	\$ 85,194.60
1	Wrap Around Service	\$257,000.00	\$257,000.00
Total Annual Funding			\$583,456.58

The Wellington region service is one of a small number of such services nation-wide. Hutt Valley DHB won the contract through an RFP process run by then Ministry of Health (MOH) during 2000/01. MidCentral and Hawke's Bay DHBs were joint partners in the RFP with Hutt Valley DHB, however the MOH awarded the contract to Hutt Valley only, as they did not think it wise to stretch the resources over such a large geographical area. The outcome of MidCentral and Hawke's Bay DHBs bid was that each received an increase of 1FTE to their existing CAFS contract, effective from 1 July 2001.

New Child and Youth Regional Acute Inpatient Unit

Prior to DHBs taking on funding responsibility for mental health, the Ministry of Health arranged for Capital and Coast to develop a new unit of 10 beds. This is to provide mental health inpatient services for children and youth from throughout the region, together with an associated day hospital service for children and youth from the Wellington and Hutt areas. Capital and Coast DHB will have access to 4-day hospital places and Hutt Valley DHB will have access to 2.

This unit is now being built at Porirua. The inpatient service and day hospital are expected to be operational by 1 July 2002. There is very little information available yet as to how other DHBs will access the inpatient service. Funding for the inpatient unit and day hospital is as follows:

Volume	Unit	Unit Price	Total Funding
10	CYP Inpatient Beds	\$ 535.00	\$1,952,750.00
1.5	Cultural Advisor	\$71,839.00	\$ 107,758.50
6	Day Hospital Places	\$ 279.00	\$ 611,010.00
Total 'Ongoing' Funding			\$2,671,518.50

Te Whatuiapiti

A mainstream residential A&D service for youth is being established in Hawke's Bay. This will provide 10 beds for youth from throughout the Central region and Tairāwhiti. Due to the establishment phasing, the service is expected to have a minimum of 6 beds operational by April 2002 and have all 10 beds operational by December 2002. Access and referral arrangements are to be made through the relevant A&D Councils. The average programme length is expected to be 8 weeks, however a degree of flexibility has been built into the contract to allow shorter or longer stays where appropriate.

Total funding for this service is \$500,000.00 annually and there was an establishment period from 1 August 2001 to 1 December 2001, which was funded to the value of \$166,167.00.

The services listed above that are funded currently, have a combined 'ongoing' contract value of \$4,928,800.50 per annum. Once all these services come on stream they will add considerably to the region's mental health resources and services for children and youth.

In addition individual DHBs are planning to use some additional Blueprint funding to further develop services for children and youth in 2002/03. Details of these new services are not yet available but an example is Wairarapa DHB are looking to purchase a locally run Youth A&D programme.

DHB provider arm services funded currently for children and youth have difficulty filling funded staff positions. At 30 June 2001 Central region DHBs reported variances to contract for child and youth mental health services as follows:

	Contract FTE	Delivered FTE	Variance	Surplus/(Deficit) in 2000/01	Surplus/(Deficit) as % revenue
Capital and Coast	22.7	27.0	4.3	(\$999,000)	(38.3%)
Hutt Valley	18.4	19.6	1.2	\$ 4,000	0.2%
Hawke's Bay	21.1	15.4	(5.7)	\$221,000	9.6%
Mid Central	23	20.5	(2.5)	\$268,000	16.3%
Wairarapa	5.6	4.3	(1.3)	\$241,000	39.7%
Whanganui	12.0	9.2	(2.8)	\$145,000	12.4%
Total	102.8	96.0	(6.8)	(\$120,000)	

Source: Review of Mental Health Services Expenditure for 2000/01, Mental Health Commission

Appendix G. Regional Mental Health Services in the Central Region, 2001/02

Service Type	PU ID	PU Description	Principal DHB	Provider	Beneficiary DHB						
					CAP	HWB	HUT	MCH	WRP	WNI	Out of Region
1. Inpatient – Beds / Care Packages	MHIS03	Clinical Rehabilitation/Sub-Acute/ Extended Care – Inpatient	Capital & Coast	Capital & Coast DHB	✓	✓	✓	✓	✓	✓	✓
			Hutt Valley	Heritage Health Group Ltd	✓		✓		✓		
			Whanganui	Whanganui DHB		✓		✓		✓	
	MHIS04	Long Term Secure Forensic	Whanganui	Whanganui DHB	✓	✓	✓	✓	✓	✓	✓
2. Community Mental Health Teams – FTE / Care Packages	MHCS04	Specialist Dual Diagnosis Service	Capital & Coast	Capital & Coast DHB	✓	✓	✓	✓	✓	✓	
	MHCS06A7	Clinical Rehabilitation Service - Community (Other Clinical FTEs)	Ministry of Health	Pathways Trust - (Rakau Ora Trust)	✓		✓			✓	✓
	MHCS08A	Child and Youth Community Service (Other Clinical FTE)	Capital & Coast	Capital & Coast DHB	✓		✓				
			Canterbury	Richmond Fellowship NZ Inc - National Office		✓					✓
	MHCS08B	Child and Youth Community Service (Senior Medical FTE)	Capital & Coast	Capital & Coast DHB	✓	✓	✓	✓	✓	✓	
	MHCS09	Eating Disorders Service – Community (Clinical FTE)	Hutt Valley	Wellington Eating Disorder Support Group Inc	✓	✓	✓	✓	✓	✓	
	MHCS10	Specialist Psychotherapy Service	Capital & Coast	Capital & Coast DHB	✓	✓	✓	✓	✓	✓	
			Hawkes Bay	Serenity Trust	✓	✓	✓	✓	✓	✓	
	MHCS11	Community Forensic Service	Capital & Coast	Capital & Coast DHB	✓	✓		✓	✓	✓	✓
			Whanganui	Capital & Coast DHB	✓	✓	✓	✓	✓	✓	
	MHCS27	Refugee Mental Health Service	Capital & Coast	Wellington Refugees as Survivors Trust	✓		✓				
MHCS28	Specialist Maternal Mental Health Service	Capital & Coast	Capital & Coast DHB	✓	✓	✓	✓	✓	✓		
MHCS31	Dual Diagnosis with Intellectual Disability	Capital & Coast	Capital & Coast DHB	✓	✓	✓	✓	✓	✓		
MHCS33	Liaison with Child and Young Persons Service	Capital & Coast	Wellington Refugees as Survivors Trust	✓	✓	✓	✓	✓	✓		
MHCS47A	Child and Youth Intensive Clinical Support Service (Other Clinical FTEs)	Hutt Valley	Hutt Valley DHB	✓		✓		✓			

Service Type	PU ID	PU Description	Principal DHB	Provider	Beneficiary DHB						
					CAP	HWB	HUT	MCH	WRP	WNI	Out of Region
	MHCS47B	Child and Youth Intensive Clinical Support Service (Senior Medical FTEs)	Hutt Valley	Hutt Valley DHB	✓		✓		✓		
3. Residential - Beds	MHCR02	Residential Rehabilitation Level II	Capital & Coast	The Wellink Trust	✓		✓				
			Canterbury	Richmond Fellowship NZ Inc - National Office			✓		✓		✓
	MHCR03	Residential Rehabilitation Level III	Canterbury	Richmond Fellowship NZ Inc - National Office			✓		✓		✓
	MHCR04	Residential Rehabilitation Level IV	Capital & Coast	The Wellink Trust	✓		✓				
			Hawkes Bay	Serenity Trust	✓	✓	✓	✓	✓	✓	
			Hutt Valley	Wellington Eating Disorder Support Group Inc	✓		✓				
			Mid Central	M.A.S.H Trust Board	✓			✓			
	Canterbury	Richmond Fellowship NZ Inc - National Office					✓		✓		
MHCR10	Child and Youth Community Residential Care	Canterbury	Richmond Fellowship NZ Inc - National Office			✓	✓			✓	
MHCR19	Child and Youth Community Alcohol and Drug Residential Services	Hawkes Bay	Te Whatuiapiti Trust Inc	✓	✓	✓	✓	✓	✓	✓	
4. Community Support – FTE / Care Packages	MHCR09.1	Other Residential Support - Home Based Support Services	Canterbury	Richmond Fellowship NZ Inc - National Office			✓		✓		✓
	MHCR09.2	Other Residential Support – Community Support Work	Capital & Coast	The Wellington Mental Health Consumers Union Incorporated					✓		
			Hutt Valley	Step Ahead Together Incorporated	✓		✓				
			Canterbury	Richmond Fellowship NZ Inc - National Office			✓				✓
			Ministry of Health	Pathways Trust - (Rakau Ora Trust)	✓		✓			✓	✓
	MHCR17	Supported Landlord Service	Hutt Valley	Step Ahead Together Incorporated	✓		✓				
MHCS14C	Work Rehab/Employment and Educational Support (Non-Clinical FTE)	Capital & Coast	Wellington After Care Association Incorporated	✓		✓					

Service Type	PU ID	PU Description	Principal DHB	Provider	Beneficiary DHB							
					CAP	HWB	HUT	MCH	WRP	WNI	Out of Region	
	MHCS16C	Activity-Based Rehab Service/ Day Activity & Living Skills (Non-Clinical FTE)	Capital & Coast	The Wellington Mental Health Consumers Union Incorporated	✓		✓					
			Canterbury	Richmond Fellowship NZ Inc - National Office					✓		✓	
	MHRE01	Adult Planned Respite	Capital & Coast	The Wellink Trust	✓		✓					
5. Consumer – FTE / Programme	MHCS21	Advocacy/Peer Support - Consumers	Hawkes Bay	The Consumer Operated Mental Health Support Service Trust	✓	✓	✓	✓	✓	✓		
	MHCS21.1	Advocacy/Peer Support – Consumer (Adults)	Hutt Valley	Earthlink Inc	✓							
			Canterbury	Schizophrenia Fellowship NZ Inc - National Office				✓			✓	
	MHCS22	Advocacy/Peer Support - Families/Whanau	Canterbury	Schizophrenia Fellowship NZ Inc - National Office	✓			✓	✓	✓	✓	
	MHCS22.1	Advocacy/Peer Support – Families/Whanau (Adults)	Canterbury	Richmond Fellowship NZ Inc - National Office		✓						
6. A&D Residential - Beds	MHCR07	Residential Treatment Service	Canterbury	Nova Trust Board	✓							✓
			Ministry of Health	The Salvation Army Property (New Zealand) Trust Board 02	✓							✓
				Care NZ Limited	✓	✓	✓	✓	✓	✓	✓	✓
7. A&D Community – FTE / Care Packages	MHCS01C	Community Alcohol and Drug Service (Non-Clinical FTE)	Ministry of Health	The Salvation Army Property (New Zealand) Trust Board 02	✓							✓
				Care NZ Limited	✓							
8. Methadone - Places	-	-	-	-	-	-	-	-	-	-	-	-
9. Non Blueprint Services	MHWD01	Workforce Development	Capital & Coast	Schizophrenia Fellowship - Wellington Branch Inc.	✓	✓						
			Canterbury	Schizophrenia Fellowship NZ Inc - National Office	✓	✓	✓	✓	✓	✓	✓	✓