

## 2.07 Objective: Minimising Harm Caused by Alcohol and Illicit and Other Drug Use

Alcohol and illicit drug use are important causes of morbidity and mortality in New Zealand. Whilst alcohol consumption is linked to the development of conditions such as pancreatitis, cirrhosis and high blood pressure etc, illicit drug use in New Zealand is linked to the transmission of infectious diseases (HIV, Hepatitis C), injury, premature death etc. The New Zealand Health Strategy recognizes the significance of the negative health effects caused by substance abuse and seeks to minimise the harm it causes in the population.

### Services Available

#### *Alcohol and drug hospital and community services*

Table 33 lists alcohol and drug hospital and community services. Each of these services are regional services and target all ethnic groups. A total of 92.8 FTEs and 10 beds are devoted to alcohol and drug hospital and community services in the Auckland region.

**Table 33. Alcohol and drug hospital and community services**

Services	Service Location	Service Coverage	Volume	
			FTE	Beds
<i>Community A&amp;D Services</i>	Waitemata DHB	Regional	78.5	
<i>Home/Community support for detoxification</i>	Waitemata DHB	Regional	8.0	
<i>New Mason Dual Diagnosis</i>	Waitemata DHB	Regional	6.3	
<i>A&amp;D Dedicated Inpatient Detox</i>	Waitemata DHB	Regional		10

Data Source: MOH

Table 34 presents a description of the alcohol and drug hospital and community services outlined in Table 33.

**Table 34: Alcohol and drug hospital and community services service description**

<p>Community Alcohol &amp; Drug Services (Other Clinical FTEs)</p>	<p>Alcohol and drug assessment and treatment services provided out of a community based facility. Community treatment services includes: comprehensive assessment &amp; treatment planning; the provision of range of time limited treatment interventions such as individual or family counselling, home based detoxification, day programmes, referral to specialist services and aftercare and follow up; liaison, consultancy and brokerage; provision of A&amp;D information and harm reduction strategies; community development</p>
<p>Community Alcohol &amp; Drug Services (Senior Medical Clinical FTEs)</p>	<p>Alcohol and drug assessment and treatment services provided out of a community based facility. Community treatment services includes: comprehensive assessment &amp; treatment planning; the provision of range of time limited treatment interventions such as individual or family counselling, home based detoxification, day programmes, referral to specialist services and aftercare and follow up; liaison, consultancy and brokerage; provision of A&amp;D information and harm reduction strategies; community development.</p>
<p>Detoxification - Home/Community</p>	<p>Detoxification occurring in a community setting targeting at those with drug dependency and related issues.</p>
<p>Dual Diagnosis - Mental Health and Alcohol &amp; Drug</p>	<p>Specific services targeting people with co-existing alcohol and drug use and severe mental health disorders. The services provided include clinical, consultation/liaison and support services.</p>
<p>Detoxification – Medical Inpatient</p>	<p>Detoxification occurring in a designated inpatient facility targeting at those with complex drug dependency and related issues.</p>

Data Source: MOH.

*Alcohol and Drug NGO providers and services*

Table 35 lists the alcohol and drug NGO service providers in the Auckland region. A description of these services is provided in Table 36. All alcohol and drug NGO services are regional and there are 91.4 FTE and 276 beds devoted to these services in the Auckland region. In addition to the volumes shown in the table, His Highest Praise has 0.24 FTEs and Ara Tu Tika Trust has 0.25 FTEs.

The MOH also funds the provider arm of the Auckland DHB to liaise with other providers to ensure regional co-ordination of alcohol and drug public health services. Some of the Auckland DHB's alcohol and drug outputs include peer education training for rangitahi in South Auckland, in collaboration with the Goodfellow Unit pilot programme on alcohol peer education; appropriate alcohol and drug information packages for youth providers in South Auckland, and other drug peer education programmes for West Auckland youth.

In addition, the MOH fund Hapai Te Hauora Tapui Ltd to work with Te Runanga o Ngati Whatua, Raukura Hau Ora o Tainui and Te Whanau o Waipareira Trust to co-ordinate and strengthen public health foundations and develop and provide health promotion services in four public health priority areas including drug and alcohol services.

**Table 35: Alcohol and Drug NGO providers in the Auckland region**

Provider	Service Location	Service Coverage	Volume (FTE)	Volume (Beds)
Lords Haven Trust	Waitemata DHB	Regional		1
Te Runanga o Ngati Whatua	Waitemata DHB	Regional	2	
Te Whanau O Waipareia Trust	Waitemata DHB	Regional	4	
Raukura Hauora O Tainui Trust	Counties-Manukau DHB	Regional	4	10
Raukura Hauora O Tainui – Auckland	Counties-Manukau DHB	Regional	3	
His Highest Praise	Counties-Manukau DHB	Regional		
Ara Tu Tika Trust	Counties-Manukau DHB	Regional		

NSAD	Counties-Manukau DHB	Regional	3	
Integrated Support Services Ltd	Auckland DHB		4.5	20
Higher Ground	Auckland DHB	Regional	8	30
Odyssey House	Auckland DHB	Regional	17	100
Odyssey House Auckland Ltd	Auckland DHB	Regional	7.5	10
Salvation Army	Auckland DHB	Regional	26.5	60
Wings	Auckland DHB	Regional	2.5	35
Auckland City Mission	Auckland DHB	Regional	2.5	10
Piritahi Hauora Trust	Auckland DHB	Regional	2.7	
TRANX Services	Auckland DHB	Regional	4.2	

Data Source: MOH.

**Table 36: Auckland region alcohol and drug service description**

Residential Treatment – Alcohol and Drug Service	Treatment for alcohol and drug clients in a residential facility.
Community Alcohol & Drug Services (Non-Clinical FTEs)	Alcohol and drug assessment and treatment services provided out of a community based facility. Community treatment services includes: comprehensive assessment & treatment planning; the provision of range of time limited treatment interventions such as individual or family counselling, home based detoxification, day programmes, referral to specialist services and aftercare and follow up; liaison, consultancy and brokerage; provision of A&D information and harm reduction strategies; community development.
Kaupapa Maori Alcohol & Drug Services (Non-	Kaupapa Maori alcohol and drug assessment and treatment services provided out of a community based facility. Community treatment services includes: comprehensive assessment & treatment planning;

Clinical FTEs)	<p>the provision of range of time limited treatment interventions such as individual or family counselling, home based detoxification, day programmes, referral to specialist services and aftercare and follow up;</p> <p>liaison, consultancy and brokerage;</p> <p>provision of A&amp;D information and harm reduction strategies;</p> <p>community development.</p> <p>This treatment model is expected to contain traditional Maori healing practices including holistic approach, whanau input and Maori ownership.</p>
Community Alcohol & Drug Services (Other Clinical FTEs)	<p>Alcohol and drug assessment and treatment services provided out of a community based facility. Community treatment services includes:</p> <p>comprehensive assessment &amp; treatment planning;</p> <p>the provision of range of time limited treatment interventions such as individual or family counselling, home based detoxification, day programmes, referral to specialist services and aftercare and follow up;</p> <p>liaison, consultancy and brokerage;</p> <p>provision of A&amp;D information and harm reduction strategies;</p> <p>community development.</p>
Children and Youth Alcohol and Drug Community Services (Other Clinical FTEs)	<p>Alcohol and drug assessment and treatment services for people under the age of 20, provided out of a community based facility. Community treatment services includes:</p> <p>comprehensive assessment &amp; treatment planning;</p> <p>the provision of range of time limited treatment interventions such as individual or family counselling, home based detoxification, day programmes, referral to specialist services and aftercare and follow up;</p> <p>liaison, consultancy and brokerage;</p> <p>provision of A&amp;D information and harm reduction strategies;</p> <p>community development.</p>
Child & Youth Community Residential Care	<p>Dedicated services for consumers who are under the age of 20 in a residential setting.</p>
Detoxification – Residential	<p>Detoxification occurring in a residential facility targeting at those with drug dependency and related issues.</p>
Kaupapa Maori Alcohol & Drug Services (Non-Clinical FTEs)	<p>Kaupapa Maori alcohol and drug assessment and treatment services provided out of a community based facility. Community treatment services includes:</p> <p>comprehensive assessment &amp; treatment planning;</p> <p>the provision of range of time limited treatment interventions such as individual or family counselling, home based detoxification, day programmes, referral to specialist services and aftercare and follow up;</p> <p>liaison, consultancy and brokerage;</p> <p>provision of A&amp;D information and harm reduction strategies;</p> <p>community development.</p> <p>This treatment model is expected to contain traditional Maori healing practices including holistic approach, whanau input and Maori ownership</p>

Detoxification - Home/Community	Detoxification occurring in a community setting targeting at those with drug dependency and related issues.
Dual Diagnosis - Mental Health and Alcohol & Drug	Specific services targeting people with co-existing alcohol and drug use and severe mental health disorders. The services provided include clinical, consultation/liaison and support services.

Data Source: MOH.

All alcohol and drug (hospital and community services and non-governmental organisation provider services) are regional. Many providers offer more than one service and a number of services target Maori and Pacific Island people specifically. Because the information is current and has proved to be readily accessible, a reliable stock take of alcohol and drug services has been presented here for the Auckland region.

The locations of various drug and alcohol services in the Auckland region are provided in Appendix III.

### The Prevalence of Alcohol and Illicit Drug Use in the Community

#### *Alcohol*

The New Zealand Health Strategy found that 82 percent of New Zealanders consume alcohol and at least one in five will develop an alcohol-use disorder at some stage in their lives (MOH, 1999). There also appears to be a relationship between increasing consumption levels of alcohol and associated health effects. Whilst low levels of consumption may be protective against conditions such as IHD, it appears that heavy drinking is associated with negative health outcomes and the development of conditions such as cirrhosis, high blood pressure etc.

**Table 37: Prevalence of alcohol consumption in the New Zealand population, 1996/97.**

Age (Years)	Females			Males		
	Abstainers	AUDIT score under 8	AUDIT score 8 or more	Abstainers	AUDIT score under 8	AUDIT score 8 or more
15-19	61	18	22	55	15	30
20-24	34	42	24	28	27	45
25-29	49	40	11	29	37	34
30-34	49	43	8	26	51	23
35-39	47	47	6	27	50	23
40-44	47	48	5	29	50	21
45-49	47	50	4	26	54	20
50-54	47	49	5	32	46	22
55-59	45	54	1	28	49	23
60-64	55	44	2	32	56	12
65-69	53	47	0	32	54	14
70-74	64	35	1	32	61	7
75-79	65	35	0	42	50	8
80-84	76	24	0	50	50	0
85+	80	20	0	75	22	3
<b>Total 15yrs+</b>	50	42	8	32	44	24

Data Source: MOH, 1999.

Prevalence data from the New Zealand Health Survey 1996/97 is provided in Table 37 below. As can be seen, adult males in the New Zealand population appear to drink far more heavily than females and the prevalence of heavy drinking appears to be highest among youth for both males and females.

The Alcohol and Public Health Research Unit conducts a yearly survey of alcohol use in the Auckland region (Casswell & Bhatta, 2001). The data collected in 1999 showed that approximately 85 percent of people in the Auckland region had consumed alcohol in the 12 months preceding survey.

The survey showed that the prevalence of alcohol consumption had not changed significantly in the region over the previous decade. However, the total amount of alcohol consumed and the problems associated with consumption of alcohol had increased over the period 1990 to 1999. The data also showed that the quantity of alcohol consumed at a typical drinking session had increased from approximately three drinks in 1990 to four or five drinks in 1999.

The survey also showed that large numbers of adolescents in the region regularly consume alcohol. Indeed, 77 percent of 14-19 year olds were shown to be regular consumers of alcohol and the evidence presented suggested that this age group had increased their alcohol intake between 1990 and 1999. The increase in alcohol consumption noted in the Auckland survey was particularly marked amongst younger drinkers, with 14-17 year olds drinking two or three drinks in an average session in 1990 and five or six drinks in 1999.

Surprisingly, there was a very low level of concern expressed by survey participants about their individual drinking patterns. For instance, heavy drinkers felt their drinking was “about right” in 65 percent of cases and approximately 51 percent agreed to the statement that “getting drunk is fun”.

Alcohol consumption can also have harmful effects on other people in the community. The Auckland survey indicated that 19 percent of people have experienced a medium, or large level of harm, in at least one area of their lives, caused by other peoples drinking. The harm experienced included assault (eight percent) and sexual harassment (eight percent, but twenty percent of women under thirty years of age).

**Table 38: Proportion of people reporting harmful effects of alcohol use**

Effects	All (%)		Maori (%)	
	Male	Female	Male	Female
Energy and vitality	20	15	20	21
Financial	14	9	16	14
Home life	5	3	8	8
Health	8	6	11	9

Table 38 shows the proportion of men and women who identified alcohol as having harmful effects on a range of life areas. The figures for Maori were derived from a

separate (National) survey done in 1998 by Whariki Maori Health Research Group (Dacey & Moewaka Barnes, 2000).

As can be seen, a greater proportion of Maori appear to experience harmful effects than other groups in the population.

#### *Illicit Drug Use*

The prevalence of illicit and other drug use in the New Zealand population has been derived from the MOH and the New Zealand Drug Survey 1998:

- ❑ **Cocaine** - Four percent of people in urban areas had tried cocaine and one percent had used the drug in the 12 months preceding interview in the survey;
- ❑ **Ecstasy** - Two percent of people in urban areas used the drug in the 12 months preceding interview in the survey;
- ❑ **Hallucinogens** - Sixteen percent of people had tried hallucinogens and seven percent had used them in the 12 months preceding interview in the survey. The most popular forms of hallucinogens were LSD and magic mushrooms;
- ❑ **Opiates** – The MOH estimated that between 13,500 and 26,600 people in New Zealand were dependent upon opiates in 1996;
- ❑ **Amphetamines** - Nine percent of people surveyed had ever tried the drug in 1998;
- ❑ **Cannabis** – Fifty percent of people had tried cannabis in 1998. Twenty-four percent of males and 15 percent of females had used cannabis in the 12 months preceding interview in the survey. The survey found that the young were most at risk of cannabis dependence.

Recent information on the prevalence of illicit drug use in the Auckland DHB zone was not available to this level of detail, at the time of writing.

#### Harm Caused by Alcohol and Illicit Drug Use

Information available from the New Zealand Police (Central Auckland branch) provides further insights into the harm caused by both alcohol and illicit drug use in the community. Table 39 shows the reported crime per 10,000 population that relates to drug and alcohol use.

Although reported crime for illicit drug use (excluding cannabis) has increased in recent years, it appears that reported crime relating to cannabis use and liquor has decreased over recent years. It is important to note that changes in these figures may reflect not only changes in the pattern of drug and alcohol use in the community, but also reported crime patterns, police staffing levels etc.

**Table 39: Recorded drug-related crime per 10,000 pop. for Auckland Central, 1998-2000**

	1998	1999	2000
<b>Drugs (not cannabis)</b>	5.5	7.0	9.7
<b>Drugs (cannabis only)</b>	71.0	65.4	58.6
<b>Liquor</b>	8.2	6.6	1.4

Data Source: [www.aucklandcitypolice.govt.nz/facts\\_and\\_figures/population\\_rates\\_calendar.html](http://www.aucklandcitypolice.govt.nz/facts_and_figures/population_rates_calendar.html)

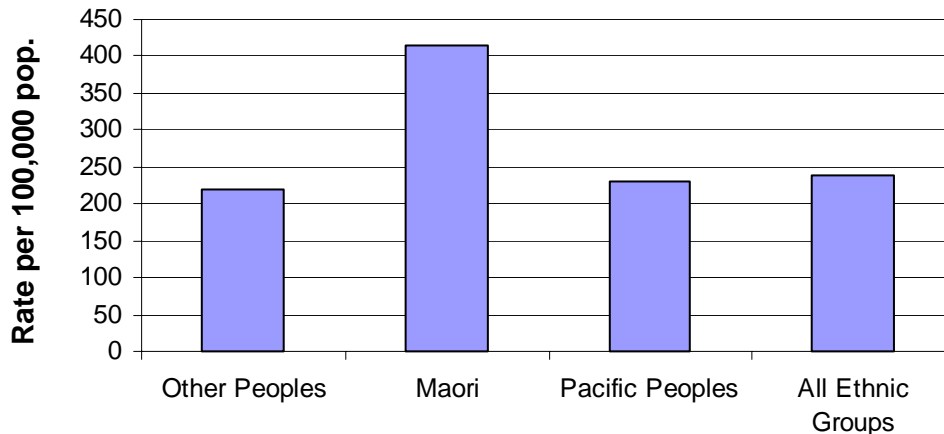
There are national figures available that provide insights into the burden of heavy alcohol consumption on the New Zealand population. Alcohol causes significant harm among males, accounting for almost five percent of all DALYs, but this is offset by the protective benefits of moderate alcohol consumption on IHD. The net effect of alcohol on DALYs is thus relatively small (MOH, 1999). Similarly, although alcohol use causes many deaths in New Zealand each year, this is offset by the number of deaths it prevents each year. However, there are few benefits from alcohol use among young people in the population. Alcohol consumption appears to cause more deaths than are prevented, among young people.

Evidence suggests that at least fifty people die a year, directly from illicit drug use (MOH, 1995). However, this accounts for only a small proportion of the total harm caused by illicit drug use in society. There are also significant psycho-social effects on individuals, families and friends.

### Service Utilisation

The data presented in this section is based upon public hospitalisations, which provide further insights into both the prevalence of drug and alcohol use in the community and the level of harm caused.

**Figure 49: Auckland DHB age-standardised public hospitalisation rates for alcohol-related conditions, by ethnicity, 1999/00**

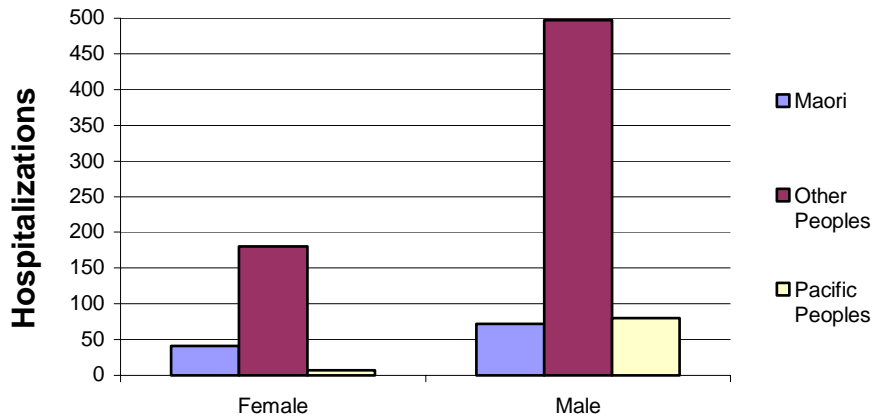


Data Source: NMDS

Figure 49 presents Auckland DHB resident's age-standardized public hospitalisation rates for alcohol-related conditions, by ethnicity, in 1999/00. As can be seen, Maori appear to have extremely high rates of hospitalisation for alcohol-related conditions compared to people from other ethnic groups in the zone. Indeed, the rates for Maori are almost two times as high as the rates presented for other ethnic groups.

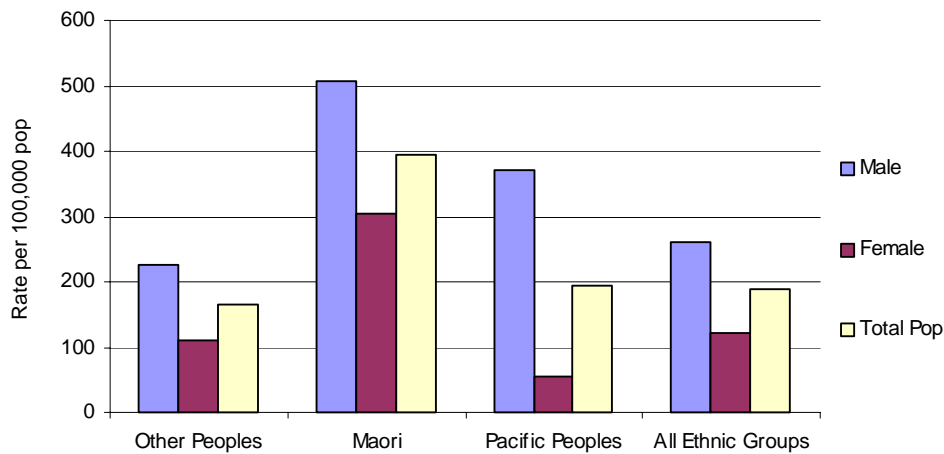
Figure 50 presents Auckland DHB resident's age-standardized public hospitalisation rates for alcohol-related conditions, by ethnicity and gender, in 1999/00. As can be seen, male rates are higher than female rates and the rates for Maori are again extremely high. The rate for male Maori is of particular concern as it is several times higher than the other rates presented in the graph.

**Figure 50: Auckland DHB age-standardised public hospitalisation rates for alcohol-related conditions, by ethnicity and gender, 1999/00.**



Data Source: NMDS

**Figure 51: Auckland DHB age-standardised public hospitalisation rates for drug-related conditions, by ethnicity and gender, 1999/00.**



Data Source: NMDS

Figure 51 presents Auckland DHB resident's age-standardized public hospitalisation rates for drug-related conditions, by ethnicity and gender, in 1999/00. As can be seen, the rates for Maori are very high compared to the other ethnic groups presented. The rates for males appear to exceed rates for females across ethnic groups. The hospitalisation rates for both Maori and Pacific males are of particular concern.

#### Key Issues:

- ❑ The amount of alcohol consumed in a typical drinking session appears to have increased in the Auckland region in recent years;
- ❑ Surveys indicate that attitudes towards heavy drinking, especially among young people, are of concern in the Auckland region;
- ❑ The prevalence of alcohol use is very high among young people in the Auckland region;
- ❑ The prevalence of alcohol use is very high among males in the New Zealand population;
- ❑ Survey data suggests that the level of harm caused by alcohol is high among Maori;
- ❑ Burden of disease data suggests that the level of harm caused by alcohol is high among men and among young people in the New Zealand population;
- ❑ Maori hospitalization rates for alcohol related conditions are very high in comparison to other ethnic groups;
- ❑ Male hospitalization rates for alcohol related conditions are very high in comparison to female rates;
- ❑ The data suggests that the level of harm caused by illicit drugs (excluding cannabis) has increased in recent years in the Auckland DHB zone;
- ❑ Maori hospitalization rates for drug related conditions are very high in comparison to other ethnic groups;
- ❑ Male hospitalization rates for drug related conditions are very high in comparison to female rates.

#### Future Tasks:

- ❑ Obtain prevalence data on illicit drug use in the Auckland region;

- ❑ Obtain more information on the level of harm caused by illicit drug use in the Auckland region;
- ❑ Obtain service utilization information from local community drug and alcohol services, for further analysis.

## **2.08 Objective: Improve the health status of people with severe mental illness**

Mental illness is a significant health issue in New Zealand. It is a major cause of disability and as such, mental illness has been recognized as a priority health issue in the New Zealand. In particular, government has signaled a desire to see improved health outcomes for people with severe disorder in the community.

In addressing the issue, government requires DHBs to go beyond the provision of traditional treatment in primary and secondary settings. It also requires DHBs to engage intersectorally in order to tackle some of the wider environmental factors (eg housing, employment) that impact upon people’s mental health and bring about real change.

### **Services Available**

The Auckland District Health Board mental health services provide a broad range of services that aim to meet the needs of people with serious and enduring mental illnesses living within the catchment zone and beyond. Service delivery, including assessment, treatment and rehabilitation functions, are available on an inpatient basis where necessary, as well as through a range of interventions based in the community - including the homes of consumers. Services are provided directly or indirectly, to all age groups and all cultures. Child and Adolescent inpatient services are currently provided by the Starship Hospital, including Liaison Services (see Child Health section). Services continue to develop for Maori and Pacific peoples, and future developments will also focus on people from other cultures, especially the growing Asian population, refugees and other immigrants. The current service mix is split between secondary services and those that are provided on a tertiary, regional or sub regional basis. These are detailed below, but do not include regional services that are provided by other DHBs in the Auckland region:

#### *Acute Inpatient & Associated Services*

##### **The Conolly Unit**

The Connolly Unit is a 58-bed acute inpatient unit located on the Grafton Rd hospital site. The service provides intensive inpatient care to the population of Central Auckland in response to need identified by the Community Mental Health Services. A locked ward provides eight intensive care beds. The two open wards can accommodate 24 and 26 patients respectively. The service is accessed by adults between 18 and 65 years, with some exceptions, and admissions are accepted from Central Auckland and beyond, as space permits. The Community Mental Health teams make most referrals and admissions are usually of a limited duration – an average of twenty-two days, as our objective is to

provide support in the community wherever possible. The Kai Atawhai team ensures the cultural needs of patients are met. Liaison Psychiatry services are provided to the Green Lane and Grafton sites for patients requiring specialist psychiatric input.

#### The Medical Information Service

The Medical Information Service provides mental health records support for inpatient and community mental health services. The service tracks the legal status of mental health patients to ensure legal requirements under the Mental Health (Compulsory Assessment and Treatment) Act (1992) are maintained, co-ordinates judicial hearings, codes Mental Health data for the Ministry of Health, provides statistical information as required and co-ordinates the release of patient information.

#### *Rehabilitation Services*

##### Buchanan Rehabilitation Centre

The Buchanan Rehabilitation Centre on the Pt Chevalier site currently provides post acute, reduced stay, recovery focussed rehabilitation for forty patients. The service structure has two components- a twenty-bed early rehabilitation intervention service and a twenty-bed late rehabilitation intervention service. The service enjoys positive relationships with a range of other providers in the community. This is critical to ensuring that an adequate range of accessible clinical, support and accommodation options are available for consumers' timely transition back into the community.

##### Community Support Work Service

The Community Support Work Service provides for people with mental health problems who have high and ongoing support needs related to community living and self management of their problems. The service assists people in determining their support needs and using this information provides a lead service/co-ordination role between the person, their family/whanau, the community, the services and resources they wish to access and use, to optimize independent functioning.

##### Crossroads

Crossroads is a consumer driven rehabilitation service. It has been developed according to the American Clubhouse model of psychosocial rehabilitation. It has a membership in excess of 60 people who attend at the premises in Grey Lynn for a variety of programmes and social activities. In the latter part of 2000/01 we have undertaken an options analysis process to determine the best option for the future of this non-clinical service which is delivered in addition to our contract. We anticipate exiting this service in 2001/02, but have a plan to provide some funding to sustain the service through a transition period under the management of an alternative provider.

#### *Community Mental Health Centres (CMHC)*

Community based services are delivered from four conveniently located centres throughout Central Auckland. Multidisciplinary teams provide acute, crisis, early intervention/relapse prevention and continuing care interventions for adults aged 18-65 years. Specialist teams provide a range of focused services, for clients with a first episode of psychosis, or who are homeless, for example. The community centres liaise with the Connolly unit, Buchanan Rehabilitation Centre, and the Maori inpatient service,

Manawanui to secure admissions and to facilitate discharge. The teams also work in partnership with a wide range of other support and accommodation services to enable clients to remain in their communities.

#### *Pacific Island Mental Health Service*

This service, known as 'Lotofale' operates from the Carrington site and provides clinical and community support work services for the Pacific Island population of central Auckland, linking closely with the CMHC's to ensure culturally appropriate assessment and clinical service delivery.

#### *Acute Child and Adolescent Inpatient Services*

See Child Health section for details.

#### *Community Child, Adolescent and Family Service (CCAFS)*

See Child Health section for details. Note that the current level of service is insufficient to meet demand from the community.

#### *Mental Health Services For Older People*

Mental Health Services for Older People provide assessment, treatment and rehabilitation services for people over the age of 65 years. The Community (CARE) team is located on the Green Lane site along with a day programme facility, and works to assess, treat and manage people within their home or community setting. Those requiring inpatient treatment access the Fraser McDonald unit on the Grafton site. Staff of this 12-bed facility liaise with Health Services for Older People and the Community (CARE) team, to ensure continuity of care for their clients. The current level of service is insufficient to meet demand in the community.

#### *Maori Services*

Three teams provide a comprehensive range of services for Maori consumers. A post acute inpatient rehabilitation service consisting of sixteen beds, known as **Manawanui** is located on the Carrington Hospital site. Some Consumers also attend on a daily basis to participate in the range of programmes offered there. These Kaupapa Maori services have the opportunity to provide leadership in the development of service delivery models that ensure good outcomes for Tangata Whaiora. A service redesign process is a priority for the year, as we need to address issues such as under utilization of post acute beds and the lack of clear referral and discharge management processes.

#### *Arahina*

Arahina is the community team, staffed by clinicians, which assesses, treats and manages clients in their homes and other community settings. The team liaises with the CMHC's and provides cultural assessments as required.

#### *Te Puau Ora*

Te Puau Ora, located at Panmure, is the Maori community support work team that supports people with mental illness to function safely and well within their community, without recourse to institutional care.

### *Specialist Services*

Four independent specialist teams provide highly focussed services to people who reside in central Auckland and beyond. These have been redesigned in the last year to ensure service delivery is based on evidence of best practice.

#### Segar House

Segar House, is a long established centre for psychotherapy services and offers individual and group treatment models. Staffed by a small multidisciplinary team of health professionals it has worked hard over the years to ensure that outpatient psychotherapy continues to be available within our service options. A residential component of the service has been developed over the past 18 months and is operating very successfully. It will be necessary to review funding for this service as the funding stream is not adequate to provide the scope of service agreed in the contract

#### Maternal Mental Health

Maternal Mental Health works with women who have a mental disorder prior to, during or after childbirth. It is mainly an acute service and provides an essential assessment and support service for National Women's clients as well as accepting referrals from primary practitioners and the internal Auckland DHB service. The current level of service is insufficient to meet demand in the community.

#### Eating Disorders

The Eating Disorders team, located in Ponsonby, provides an outpatient service with a small multidisciplinary team. They accept referrals from the sub-region and provide consultation services to Northland and education to Health Waikato. The current level of service is insufficient to meet demand in the community, producing a high level of risk.

#### Community Neuro-behavioural Service

The Community Neuro-behavioural Service is based on the Carrington site. The team provides assessment, treatment and support services for people with head injury, or intellectual disability, who have problems of challenging behaviour.

### *Non-Governmental Mental Health Services*

#### Residential rehabilitation

Table 40 lists the residential rehabilitation providers in the Auckland region. Within the residential rehabilitation services setting there are four levels of care available. Level I care provides the minimal level of care, and level IV the maximum level of residential care. All residential rehabilitation services are regional. Table 41 provides a full description of each level of service including the Kaupapa Maori support service.

Thirteen residential rehabilitation providers are located in the Waitemata DHB area. Residential rehabilitation support services are available to all ethnic groups from these providers. Two providers specifically deliver residential rehabilitation support services

to Maori, and one to Pacific Island People. There are eight level I, 66 level II, 94 level III and 32 level IV residential rehabilitation support services in the Waitemata DHB area.

In the Counties-Manukau DHB area there are eight residential rehabilitation providers and five level I, 64 level II, 56 level III and 26 level IV residential rehabilitation support services.

There are 17 residential rehabilitation providers located in the Auckland DHB area including 51 level I, 120 level II, 151 level III and ten level IV residential rehabilitation support services.

In addition to these providers two national providers, the Richmond Fellowship NZ and Pathways Trust, have sixty and 63 beds respectively for residential rehabilitation services.

**Table 40: Residential rehabilitation providers in the Auckland region**

Provider	Service Location	Service Coverage	Level*			
			1	2	3	4
Accommodation for Mental Health Services	Waitemata DHB	Regional		19	4	16
Dayspring Trust	Waitemata DHB	Regional		5		
Delamore and Reidy	Waitemata DHB	Regional		9		
Forest Hill Cottages (1999) Ltd	Waitemata DHB	Regional		9		
Framework Trust	Waitemata DHB	Regional			5	
Goodwood	WDHB	Regional	8	4	25	
Links Integrated Health	Waitemata DHB	Regional			14	
Pacificare Trust	Waitemata DHB	Regional			5	
Spectrum Care	Waitemata DHB	Regional			5	
Te Ara Hou	Waitemata DHB	Regional		20		

Te Ha O Te Oranga	Waitemata DHB	Regional			5	
Te Kotuku Ki Te Rangi	Waitemata DHB	Regional			19	11
West Auckland Living Skills Trust	Waitemata DHB	Regional			12	5
Challenge Trust	Counties-Manukau DHB	Regional			8	21
Facey Holdings Ltd	Counties-Manukau DHB	Regional		9		
Rapua Te Oranga Hinengaro Trust	Counties-Manukau DHB	Regional and local		5	22	
Te Puawai Aroah Ki Otara	Counties-Manukau DHB	Regional		6	6	
Te Whare Tiaki	Counties-Manukau DHB	Regional		13		
Hinemoa Lodge	Counties-Manukau DHB	Regional		4	7	
Pacificare Trust	Counties-Manukau DHB	Regional and local	5		5	
Te Korowai Aroha	Counties-Manukau DHB	Regional		27	8	5
Arahura Charitable Trust	Auckland DHB	Regional	4	12		
Burnley Lodge Limited	Auckland DHB	Regional		9		
Beverley RH(1986) Ltd	Auckland DHB	Regional		11		
Blue Water	Auckland DHB	Regional	6	4	16	
Braefield Holdings	Auckland	Regional		8		

	DHB					
Cardigan House Ltd	Auckland DHB	Regional		12		
Carrick House Ltd	Auckland DHB	Regional		12		
Fairleigh	Auckland DHB	Regional			25	
Clair House Ltd	Auckland DHB	Regional		10		
Community for Refuge Trust	Auckland DHB	Regional	23			
Maranga House Trust	Auckland DHB	Regional		5		
WISH Trust	Auckland DHB	Regional			10	
Delamore and Reidy	Auckland DHB	Regional			31	10
Framework Trust	Auckland DHB	Regional			15	
Hinemoa Lodge	Auckland DHB	Regional		19		
Spectrum Care	Auckland DHB	Regional			15	
Te Korowai Aroha	Auckland DHB	Regional	18	18	39	

**Data Source: MOH.**

**Table 41: Residential rehabilitation service descriptions**

Community Residential - Level I	This is a community-based residential rehabilitation and support service for people with psychiatric disabilities. The service will provide "brief daily support provided by experienced non-clinical staff" in a home-like atmosphere with partial supervision and a low-key rehabilitation programme for each resident
Community Residential - Level II	This is a community-based residential rehabilitation and support service for people with psychiatric disabilities. The service will provide "24 hour support provided by non-clinical staff. May include sleepovers" in a home-like atmosphere with partial supervision and a low-key rehabilitation programme for each resident
Community	This is a community-based residential rehabilitation and support service for people with

Residential - Level III	psychiatric disabilities. The service will provide "24 hour support provided predominately by non-clinical staff with some clinical staff available short term (day hours/sleepovers)" in a home-like atmosphere with partial supervision and low-key rehabilitation programme for each resident.
Community Residential - Level IV	This is a community-based residential rehabilitation and support service for people with psychiatric disabilities. The service will provide "24 hour intensive support - mix of clinical/non-clinical staff providing: - 24 hour access to medication, behaviour management strategies, daily consultation with clinical team, harm reduction strategies" in safe and comfortable accommodation with a home-like atmosphere for each resident.
Kaupapa Maori Residential Rehabilitation Level I	This is a community-based residential rehabilitation and support service for Maori with psychiatric disabilities. The service will provide "brief daily support provided by experienced non-clinical staff" in a home-like atmosphere with partial supervision and a low-key rehabilitation programme for each resident. This treatment model is expected to contain traditional Maori healing practices including holistic approach, whanau input and Maori ownership.
Kaupapa Maori Residential Rehabilitation Level II	This is a community-based residential rehabilitation and support service for Maori with psychiatric disabilities. The service will provide "24 hour support provided by non-clinical staff. May include sleepovers" in a home-like atmosphere with partial supervision and a low-key rehabilitation programme for each resident. This treatment model is expected to contain traditional Maori healing practices including holistic approach, whanau input and Maori ownership.
Kaupapa Maori Residential Rehabilitation Level III	This is a community-based residential rehabilitation and support service for Maori with psychiatric disabilities. The service will provide "24 hour support provided predominately by non-clinical staff with some clinical staff available short term (day hours/sleepovers)" in a home-like atmosphere with partial supervision and low-key rehabilitation programme for each resident. This treatment model is expected to contain traditional Maori healing practices including holistic approach, whanau input and Maori ownership.
Kaupapa Maori Residential Rehabilitation Level IV	This is a community-based residential rehabilitation and support service for people with psychiatric disabilities. The service will provide "24 hour intensive support - mix of clinical/non-clinical staff providing: - 24 hour access to medication, behaviour management strategies, daily consultation with clinical team, harm reduction strategies" in safe and comfortable accommodation with a home-like atmosphere for each resident. This treatment model is expected to contain traditional Maori healing practices including holistic approach, whanau input and Maori ownership.

*Data Source: MOH.*

### Iwi support work

Iwi support work is a Kaupapa Maori mental health service, which provides dedicated outpatient services for Maori consumers through non-clinical staff. This is provided by a specialist, multidisciplinary team, from a dedicated base facility, and includes some outreach clinics. This treatment model is expected to contain traditional Maori healing practices including holistic approaches, whanau input and Maori ownership. All Iwi support work services are regional. Table 42 lists the six Iwi support providers in the Auckland region and the FTE of each provider. A total of 28.85 FTEs are devoted to this service in the Auckland region.

**Table 42: Iwi support work providers in the Auckland region**

<b>Provider</b>	<b>Service Location</b>	<b>Service Coverage</b>	<b>Volume (FTE)</b>
Mahitahi Trust	Counties-Manukau DHB	Regional	4
Rapua Te Oranga Hinegaro Trust	Counties-Manukau DHB	Regional	3.6
Raukura Hauora O Tainui	Counties-Manukau DHB	Regional	8.75
Te Kotuku Ki Te Rangi	Waitemata DHB	Regional	4
Te Puna Hauora o Te Raki Pae Whenua Inc	Waitemata DHB	Regional	3
Te Whanau O Waipareira Trust	Waitemata DHB	Regional	5.5

Data Source: mOH.

### Community Support Work

Community support work includes community and home based support services, which are provided to consumers/clients with a mental disorder to enable them to have the independence to stay in their own homes. All community support work services are regional and 65.63 FTEs are allocated to community support work services in the Auckland region. Table 43 lists the nine community support providers in Auckland region.

**Table 43: Community Support Work providers in the Auckland region**

<b>Provider</b>	<b>Service Location</b>	<b>Service Coverage</b>	<b>Volume (FTE)</b>
Accommodation for Mental Health Society	Waitemata DHB	Regional	8
Spectrum Care Trust	Waitemata DHB	Regional	7.5
T/a Pacifica Inc	Waitemata DHB	Regional	3.5
WALSH	Waitemata DHB	Regional	7
Challenge Trust	Counties-Manukau	Regional	7.5

	DHB		
Pacificare Trust	Counties-Manukau DHB	Regional	10.13
Framework Trust	Auckland DHB	Regional	11.5
Malaloga (Richmond Umbrella)	Auckland DHB	Regional	3
Te Korowai Aroha	Auckland DHB	Regional	7.5

Data Source: MOH.

#### Family/whanau support work

Family/whanau support includes advocacy/peer support provided to families/whanau of consumers of Mental Health services by dedicated health professionals and non-clinical staff. The Raukura Hauoria O Tainui provides this service for child and youth and also provides a Kaupapa Maori Mental Health Service. This is an Early Intervention Alcohol and Drug Service for Maori consumers provided by specialist and multidisciplinary teams to assess and treat people with an alcohol or drug related problem in the early stages of illness. The Challenge Trust, Penina Pacific Health Ltd and Rapua Te Oranga Hinegaro Trust all provide an advocacy/peer support service to adults. The Schizophrenia Fellowship is a National organisation that provides local services in each of the DHB areas. There is a total of 18 FTEs for Family/whanau Support Work services in the Auckland region.

**Table 44: Family/whanau Support Work providers in the Auckland region**

Provider	Service Location	Service Coverage	Volume (FTE)
Te Puna Hauora o Te Raki Pae Whenua Inc	Waitemata DHB	Local	1.5
Te Whanau O Waipareira Trust	Waitemata DHB	Local	4.5
Mahitahi Trust	Counties-Manukau DHB	Local	2.5
Raukura Hauora O Tainui	Counties-Manukau DHB	Local	4.5
Challenge Trust	Counties-Manukau DHB	Local	1

Penina Pacific Health Ltd	Counties-Manukau DHB	Local	1
Rapua Te Oranga Hinegaro Trust	Counties-Manukau DHB	Local	1
Schizophrenia Fellowship	Auckland DHB	National	2

Data Source: MOH.

### Social and recreational services

Table 45 lists the social and recreational service providers in the Auckland region. All these services are local services and the Richmond Fellowship is a national provider of social and recreation services. Table 46 provides a description of social and recreational services.

**Table 45: Social and recreational service providers in the Auckland region**

Provider	Service Code*	Service Location	Service Coverage	Volume (FTE)	Volume (FTE equivalent)
Dayspring Trust	MHCS16C	WDHB	Local		0.4
Te Whanau O Waipareira	MHCS42	WDHB	Local	2	
The Cottage Farm Trust	MHCS14C	WDHB	Local		0.6
West Auckland Living Skills Trust	MHCS21.1	WDHB	Local	1	
West Auckland Mental Health Support Trust	MHCS14C	WDHB	Local		0.90
Auckland Refugees as Survivors	MHCS27	CMDHB	Local	2	
Pacificare Trust	MHCS21	CMDHB	Local	2	
Post Natal Psychosis Support Group	MHCS21	CMDHB	Local		0.60
Rapua Te Oranga Hinengaro Trust	MHCS14C MHCS42	CMDHB	Local	1	

Waimokoia School	MHCS22.7	CMDHB	Local		0.20
Challenge Trust	MHCS16C	CMDHB	Local	2	
Mahitahi Trust	MHCS42	CMDHB	Local	1	
Eating Disorders Association (NZ)	MHCS22.1	ADHB	Local		0.20
Framework Trust	MHCS16C	ADHB	Local		10.70
Grow NZ Inc - Auckland	MHCS21	ADHB	Local		1.70
Hapai Te Hauora Tapui Ltd	MHCS21	ADHB	Local	2.3	
Mt Albert Community Club	MHCS22.1	ADHB	Local		0.30
Richmond Fellowship NZ Inc – National Office	MHCS16C	ADHB	National	6	
Te Korowhai Aroha	MHCS14C	ADHB	Local	2	
The Phobic Trust of New Zealand Inc	MHCS10	ADHB	Local		1.20
Toi Ora Live Art	MHCS21	ADHB	Local		1.50
Maranga House	MHCS14C	ADHB	Local		2.50

Data Source: MOH.

Table 46: Social and Recreational service description

<p>MHCS16C Activity-Based Rehabilitation Service/Day Activity and Living Skills (Clinical FTEs)</p>	<p>Activity rehab services/day &amp; activity living skills and recreational support and services provided to psychiatric clients in the community by dedicated health professionals.</p>
<p>MHCS42 Kaupapa Maori Mental Health Services - Day Programmes</p>	<p>Day programmes to assist eligible Maori people to improve their life skills, strengthen their sense of identity and knowledge and understanding of their Maoritanga and overcome social isolation. The treatment model is expected to contain traditional Maori healing practices including holistic approach, whanau input and Maori ownership.</p>
<p>MHCS14C Work Rehabilitation/ Employment and Educational Support Services (Non- Clinical FTEs)</p>	<p>Work rehab, employment, vocational, educational and skills enhancement support and services provided to psychiatric clients in the community by dedicated non-clinical staff.</p>
<p>MHCS21 Advocacy/Peer Support – Consumers Includes sub-units as follows: MHCS21.1 Adults</p>	<p>Advocacy/Peer Support provided to Consumers by dedicated health professionals &amp; non-clinical staff.</p>
<p>MHCS27 Refugee Mental Health Service</p>	<p>Psychiatric assessment, treatment and other related services provided to refugees with a psychiatric (trauma) disorder.</p>
<p>MHCS22 Advocacy/Peer Support - Families/Whanau Includes sub-units as follows: MHCS22.1 Adults MHCS22.7 Child &amp; Youth</p>	<p>Advocacy/Peer Support provided to Families/ Whanau of consumers of Mental Health services by dedicated health professionals and non-clinical staff.</p>
<p>MHCS10 Specialist Psychotherapy Service</p>	<p>Therapeutic interventions that are primarily targeted at consumer group with severe personality disorder.</p>

Data Source: MOH.

MOH Public Health Services – Mental Health

Table 47 provides information on public health services funded by the MOH for 2001/2002 for Mental Health in the Auckland region. The focus of these services is countering stigma and discrimination associated with mental illness.

**Table 47: Public Health Mental Health Providers in the Auckland region**

<b>Provider name</b>	<b>Service description</b>
Hapai Te Hauora Tapui Ltd	Project to counter Stigma and Discrimination associated with mental illness – co-ordination, workforce development and resources, action/education in and by communities, sector work
Mental health Foundation	Project to counter Stigma and Discrimination associated with mental illness – co-ordination, workforce development and resources, action/education in and by communities, sector work
Framework Trust	Project to counter Stigma and Discrimination associated with mental illness – co-ordination, action, education, sector work, workforce development
Framework Trust	Project to improve the mental health of consumers in the wider community by providing an access radio programme
Pacificare Trust	Project to counter Stigma and Discrimination associated with mental illness – co-ordination, workforce development and resources, action/education in and by communities, sector work
Auckland Refugees As Survivors	Community and provider development training and education programme to address refugee and asylum seeker health needs

Data Source: MOH.

*General Practitioners*

General Practitioners in the community also provide limited mental health services to people in the community.

Appendix III provides information on the location of various mental health services in the region.

There is a need to provide comprehensive care for people accessing services and a need to enable access for those who are currently unable to achieve service access when it is required. It is essential to support and consolidate current services to ensure service quality and promote better service access. In addition, there are gaps in core community services, services for people with eating disorders and maternal mental health services. These services are not meeting current demand.

## Mental Health Status in the Community

The Northern Regional Health Survey carried out in 1996/97 measured the self-assessed health status of the Auckland and Northland populations. The SF-36, as mentioned previously (see section on health status), is a tool that measures eight dimensions of health, from the physical, though to the mental, scaling them from 0 to 100 – indicating perfect health (Table 48).

**Table 48: Average SF-36 average scores for Auckland region, 1996/97**

	North Auckland	West Auckland	Central Auckland	South Auckland	Total Auckland
<b>Physical Functioning</b>	86.3	82.9	84.7	79.8	83.1
<b>Role Functioning – Physical</b>	81.4	79.4	79.6	76.1	78.7
<b>Bodily Pain</b>	76.9	74.7	77.5	75.0	75.7
<b>General Health</b>	69.8	67.6	69.8	67.3	69.0
<b>Vitality</b>	65.8	63.8	65.9	63.4	65.1
<b>Social Functioning</b>	84.4	82.0	82.9	81.0	82.5
<b>Role Functioning – Emotional</b>	88.9	83.6	83.6	82.7	84.5
<b>Mental Health</b>	78.7	75.6	77.4	75.7	77.3

Data Source: Parr et al, 1998

Auckland Central (equivalent to the Auckland DHB population) district scores were consistently high with the highest average score on three of the eight scales. Along with people from the North Shore, people from Auckland Central had the highest average mental health scores, indicating that they had better mental health status in 1996/97 than people in either South Auckland or West Auckland. However, the average New Zealand mental health score from the National Health Survey was 78 (MOH, 1999) and at 77.4, the Auckland Central score was below the national average.

## The Prevalence of Disorder in the Community

The prevalence of disorder in a population is difficult to measure accurately in New Zealand. Data recording the use of mental health services by individuals is often assumed to represent the prevalence of mental disorder in New Zealand. However, use of services by those seeking treatment for episodes of ill health do not represent the total number of people afflicted by disorder at one point in time in the community. Rather, the data presented in numerous reports on hospitalizations and attendances at clinic sessions (New Zealand Health Information Service, 1998) represents the total number of people successful in obtaining care for their episode of ill-health, not the total number of people in the community suffering from mental disorder, at one point in time.

The best means of obtaining an accurate picture of the actual prevalence of disorder in the New Zealand population is through detailed research. However, the research data available in New Zealand at present on the prevalence of mental disorder is scarce, and that which is available is dated. It is also often focused on individual disorders, or has been undertaken on select sub-groups of the population. This limits the potential applicability of prevalence-related research results to the wider population.

A model developed by the Mental Health Commission (1998), which is based upon the results of both local and international studies suggests that twenty percent of the population have a diagnosable disorder at any one point in time, an additional ten percent of the population have mental health problems that are not severe, or specific enough to be classified as ‘diagnosable disorders’. Thus the prevalence of mental ill health in the population is approximately thirty percent.

The model developed by the Mental Health Commission also suggests that approximately five percent of children and three percent of adults in the national population suffer severe disorder requiring specialist care, at any one point in time. Table 49 shows the approximate numbers of people within the Auckland DHB zone suffering mental ill health in 2001, using the prevalence estimates developed by the Mental Health Commission.

**Table 49: The estimated prevalence of mental ill health in the Auckland DHB population, 2001.**

	Prevalence (%) of Disorder		No. of ADHB people suffering disorder	
	Child (0-14yrs)	Adult 15yrs+	Child (0-14yrs)	Adult 15yrs+
<b>Mental Health Problem/Issue</b>	10	10	8,025	31,125
<b>Mental Health Diagnosable Disorder</b>	20	20	16,050	62,250
<b>Severe Mental Health Disorder</b>	5	3	4,013	9,338

Data Source: MHC 1998

### Unmet Health Need in the Community

At the time of writing, the Auckland DHB provider-arm mental health services were addressing the mental health needs of approximately two percent of the adult population and approximately 1.8 percent of the child population. These figures fall short of the adult (three percent) and child (five percent) mental health need estimates from the Mental Health Commission model and would suggest that approximately one percent of the adult population and 3.2 percent of the child health population in the zone have serious mental health needs that are not being met by specialist services. In addition, there is reason to suspect that the prevalence of severe disorder is increasing, as available services in the community are struggling to meet growing levels of demand and more people are becoming seriously unwell as a result (Auckland DHB, 2001).

The real level of unmet health need is very difficult to determine however, as there are a number of other services provided in the region that Auckland DHB residents are able to access. At the time of writing, the number of Auckland DHB residents accessing specialist services elsewhere in the region was unknown. In addition, the prevalence estimates from the Mental Health Commission may not be entirely accurate. As already mentioned, they are largely based upon dated data and research that has focused on particular sub-groups of the New Zealand population, that may not be applicable to the wider population. Therefore, the true level of unmet need in the Auckland DHB population is largely unknown. All that can be said is that the data available suggests that there may be as many as 2,568 children and 3,113 adults living within the Auckland DHB zone who require access to specialist care, but are not currently receiving this care.

If the Auckland DHB is to improve the health status of people that reside in the zone with a mental disorder, then it is important to identify and assist the people who do not currently access services but who require professional care. In order to achieve this goal it will be important for the DHB to a) encourage and assist providers, where possible, to improve service access and service quality b) encourage and assist providers, where possible, to commit to best practice guidelines and c) consolidate and build upon the existing service base.

## Service Utilization

Service utilization data provides insights into the patterns of service use by sub-groups of the population. This type of information can assist in identifying service gaps and in the profiling of population groups with high levels of unmet need in the community. For instance, Table 50 presents Auckland DHB resident's hospitalization rates (public hospitals only) for psychiatric disorder in 1999. As can be seen, females appear to have higher rates of hospitalization than males.

Evidence suggests that the prevalence of disorder among Maori is high and Maori males residing in the Auckland DHB zone appear to have the highest rates of hospitalization for psychiatric disorder among all males presented in the table. Note that Maori females residing in the Auckland DHB appear to have the highest rates of any group presented.

**Table 50: Age-standardized discharge rate for psychiatric disorder for Auckland DHB & NZ, 1999.**

		Others	Maori	PI	Total
<b>Male</b>	<b>ADHB</b>	239.8	300.3	192.7	241.8
	<b>NZ</b>	205.8	190.4	128.1	202.1
<b>Female</b>	<b>ADHB</b>	389.1	392.4	237.5	378.7
	<b>NZ</b>	367.8	363.8	234.9	364.7

Data Source: NMDS.

The rates presented for Pacific people are very low in comparison to other groups, yet evidence suggests that the prevalence of disorder in Pacific populations may be high (MOH, 1997). This could also indicate that Pacific peoples requiring care are not accessing available publicly funded health services. The extent to which Pacific perspectives on mental ill health contribute to the observed utilization rates is unknown.

It is interesting to note that the Auckland DHB hospitalization rates all exceed the rates for the total New Zealand population. This may indicate that the prevalence of disorder among the local population is extremely high, or demand for community support services exceeds service supply and more people are hospitalized per head of population as a result, or simply that Auckland DHB residents get better access to psychiatric hospital services when they require them, compared to the New Zealand population as a whole.

A comparison of available public hospital inpatient beds suggests that the Auckland DHB has more beds per head of population than other DHBs in the region and more community service FTEs per head of population than elsewhere (Table 51). However, mental health service teams within the provider-arms of the region's three DHBs co-

operate across the region to ensure that those requiring access to inpatient services receive services when required. An acute bed shortage across the region ensures that all available beds are well utilized. There is also a post-acute bed shortage and ‘secure-bed’ (for dangerous patients) shortage across the region. In addition, there is a serious shortage of trained staff (especially psychiatrists and nurses) in the region to work within mental health services.

**Table 51: Ratio of beds and community FTEs per head of population, Auckland region, 1999.**

	Waitemata DHB	Auckland DHB	Counties-Manukau DHB
<b>Adult Community FTEs</b>	1 FTE:1,678 pop.	1 FTE:1,079 pop.	1 FTE:1,542 pop.
<b>Adult Inpatient Beds</b>	1 Bed: 3,559 pop.	1 Bed: 2,735 pop.	1 Bed: 4,518 pop.

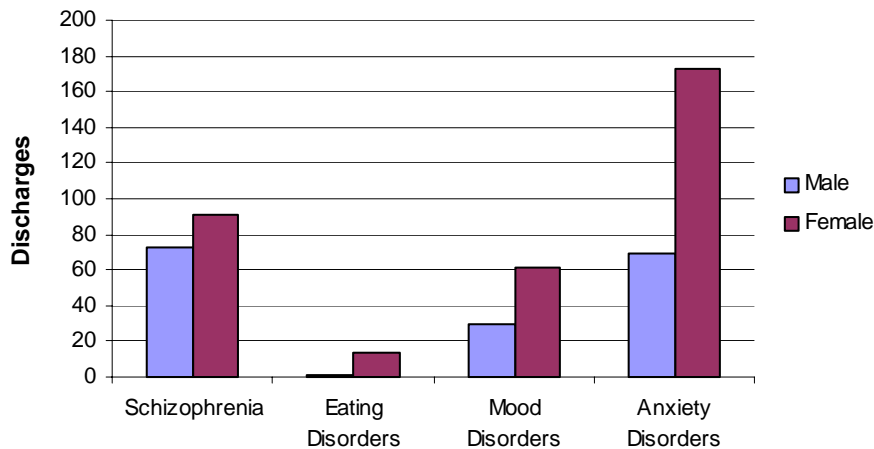
The acute inpatient unit admits approximately nine hundred adults each year, most of whom live in the Auckland DHB zone. Admissions are accepted from other catchments if beds are available. Up to eighty percent of patients are admitted under compulsory treatment orders. The average occupancy of the acute unit exceeds 93 percent.

**Table 52: Auckland DHB Acute Adult Unit Discharge Projections**

Age Groups	Acute Adult Unit Discharge Projections		
	1998/99 (Actuals)	2006	2021
15-24	172	191	209
25-44	496	539	548
45-64	190	281	399
65+	7	7	11
<b>Total</b>	<b>865</b>	<b>1018</b>	<b>1,168</b>

Data Source: Auckland DHB Mental Health Service

**Figure 52: Auckland DHB public hospital discharges for selected conditions, by gender, 1999/00.**



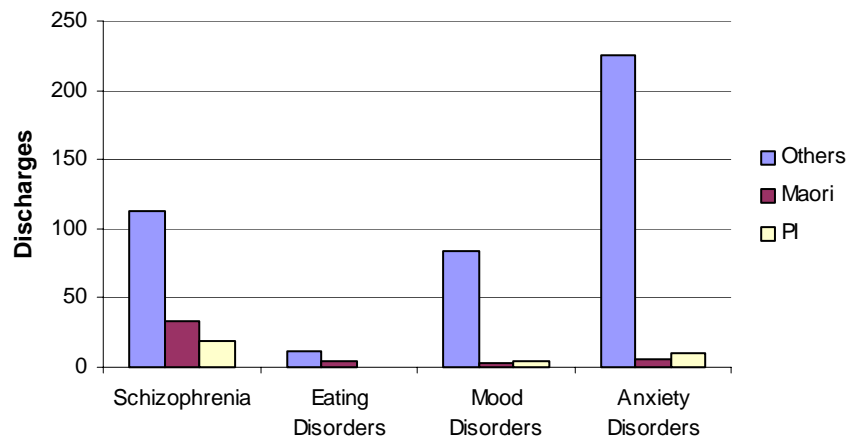
Data Source: NMDS

The Auckland DHB population is expected to grow by approximately 32 percent over the next twenty years (from an estimated 377,900 in June 1995 to 500,000 within 15-20 years). If current discharge patterns continue, discharges can be expected to grow from 865 to 1,018 in 2006 and 1,168 in 2021 (Table 52).

These discharge projections suggest that high occupancy rates and shorter lengths of stay would be required for the Service to meet the Mental Health Commission’s guideline bed numbers. The current average length of stay for the acute ward is approximately 22 days.

Figures 52 and 53 present the numbers of people that were hospitalized (public hospitals only) with selected disorders by gender and ethnicity in 1999/00.

**Figure 53: Auckland DHB public hospital discharges for selected conditions, by ethnicity, 1999/00.**



Data Source: NMDS

As can be seen, more women were hospitalized than men for each of the disorders presented and more people from ‘Other’ ethnic groups were hospitalized. Interestingly, more people were hospitalized for anxiety disorders than any other condition - the majority of patients were women from ‘Other’ ethnic groups.

### Key Issues

- ❑ There is a shortage of acute, post-acute and ‘dangerous patient’s’ beds across the region;
- ❑ The ability to provide comprehensive care for those accessing services is an issue;
- ❑ The prevalence of serious mental health disorder appears to be increasing and existing services are not meeting current demand;
- ❑ There is a serious shortage of trained staff (psychiatrists and nurses especially) available across the region;

- ❑ The current level of service for child and adolescent services, core community services, maternal mental health, eating disorders and older adult's mental health services is currently insufficient to meet demand in the community;
- ❑ Maori have high hospitalization rates for psychiatric disorder;
- ❑ Maori have high service needs;
- ❑ Males and Pacific peoples have very low hospitalization rates for psychiatric disorder;
- ❑ Women and people from 'Other' ethnic groups predominate the psychiatric disorder hospitalization data;
- ❑ There may be as many as 2,568 children and 3,113 adults living within the Auckland DHB zone who require access to specialist care, but are not currently receiving this care;
- ❑ Mental health was a major issue arising from community engagement (see community engagement section for details)

#### Future Tasks

- ❑ Follow-up on quantifying the level of unmet health need in the community with new prevalence data when it becomes available.

### **2.09 Objective: Improving Oral Health**

Tooth and gum diseases are among the most common of all health problems in New Zealand. Oral health status is influenced by a number of factors including genetic factors, diet, dental hygiene, fluoride exposure and access to oral health services. There are significant inequalities in oral health status between different population groups in New Zealand. In particular, at the national level, Maori and Pacific children and adolescents have worse oral health than non-Maori, non-Pacific children and adolescents.

#### Services Available

##### *Oral Health Regional Service*

The Auckland DHB currently provides the Oral Health Regional Service to the greater Auckland region. These services include primary, specialised secondary and tertiary services, which are provided to groups within the region with special needs. Clinics are currently provided at Middlemore Hospital, at a clinic on Buckland Road, Greenlane Hospital, Waitakere Hospital and North Shore Hospital.

## Location of Services

Green Lane Hospital	8 dental surgeries and a small dental laboratory with access to day stay theatres
Middlemore Hospital	5 dental surgeries, 8 chairs and a substantial dental laboratory
Buckland Road, Mangere	1 surgery, 2 chairs
North Shore Hospital	1 chair
Waitakere Hospital	1 chair

Some services take place on site at Starship Children's Hospital theatre, and some at Auckland Hospital. In addition, the Oral Health Service provides nominal supervision for a dental therapist with the Waipareira Trust in Waitakere City.

Oral health related services and their locations in the Auckland region are further profiled in Appendix A for reference.

Within the Oral Health Regional Service, the following dental health specialties are represented:

- Oral and Maxillofacial Surgery
- Oral Medicine
- Orthodontics
- Paedodontics
- Periodontics
- Prosthodontics
- Maxillofacial Prosthodontics
- Special needs
- Relief of Pain only
- Dental laboratory

Each of these specialties is provided through multi-disciplinary teams dedicated to the treatment of complex problems in both in-patient and outpatient settings across the Auckland region. These teams include health professionals from the following disciplines:

- ORL / ENT
- Cardiac and General Surgery
- Regional Plastic, Maxillofacial & Hand Reconstructive Centre
- Department of Critical Care
- Mental Health
- Psychiatric Disability Services
- Haematology Services
- Oncology and Radiotherapy Services
- Ophthalmology Services
- Diabetes and Renal Services
- Spinal Units & Auckland Rehabilitation Service

- Services for the Elderly
- Paediatric Services
- School Dental Service

Oral Health's Secondary and Tertiary Services have a significant linkage with other sectors and the hospital service. The Oral Health Unit runs a 24-hour on-call acute service across the Auckland regional area. The demand is particularly high in the weekends on the Oral and Maxillofacial Surgery Service for the treatment of trauma, accidents, broken jaws, traffic accident injuries and the like.

The service also provides an acute service for those patients who cannot access services in the private sector.

There is a significant and unique relationship with ORL, particularly the Head and Neck Clinic, e.g. those patients receiving surgery of the head and neck and requiring prosthetic replacement eyes, facial parts, nose, ears, mandible. This is carried out through Specialist Prosthodontics Services and the laboratory at Middlemore Hospital. Similarly, the relationship with the Plastic Services revolves around the cleft lip and palate service delivered exclusively at Middlemore Hospital, where the service employs full time orthodontists, dental assistants and technicians to integrate with Plastics Surgeons in the long-term management of these patients.

The Green Lane unit has a close working relationship with general cardiac surgery and those patients receiving and requiring cardiac surgery bypass and transplants. These patients receive full dental work to remove any sources of infection from teeth and associated tissues, which may cause complications either prior to, or immediately after surgery. This is a continual service and house surgeons attend cardiac conferences on a weekly basis.

The Haematology Services receive support from the Oral Health Unit. Those patients who have bleeding disorders and associated oral health problems need constant care and attention and the services of our specialist hospital dentists are available to them. Similarly the Renal and Medical Services.

The Auckland Oncology Centre has a large number of outpatients who receive chemo / radiotherapy from around the region. These patients have significant oral mucosal changes in the course of their therapy. Treatment, assessment and management of these patients forms a significant part of the secondary service.

There are five dental house surgeons and a registrar available to the Emergency Departments at Auckland and Middlemore Hospitals and similarly service the Paediatric Services at Starship. A minimal domiciliary service is provided to the elderly and people with disabilities. This involves visiting private homes and residential care.

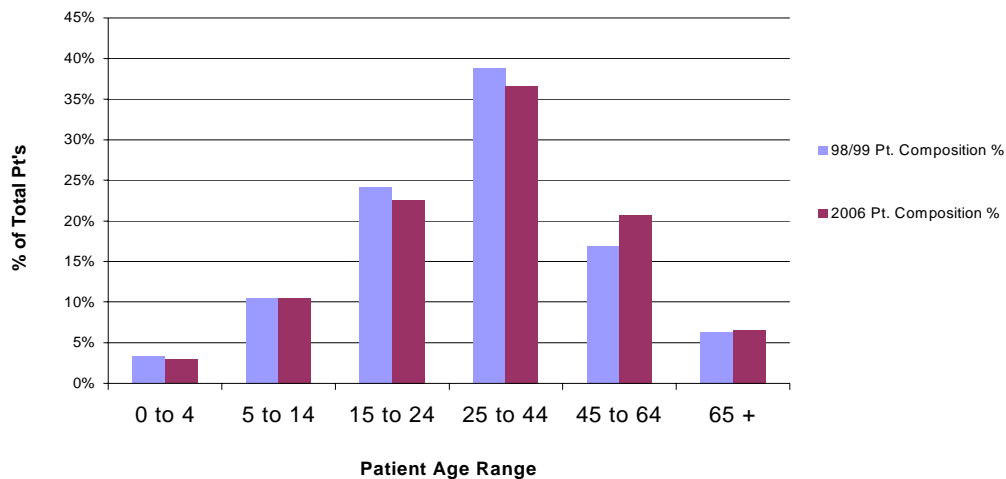
In the primary sector, the Relief of Pain service is directed to those with community service cards who cannot afford basic oral health services in the private sector. The

treatment carried out for these patients is minimal, treating mainly pain and infection that may require dressings or extractions. The Relief of Pain service is a demand service only. It does not operate under a planned booking protocol and patients are treated according to publicised hours of attendance. Many patients who attend the relief of pain clinics are of Maori or Pacific Island ethnicity. There is an expectation that demand for this service will grow overtime as these sectors of the population grow.

A service to the intellectually handicapped is managed through care centres, or through the parents of the intellectually handicapped. This is a basic service i.e. treatment is carried out to a level that ensures the patients are disease free, and where possible, encouraged to participate in preventive programmes. Clinical facilities are provided at all regional sites.

Patient ages for the Regional Oral Health Service are spread across the lifespan with a large proportion of patients [36-39%] in the 25 to 44 year-old age range. Patient numbers tail off evenly either side of this age range.

**Figure 54: Regional Oral Health Service patients by age group.**



Data Source: Auckland DHB Regional Oral Health Service

Figure 54 shows the forecasted differences in patient composition by age for the service, based on the changes in the Auckland region population from 1996 - 2006 [figures have been re-worked to represent the 1998 - 2006 period] and departmental patient volumes for the 1998/9 financial year. It is expected that there will be little change required to the basic proportion of resources given to the various Oral Health Services since patient age composition is expected to shift only minimally. It should, however, be noted that additional resources will be required to handle the expected 13.3 percent overall increase in patient numbers, from 35,086 in 1998/9 to 39,759 in 2006. This increase is in line with expected population growth for the same period in the Auckland region.

### *School Dental Service*

Within the Auckland region, the School Dental Service provides basic primary oral health services free to children. At present, the Regional School Dental Service is funded by the Waitemata DHB. The service provides for the oral health care of all children in the Auckland region, aged 0-13 years. Most of the work is undertaken at school-based clinics by dental therapists and by contracting dentists in the private sector.

Routine dental treatment is free for children and adolescents under 16 years of age, and up to 18 years of age, providing an adolescent is still at school. The majority of primary and intermediate school children in the zone access oral health services through school-based clinics. At present, adolescents in the zone who attend high school can enroll with dentists in the 'private' sector, who are currently funded by the public sector to provide free basic oral health services to adolescents. However, adolescents and their families are not always aware that these services are available or which dentists in the community are contracted to provide free adolescent services.

### Pre-School Dental Health

As part of the School Dental Service, the Waitemata DHB fund oral health services for pre-school children between 2 ½ - 4 years, or until school entry. Although children aged less than 2 ½ years may be enrolled in the service, they are generally not seen until they are aged 2 ½ years.

Health education for good oral hygiene and prevention of caries is vitally important for parents/caregivers of children in this age group. Research shows that pre-school children who have caries are significantly more likely to have more caries when they attend school compared to pre-school children who are caries free (Wendt et al, 1999).

Data for pre-school children has been collected since 1999. Table 53 shows the percentage of pre-school children in the Auckland region enrolled in the school dental service, by ethnicity, between 1999 and 2000. Note that there was no data available for Pacific children in 1999.

**Table 53: Percentage\* of pre-school children enrolled with the Auckland Regional School Dental Service, 1999 and 2000**

Ethnic Group	WDHB		ADHB		CMDHB		All Auck Region	
	1999	2000	1999	2000	1999	2000	1999	2000
<b>Maori</b>	6.9%	15.9%	12.6%	20.0%	16.1%	24.3%	12.7%	20.9%
<b>Pacific</b>	N/A	13.9%	N/A	23.8%	N/A	27.5%	N/A	23.7%
<b>Other</b>	35.3%	39.6%	34.1%	36.8%	45.3%	43.2%	37.8%	39.8%
<b>Total</b>	N/A	26.6%	N/A	26.3%	N/A	27.1%	N/A	25.3%

\*percentages were calculated using denominator numbers from population projections for 1999 and 2000, based on medium assumptions, generated by Statistics New Zealand.

Data Source: Galgali & Jack, 2001.

The Table shows that approximately 25 percent of children in the region were enrolled in the service in 2000. The enrolment rates for Maori and Pacific children were considerably

lower than the rates for children from ‘other’ ethnic groups. However, it is encouraging to see that the percentage of Maori enrolments increased between 1999 and 2000 from 12.9 percent to 20.9 percent.

There is an ongoing need for oral health education programmes in the region, especially in areas where oral health status is very poor. Access to private dentists remains costly and data from the 1996/97 Northern Region Health Survey indicates that the biggest barrier that prevents people accessing a dentist is cost.

The locations of various oral health services in the Auckland region are provided in Appendix III.

### Oral Health Status in School Children

The number of decayed, filled or missing teeth in children and the percentage of the population that are caries free are common measures of child population oral health status. These measures are presented in this section as indicators of child health status in the Auckland DHB zone.

Table 54 shows the percentage of five-year olds who were caries free in the region between 1998 and 2000. The figures for each of the three Auckland DHBs between 1998 and 2000 were consistently higher than the figures for the all New Zealand population, indicating a higher level of health status among five-year-olds in the Auckland region, compared to five-year-olds in the all New Zealand population. The figures for the Auckland DHB zone consistently fall between the figures for the Counties-Manukau DHB and the Waitemata DHB zones. The figures for the Auckland DHB also appear to be increasing overtime, indicating an improving level of oral health status for young children in the population.

**Table 54: Percentage of 5-year-old children caries-free, in the Auckland region and NZ, 1998-2000**

Year	WDHB	ADHB	CMDHB	All Auck Region	NZ
1998	65.5%	59.0%	53.5%	59.3%	53.6%
1999	64.2%	65.5%	55.1%	61.3%	52.0%
2000	65.9%	60.3%	54.3%	60.2%	52.0%

Data Source: Galgali & Jack, 2001.

Table 55 shows the average number of decayed, missed, or filled teeth (dmft) in five-year-old children in the region between 1998 and 2000. As can be seen, the figures for the Auckland region for the years presented are consistently lower than those for the all New Zealand population, again indicating that the level of health status among five-year-olds in the Auckland region, is higher than that for five-year-olds in the all New Zealand population. Once again, the figures for the Auckland DHB zone consistently fall between the figures for the Counties-Manukau DHB and the Waitemata DHB zones. The average number of decayed, missed, or filled teeth in five-year-old children in the Auckland DHB also appears to be decreasing overtime. Similar to the trend in ‘children caries-free at five

years', the data in Table 55 indicates an improving level of oral health status for young children in the population.

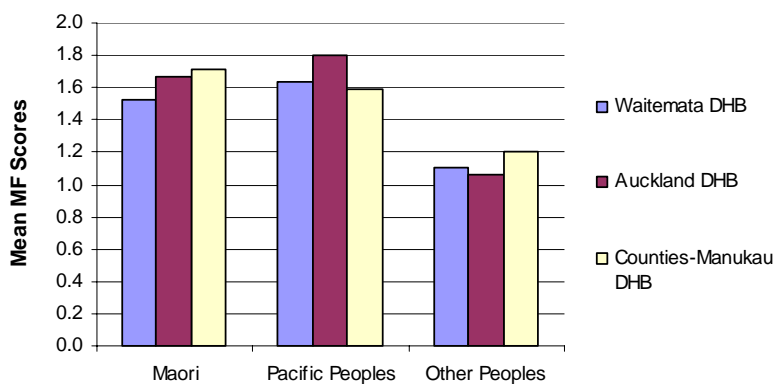
**Table 55: Average decayed, missed, filled teeth, in 5-year-old children, in the Auckland region and NZ, 1998-2000**

Year	WDHB	ADHB	CMDHB	All Auck region	NZ
1998	1.27	1.60	1.70	1.55	1.86
1999	1.30	1.50	1.80	1.51	1.91
2000	1.23	1.56	1.80	1.53	1.77

Data Source: Galgali & Jack, 2001.

The data presented in Figure 55 presents the average number of filled or missing teeth (MF score) at Form II (age 12 years), for children residing in each of the three Auckland DHBs.

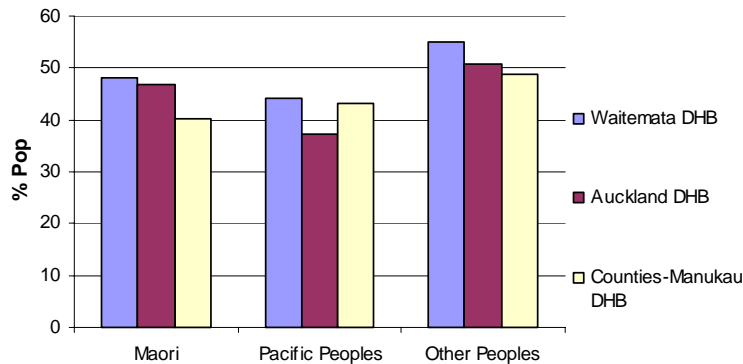
**Figure 55: Mean MF scores at Form II by ethnicity, for Auckland region DHBs**



Data Source: Waitemata Health Ltd, 2000.

As can be seen in the graph, Maori and Pacific Form II children in the Auckland region have mean MF scores that are considerably higher than the mean MF scores for children from other ethnic groups in the region. This suggests that both Maori and Pacific children have more missing and filled teeth, on average, than children from other ethnic groups. The average MF scores among Pacific children in the Auckland DHB zone are of particular concern, as these children appear to have the highest rates of any group presented.

**Figure 56: % Children Caries Free at Form II by ethnicity, for Auckland region DHBs**



Data Source: Waitemata Health Ltd, 2000.

Figure 56 shows that the percentage of Maori and Pacific children that are caries free at Form II in the Auckland DHB zone is low compared to children from other ethnic groups. The figure for Pacific children residing in the Auckland DHB zone is the lowest figure presented in the graph, indicating these children have the poorest health status using this measure, and thus, the highest health need.

*Water fluoridation and oral health status in children*

There is a wide body of literature supporting water fluoridation as one of the most cost-effective measures for improving oral health among children. The Regional School Dental Service actively promotes water fluoridation in the media and there are a number of public health initiatives in the region promoting the fluoridation of water.

**Table 56: Water fluoridation and the oral health status of 5-year-olds and Form II children in Auckland, 2000**

Fluoridation status	5-year-old children		Form II children	
	% caries free	dmft	% caries free	MF
<b>Non-Fluoride</b>	57.8%	1.73	48.1%	1.34
<b>Fluoride</b>	60.5%	1.50	48.9%	1.27

Data Source: Galgali & Jack, 2001.

Table 56 shows water fluoridation and the oral health status of children in the Auckland region in 2000. As can be seen, the percentage of children caries free was higher and the average number of decayed, missing or filled teeth was lower in five-year-olds living in fluoridated areas, compared to non-fluoridated areas of the region.

See the Public Health section of this report for details of areas in the Auckland DHB zone that do not have fluoridated water supplies.

**Service Utilisation**

**Table 57: Prevalence (% pop) of seeing a dentist in last 12 months by DHB and ethnic group, 1996/97**

	% Population
<b>DHB</b>	
North Shore	45.7
West Auckland	43.9
Central Auckland	41.9
South Auckland	37.1
<b>Ethnicity</b>	
European	45.6
Maori	33.5
Pacific Peoples	28.5
Other Peoples	35.7

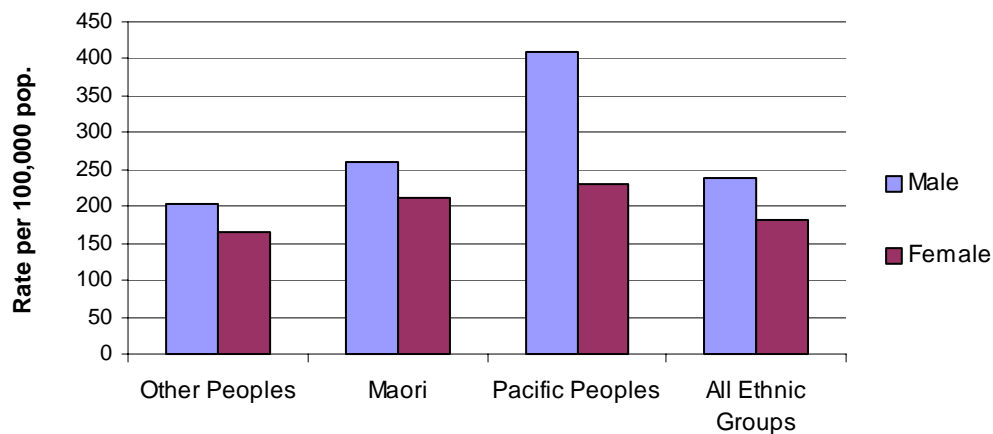
Data Source: Parr et al, 1998

Data available from the Northern Regional Health Survey (1996/97) is presented in Table 57. The table profiles the prevalence of seeing a dentist within a 12-month period by regional health district and ethnic group (for the region as a whole). As can be seen, a

greater proportion of residents in the North Shore and West Auckland health districts saw a dentist in the 12 months prior to interview in the survey, compared to other health districts in the region.

In addition, there were wide disparities between ethnic groups, as the proportion of Pacific peoples that saw a dentist in the 12 months preceding interview was very low in comparison to the figure for European peoples.

**Figure 57: Auckland DHB resident’s age-standardised oral health discharge rates, per 100,000 pop., by ethnicity and gender, 1999/00**



Data Source: NMDS

Figure 57 presents Auckland DHB resident’s hospitalisation rates for oral health conditions in 1999/00. The data is presented by ethnicity and gender. The most common diagnoses associated with oral health hospitalisations were dental caries, disturbances in tooth eruption, and abscesses. As can be seen, males had higher rates of hospitalisation than females, across ethnic groups. However, Pacific males had the highest rates of hospitalisation for oral health conditions in the population.

**Table 58: Average MF scores for children (Form II) by Auckland region DHBs**

	Maori	All Ethnic Groups
<b>Waitemata DHB</b>	1.53	1.18
<b>Auckland DHB</b>	1.67	1.27
<b>Counties-Manukau DHB</b>	1.71	1.38
<b>Total Auckland Region DHBs</b>	1.66	1.28

Data Source: Waitemata Health Ltd, 2000.

Although the national targets set out above were national targets set for 2000, data available on average MF scores in children at Form II in 2000 show that none of the Auckland DHBs attained the national targets (Table 58).

## National Targets for 2000

- ❑ *To increase the size of the population receiving fluoridated water to 70 percent of the population on reticulated water supplies by 2000;*
- ❑ *To reduce the average number of missing or filled permanent teeth in Form II children to one per child or less by 2000;*
- ❑ *To reduce the average number of missing or filled permanent teeth in Form II Maori children to 1.4 per child or less by 2000.*

Information on fluoridated water supplies to the Auckland DHB population in the Public Health section of this report indicates that greater than seventy percent of the population receive fluoridated water. Thus the first national target listed in the box above was met in 2000.

From the analysis of data presented here on child oral health status, it appears that Maori and Pacific children in the Auckland DHB zone have poorer health status compared to children from other ethnic groups. In particular, Pacific children in the Auckland DHB zone appear to have the poorest oral health status of any group in the region and this is of particular concern.

### Key Issues:

- ❑ Need to plan to accommodate future growth in the population, adolescent services, increasing demand for Relief of Pain services overtime etc;
- ❑ There is a need for dental health education programmes and educators;
- ❑ Cost is the major barrier to accessing private dental services;
- ❑ Maori and Pacific children in the Auckland DHB zone have poorer oral health status than children from other ethnic groups;
- ❑ Pacific children in the Auckland DHB zone appear to have the poorest oral health status of any children in the Auckland region;
- ❑ Available data suggests that Pacific peoples see the dentist less often than other peoples in the region;
- ❑ The Auckland DHB did not meet all of the national targets for oral health in 2000;
- ❑ Onehunga and the Hauraki Gulf Isles are the only areas of the Auckland DHB with non-fluoridated water supplies – approximately 20-21,000 people.