

Auckland District Health Board
Mental Health and Addiction Services

District Service Development Plan 2006–
2011

DRAFT

Feedback Form

Mental Health and Addiction Services District Service Development Plan 2006–2011

We want to know your views on the issues and strategies that we have developed to deliver a stronger response to the mental health and addiction needs of the population of the Auckland District. This paper contains a number of questions regarding the proposed direction within the plan. Please use these as starting points to convey your view of our intentions.

The questions are a guide only, you do not have to complete all or any of them in order to provide us with your views.

All feedback will be collated and summarised. Once the feedback has been analysed, and any changes made to the plan, it will be submitted to the Auckland District Health Board for approval.

Please forward your feedback to:

Henry Harrison
C/- Mental Health – Planning and Funding
Auckland District Health Board
PO Box 92189
Auckland

Please supply the following information with your feedback

Name:
Postal Address:
Phone:
Email Address:

And where the feedback represents the views of a group or organisation:

Organisation:
Your role:

Feedback may be made available to others (individuals and organisations) in both summary and collated form, in order to assist the planning process.

Vision

Auckland District Health Board working with others from across the Mental Health, Addictions and related sectors has developed this plan.

Our vision is to achieve environments and services that support mental wellness, reduce mental illness and enable sustained recovery.

Our focus is on improving outcomes across the continuum of wellness and illness and developing a whole-system view of mental health needs and services.

Any ideas for a title for this Plan?

What do you think about the vision?

We Will...

- ❖ Complete the development of a full continuum of mental health and addiction services, client focused and recovery oriented, across the life span
- ❖ Improve collaboration across the primary to acute interface to support early identification of problems
- ❖ Reduce progression to serious disease and support recovery
- ❖ Improve access to housing, employment and education to improve recovery and reduce stressors that contribute to acute illness
- ❖ Improve the knowledge and capacity of families/whanau to support mental illness and sustain mental wellness
- ❖ Develop the capability of specific services to meet the needs of Maori, Pacific and Asian people
- ❖ Improve service information and service access for the 20 percent of people who experience mild to moderate mental illness and their families/whanau
- ❖ Develop sustainable service designs across the continuum that function in an era of restrained workforce availability
- ❖ Identify and develop new career paths and workforces able to support mental health outcomes
- ❖ Review and develop improved services for children and young people, including:
 - School based services
 - Addiction service integration
 - Services that better cater for different age groups

Do you have any comments about this section?

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Executive Summary

Mental health and addiction service development over the past decade has concentrated on improving the quantity, quality and range of specialist services. That has contributed to a substantial improvement in service delivery.

This plan addresses service development over the next decade, the period 2006 – 2011. The *District Service Development Plan* provides the path whereby all mental health and addiction providers in the Auckland District can contribute to improved health outcomes and reduced disability for the Auckland population. All Auckland metropolitan District Health Boards (DHBs) fund and provide regional mental health services, and the plan acknowledges that, while focusing on the development of services specifically for the local Auckland population.

During the period of this plan, the opportunity exists to complete secondary service development and ensure a full continuum of mental health and addiction services, from promoting healthy populations to improving primary mental health service delivery and the opportunities for sustainable service user recovery.

Our goals are to:

- ❖ Improve service delivery across the continuum
- ❖ Support choices that sustain mental health
- ❖ Improve service responsiveness to population needs
- ❖ Improve access to quality services
- ❖ Redesign services to achieve required outcomes despite predicted constraints on workforce availability
- ❖ Develop services for children and young people

The plan has been developed with contributions from a wide range of people and organisations interested in mental health and addiction services, through the support of the Local Stakeholder Network. Implementing the plan will be the task of the Service Development Group.

Our key challenges are to improve the continuum of care through enhancing links with primary care, and meeting the need for robust outcome oriented measurement development, in order to evaluate the delivery of improved services against the plan. We all have a role to play in lifting the Mental Health of Aucklanders.

Context – Lifting the Health of people in Auckland city



One of Auckland District Health Board's (ADHB's) key strategic goals is to 'Lift the Health of the People of Auckland City'. This goal is being implemented through a district-wide planning process called *Our Health 2020*.

Our Health 2020 supports a whole system/whole society view of health and it takes a long term approach, seeking to set in place the foundations for improved community health and quality healthcare.

Our Health 2020 has defined five key outcomes to focus activity in the medium term. These are:

- Improve healthy lifestyles and environments
- Reduce the incidence and impact of long term conditions
- Reduce inequalities in health outcomes
- Achieve NZ Primary Healthcare Strategy system change
- Support appropriate use of hospital services

Developing Auckland's mental health and addiction services is one of the key objectives of the *Our Health 2020* initiative.

Developing Auckland's Mental Health and Addiction Services

The aim of health and disability service funding is to make a positive difference in the health and well being of people. To do that, we have to continue to increase people's access to services, and be able to demonstrate positive outcomes from the services we fund and provide. National and local work on developing measurable outcomes is underway, though by no means concluded as yet.

Government commitment to funding the Blueprint mental health targets by 2010 provides us with the opportunity to plan for a continuum of mental health and addiction services that truly meets the needs of Aucklanders. That continuum ranges from population health initiatives that address such public health issues as problem gambling or suicide, through access to mental health expertise by citizens and primary health practitioners, to a focus on living a life worth living while experiencing serious mental illness or addiction.

During the development of the Northern Mental Health and Addictions Services Strategic Directions 2005-2010 document¹ service users and others told us what they want to see in the following vision²:

A community that empowers us to live enriched lives where all people with experience of mental illness or addiction³ in the Northern Region have personal power, easily accessible quality services that support us to lead our own recovery, and a valued place in our families/whanau and in our community.

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

That vision was based to a considerable extent on work done by service users nationally to inform the development of *Te Tahuhu - the Second National Mental Health and Addictions Strategy Plan 2005-2015*⁴, which sets the national

¹ Northern Region Mental Health & Addictions Services Strategic Direction 2005-2010, NDSA & Network North Coalition 2004

² This vision is based in part on the vision developed nationally by people with experience of mental illness as a basis for the second National Mental Health Plan. People with experience of mental illness in the northern region have subsequently endorsed the national vision at their regional caucus.

³ The term people with experience of mental illness is an inclusive term used by people who are challenging stigma and discrimination in respect of mental health and addictions.

⁴ *Te Tahuhu - the Second National Mental Health and Addictions Strategy Plan 2005-2015*, Ministry of Health 2004.

framework to take all of New Zealand's mental health services forward over the next ten years.

This plan gives us the opportunity to take the commitment of a fully funded mental health and addictions service, and turn that commitment into the delivery of a full continuum of services, centred on the needs of its clients, focused on the recovery of those who live with the effects of mental illness, and leading to a healthier population in Auckland City.

Mental Health in New Zealand

Like many other developed nations, New Zealand had undertaken a number of reviews and inquiries into mental health service delivery during the 1970's and 1980's. These were prompted by adverse incidents affecting service users, and general perceptions that services were run down and inadequate. In order to address some of these issues and to provide national leadership and direction, the Ministry of Health commenced the current cycle of mental health planning in the early 1990's leading to the publication of *Looking Forward*, the first national mental health plan, in 1994.

In 1996, an Inquiry that became known as the second Mason Inquiry was commissioned by the government to look at the availability and delivery of mental health services in New Zealand. The Inquiry was a defining moment, and its findings set the scene for the significantly improved mental health and addictions services we have today. Findings identified included that the sector was under funded; there was a lack of co-ordination between and across services; there was poor service delivery to Maori; there was a lack of services for children and youth; there were major workforce issues particularly recruitment, retention and training; and the importance of a public awareness campaign. As a consequence of the Mason Inquiry, the Mental Health Commission was established to monitor and report to the Minister of Health on the performance of the whole mental health sector.

The Blueprint, published in 1998 by the Mental Health Commission, provided a plan for a well functioning mental health system, which ensured adequate and appropriate treatment and support for those more severely affected by mental illness in order to achieve the objectives of the government's National Mental Health Strategy. It was anticipated that the Blueprint would be used to guide funding decisions and used by providers to assess where further developments were required in their current services and practices.

The Blueprint set out a framework, key parameters, and principles for good service, and indicated how the detail should be determined from the bottom, starting with consideration of local needs and preferences. It was based on the recovery approach in the delivery of services and the importance of respect for the rights and recognition of equality, in the recovery of mental illness for not only the service user, but those around them as well.

It set out targets for access of 3 percent of the total population over any six month period, and what that access should consist of in terms of services that are required by different groups of people and what resources are required to provide those services. The services range from inpatient care, to community support, to mental illness prevention depending on the needs of the local population.

This strategic direction, together with government commitment to funding the Blueprint, has contributed to the significant improvement in the quantity of service delivery over the past decade. However the targets have not been completely achieved and there is still a way to go, both in financial and resource terms. The changes to population mix and growth provide challenges for providers, as the targets keep moving.

The access targets in the Blueprint were translated by funders into input based targets, primarily bed and staff numbers. These had the advantage of being simple to measure, and were an easy way of ensuring increases in funding translated into increased availability of service. However, two things limit the value of input targets:

- A levelling off in improvement in access rates, in spite of continued increases in funding
- A lack of effectiveness measures

Process – Whole-Sector Collaboration

Sector input into the planning process has provided a rich range of service development possibilities. Between July and October 2005 there were ten workshops/group meetings held to discuss service improvement and development with a wide range of stakeholders across the sector. Included were:

- ADHB staff and management
- NGO staff and management
- Service Users
- Family and Whanau
- Pacific, Maori and Asian Stakeholders

Collaboration by the funders, the DHB provider, and the NGO sector, engagement with the people who use and rely on the services, and those who work within them, and building a workforce and workplaces that deliver valued services are within our immediate reach.

Identifying the problems

Auckland's population is changing. While it continues to grow steadily, the significant change effecting health service delivery over the next ten years is the change in mix of age groups.

The following graph shows the change in projected age distribution of the Auckland District Population in 2006 and 2016, based on the 2001 census, using the medium projection.⁵

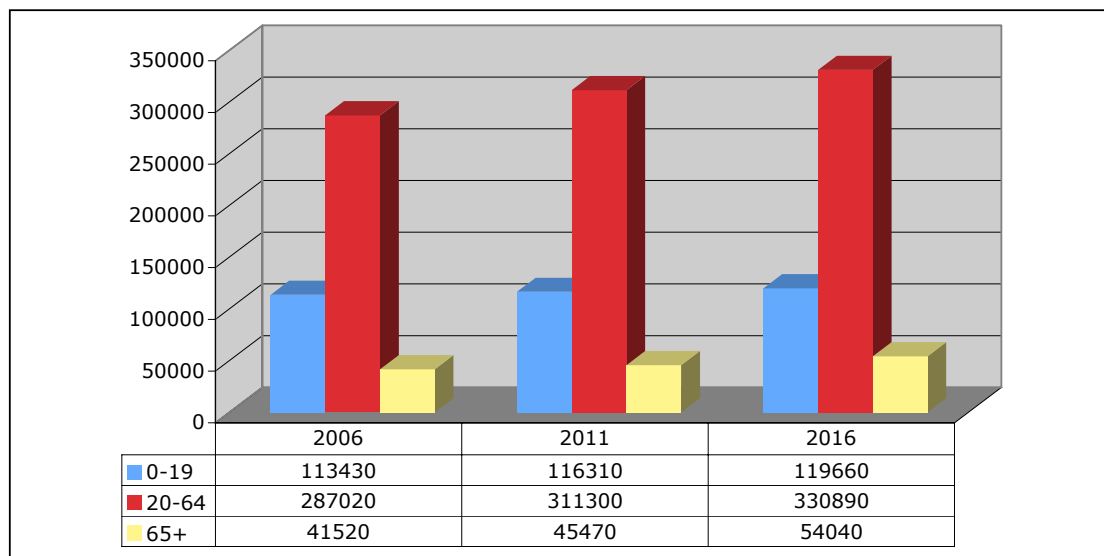


Figure 1: Change in Age Distribution ADHB Population 2006-2011

The younger and older age groups are significant consumers of health services. While the younger age group (blue) shows a significant decline as a proportion of the total population, the older age group (yellow) shows a significant rise.

The key change that impacts on our strategic planning over the next five to ten years, however, is the increase in proportion of the dependency age groups versus the working age group. Auckland Districts working age population is expected to increase at about 15.5 percent over the ten-year period. However, the population aged 65 and over, will increase by about 30 percent over the same period. While we can expect some gains in terms of older people's healthier status, we can also expect larger numbers of older people living to a greater age, and therefore increased health need. Effectively then, on a strictly population basis, we are faced with a growth in older people's mental health and addiction needs at about twice the rate of increase of potential workers.

⁵ Medium fertility, medium mortality, medium migration

Mental Health Needs

Auckland District Health Board has been undertaking a detailed Health Need Assessment since July 2005. The first completed sections reviewed disease risk factors, deaths and hospitalisations for the period 2001-2004 for Auckland population. Analysis has highlighted the most significant health priorities for ADHB, and mental health problems are included in these.

Further work is underway and detailed mental health needs analysis is included in this additional work. Details of the Health Needs Assessment can be obtained from <http://www.adhb.govt.nz/healthneeds>.

Regional analysis of the needs of people with significant mental ill health has been undertaken using the Camberwell Assessment of Need tool, a follow up to a previous assessment undertaken in the late 1990s. This analysis will inform the development of additional secondary mental health services.

The New Zealand Mental Health and Wellbeing Survey, Te Rau Hinengaro is due to report in 2006. This national survey is the first conducted in New Zealand to gather information about how many people experience problems with their mental health. It is expected to provide considerable information about the numbers of people in New Zealand who experience mental illness.

Service Utilisation Differences

While the age mix in the Auckland population is expected to change significantly, the ethnic mix remains more consistent, with the largest shift being the growth in the Asian population. Those populations that have substantially worse health status than the average, Maori and Pacific, remain at similar proportions of the total population.

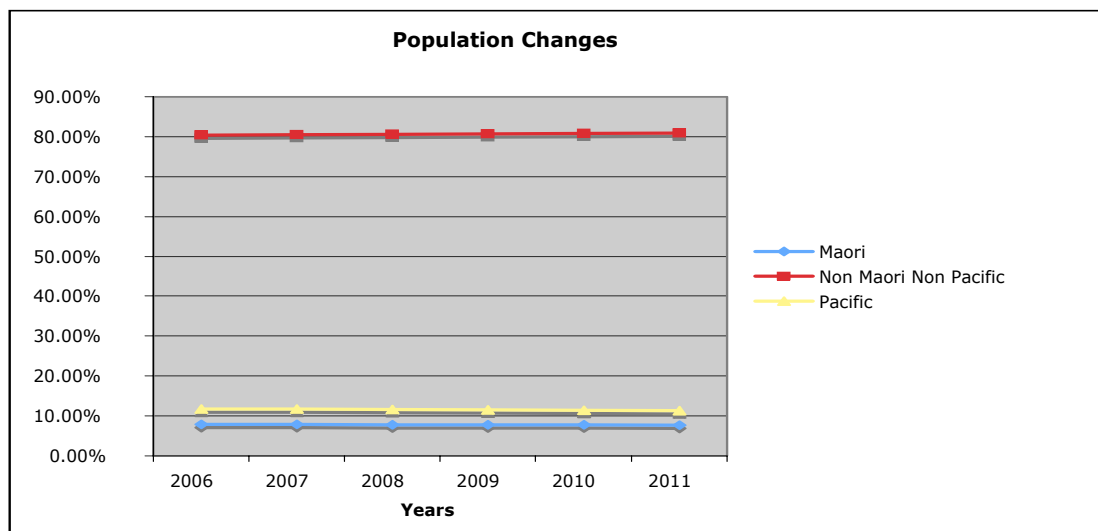


Figure 2: Change in Ethnic Mix ADHB Population 2006-2011

Previous epidemiological studies in many parts of the world indicate that populations generally have similar levels of serious mental illness. We know that Maori and Pacific people access primary health services at lower rates than their non-Maori, non-Pacific counterparts. However, Maori are using secondary mental health and addiction services considerably more often than their non-Maori, counterparts.⁶

Population	Utilisation Rate
Maori	2.18%
Pacific	1.00%
Non Maori Non Pacific	1.69%

Table 1: Auckland District Health Board – Clients Seen 2002

The projected utilisation of secondary mental health services as the Blueprint targets are reached over the next five years have very different impacts for different populations.⁷

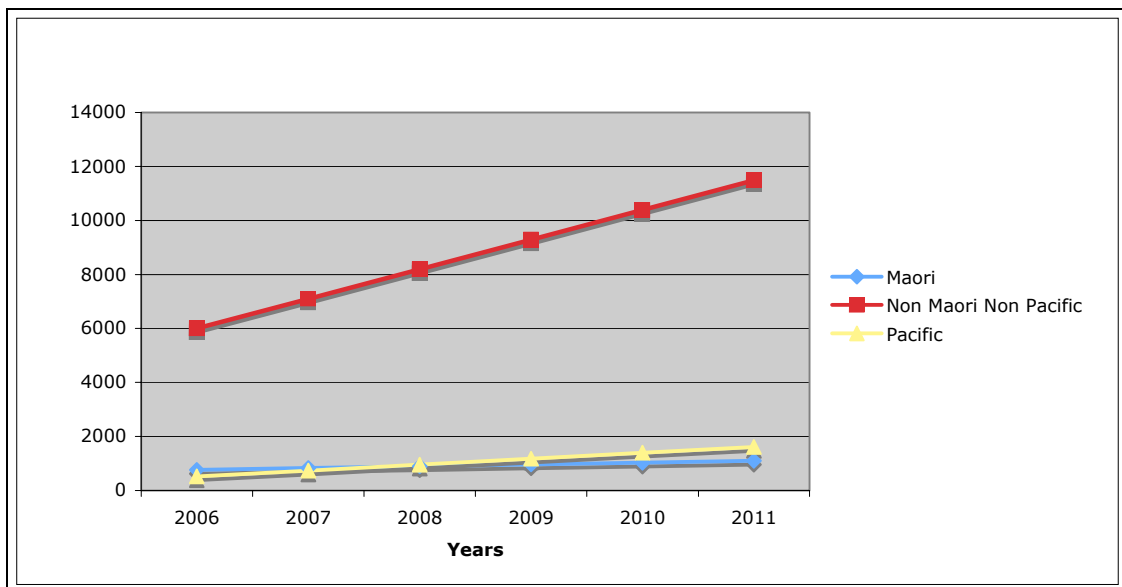


Figure 3: Projected Change in Utilisation by Ethnicity as Blueprint Targets Reached

A comparatively small increase in secondary service access will result in Maori people reaching the Blueprint target level of service whereas the remainder of the population would need to increase access two to threefold to meet the target.

⁶ New Zealand Health Information Service. 2005. Mental Health: Service Use in New Zealand 2002. Wellington: Ministry of Health.

⁷ Projected achievement of target at constant rate over next 5 years, base utilisation applied to 2006

However, the current disparity in utilisation rates of secondary services is unlikely to change without a change in the way we approach service delivery. We cannot expect Maori access rates to secondary services to level off without a much greater focus on the primary health end of the service continuum. The need for innovative primary health interventions is clear, or the current disparity in access rates will persist, even in the face of increased secondary resources.

Pacific people would need to triple their current secondary service access to reach Blueprint targets for utilisation. Innovative community based solutions will be needed in order for Pacific people to access mental health and addiction services to the level consistent with the needs of their population.

Significant Service Issues

The delivery of services to children and young people remains an area of significant difficulty. Staff availability remains significantly less than adult services, and the preponderance of staff and service development has been in the clinical and specialist areas. Potential for broadening the workforce base exists, but will face significant challenges. Analysis of the service delivery system for children and young people undertaken by the Service Development Group indicates several areas of possible system improvement. These include:

- Time delays – improving service user and family/whanau knowledge of access points and system entry.
- Inappropriate referrals – improving primary – specialist communications and clarifying accountabilities.
- Gaps in services – resolving accessibility and suitability issues
- Local environment impacts on recovery –improve school and family/whanau knowledge and interventions.

Priorities for Mental Health

Te Tahuu sets out ten challenges that the nation faces in improving mental health services over the next ten years. Each of these challenges impacts on the Auckland population in different ways and extents. Regional⁸ and Local Planning work has identified a range of issues that must be addressed in order for us to achieve a full continuum of robust mental health and addiction services.

1. Promotion and prevention

Promote mental health and wellbeing and prevent mental illness and addiction

We must...

- raise awareness, understanding and practical support among families, friends and communities

2. Workforce and culture for recovery

Build a mental health and addiction workforce – and foster a culture amongst providers that supports recovery, is person-centred, culturally capable, and delivers an ongoing commitment to assure and improve the quality of services for people

We must...

- increase the quantity, quality and range of the available mental health workforce

3. Responsiveness

Build responsive services for people who are severely affected by mental illness and/or addiction

We must...

- ensure regionally consistent access to quality services

4. Building mental health services

Build and broaden the range and choice of services and supports, which are funded for people who are severely affected by mental illness

We must...

- implement regional sustainable strategies based on strong leadership and collaborative planning to improve health outcomes, improve the quality of existing services through service makeover and establish new services

5. Transparency and trust

Strengthen trust in services and accountability and information systems

We must...

- develop robust infrastructure to support service delivery

⁸ Northern Region Mental Health & Addictions Services Strategic Direction 2005-2010, NDSA & Network North Coalition 2004

6. Addiction

Improve the availability of and access to quality addiction services, and strengthen the alignment between addiction services and services for people with mental illness

We must...

- deal with increasing alcohol and other drug use in increasingly innovative ways to meet the growing needs

7. Maori mental health

Continue to broaden the range, quality and choice of mental health and addiction services for Maori

We must...

- be innovative to combat the high youth suicide rate among males, particularly young Maori men

8. Primary health care

Build and strengthen the capability of the primary health care sector to promote mental health and wellbeing and to respond to the needs of people with mental illness and addiction

We must...

- increase collaboration to deliver services to people with mild to moderate mental health conditions, which could be provided through primary health and counselling services

9. Working together

Strengthen cross-agency working together

We must...

- build relationships and increase collaboration in order to provide more effective and efficient services

10. Funding mechanisms for recovery

Develop and implement funding mechanisms for mental health and addiction that support recovery, advance best practice and enable collaboration

We must...

- use funding to produce more and better services, that better meet the needs of those people with experience of mental illness or addictions, according to agreed regional priorities

Are there other important issues and priorities for mental health we should focus on?

Mental Health Service Development in Auckland

A series of workshops and meetings with Auckland people who use or work within mental health and addiction services has identified a range of issues that impact on our ability to deliver services. These have been broadly grouped under three headings.

Leadership

The development of improved mental health services across the continuum will require leadership from a diverse range of organisations and individuals. The role of ADHB is to foster an environment where leadership can flourish. For ADHB to have effective leadership, people must be engaged in the process so that they can claim ownership and are prepared to follow. It must be a multi levelled and collaborative approach to make the most of all resources available to reach the desired health outcomes.

The main impact on the health of the population is generally not solely achieved through the activities of the health system. Other systems and entities such as: Welfare or Housing Agencies, Families or Friends, are likely to have more significant impacts. A health agency such as ADHB working with an entity such as Housing NZ would be able to achieve improvements in both the housing and health status of Aucklanders with mental illness where they could not do so alone, which allows for more effective leadership by ADHB in an increasingly changing environment.

ADHB is supporting the new Mental Health Service Development Group (a group of NGO representatives, DHB funders and the DHB provider) to enable improved communications, service design and collaborative action across the sector.

Responsiveness

Public expectations of their health services, both culturally and individually, have grown substantially over recent years as technical improvements have increased the health sector's ability to deliver those services. Technical improvements and changes in population (increased age, increased cultural diversity) have led to greatly increased complexity in service delivery.

“Top down” solutions have been found to be not effective. Flexibility and delegation are needed to enable flexible and rapid responses. However, extra complexity also increases risk through a necessary decrease in central control. Improved cross-sector engagement is required to support a more responsive system.

The public demands focused and responsive services that are designed to meet individual needs. However, public and professional perspectives on satisfactory health outcomes are often different and our services are challenged to respond effectively to deliver both. These multiple dimensions of responsiveness and

quality will only increase as mental health services expand to encompass primary care.

Sustainability

A health service relies on its workforce and its funding to sustain its delivery. Both of these areas provide significant challenges. The health workforce is an aging one, for example the average age of a New Zealand nurse is forty-one. New Zealand is in a period of record low unemployment.

Increasing competition in the labour market impacts in many ways. Health professionals are attractive in an international market. Young people have a diverse range of career choices and many are choosing careers other than health. The impact is not all negative; however, people who have previously found difficulty entering the workforce, such as mental health service users, are finding employment easier to obtain in some instances. The tertiary service is continually recruiting overseas to maintain its skill base and capacity.

Three funding issues affect the sustainability of services:

- ADHB provides a range of tertiary services nationally and does not recover the full cost of these leading to operational funding deficits
- Some DHBs are also experiencing increases in mental health funding while their service delivery and access indicators are not showing a consequent increase
- In addition, the complexity of operating in an urban environment, where the population receives services from three separately funded DHBs, means that a focus on the costs and payment of service delivery between DHBs is critical
- Service change and reconfiguration is likely to occur in the next few years due in part to changes in the funding and service delivery environment

Are there other important issues that impact on our ability to deliver services?

Reducing Inequality

Maori health

Improving Maori health outcomes requires addressing many of the same issues as for the general population, however, looking at those same issues from different perspectives may allow for services to be delivered and accessed more effectively. There is a strong call from Maori for some significant changes to the health sector to focus on the whanau, not the individual, and to take a broader view of health than the medical model (Te Taha Tinana, Te Taha Wairua, Te Taha Whanau, Te Taha Hinengaro).

Improving Maori health requires a more supportive and responsive mainstream health system and also the continued development of the Maori provider sector. The Maori providers should be supported to take a greater leadership role and to trial new service designs that are effective for Maori, especially in relation to whanau-based care and empowering strong whanau.

An identified leading challenge is continuing to broaden the range, quality and choice of mental health and addiction services for Maori – with immediate emphasis on:

- Enabling Maori to present earlier to mental health and addiction services
- Promoting choice by supporting the implementation of Maori models of practice
- Increasing Maori participation in the planning and delivery of mental health and addiction services for Maori

Work is underway to inform the Maori component of ADHB's Mental Health Action Plan. This component is entitled *Te Pou o Te Tahuhu*.

Pacific health

Improving Pacific health outcomes requires addressing the determinants of health, the performance of mainstream health services and the development of Pacific health providers. Pacific people also wish to see health services take a whole family approach. There is also an increasing desire from Pacific communities and health planners to take a settings-based approach to health services, focussing on the particular communities where a high proportion of Pacific people live and to work more strongly through the church environment as a way of supporting improved health knowledge, access to health services and lifestyle choices.

The settings-based approach is manifested in the Healthy Village Action Zone concept that is being developed by the ADHB Pacific Health Team. The action zones aim to support increasing Pacific community leadership in improving the determinants of health and in the responsiveness of services.

The Pacific Mental Health Service aims to become a stand alone Community Mental Health Centre. They intend to develop a primary/secondary and specialist continuum of care for Pacific clients and their families. Primary health links will be strengthened. A Pacific Community Mental Health Centre will provide a clear focus for clinical service delivery. Support services will be strengthened through the combination of community support and care package services.

Refugee health

Auckland has the highest number of resettled people from refugee backgrounds in any health district. Resettled people generally have high health needs as well as problems in accessing the New Zealand health system. 'Refugee' is a legal status conferred on entry to a country and is often erroneously equated with ethnicity. People entering New Zealand as refugees come from a range of ethnic backgrounds and cultures and often have had similarly traumatic experiences which have impacted on their physical and mental health.

Asian health

All people from the continent of Asia (in effect from the Middle East to Indonesia) are bundled together under the term 'Asian' in health analysis and planning. This definition is not useful as there are diverse backgrounds and health issues related to the various ethnicities that make up the current definition of 'Asian'.

'Asian Health' needs more detailed understanding of both the risk issues and cultural issues associated with providing responsive health services to people from the various parts of Asia, particularly in relation to mental health.

There should also be clarification of the expectations of new immigrant families regarding their responsiveness to New Zealand health institutions and New Zealand cultural norms. A better understanding of health issues for the various sub-groups of Asia will help improve health planning and the responsiveness of services.

Are there other important inequalities we should focus on?

Mentally Healthy Auckland

Developing an outcomes framework

Service development aims to improve the health outcomes for both service users and for the population at large. Service development should also produce health system outcomes whereby the system is able to function more effectively.

ADHB's *Our Health 2020* long-term high-level outcomes include the following:

- **Reduce inequalities in health outcomes** – eg. The physical health of mental health service users is poorer than that of the general population, health outcomes for Maori and Pacific people are worse than they are for the rest of the New Zealand population - mortality is up to 20 years lower for some diseases and conditions in these populations
- **Reduce the impact and incidence of long-term conditions** – eg. A focus on outcomes that are recovery oriented supports service users to lead fulfilling lives
- **Improve healthy lifestyles and environments** – eg. Working with young people to reduce the harm associated with drug and alcohol use, options for reducing smoking including smokefree mental health environments
- **Achieve NZ Primary Health Care Strategy System Change** – eg. Secondary services support primary health services to improve primary mental health access, also Maori and Pacific people do not get the same access levels (for illness/population) as do the rest of the New Zealand population
- **Support appropriate use of specialist services** – eg. Collaboration between clinical and NGO services help maintain service users in the communities of their choice

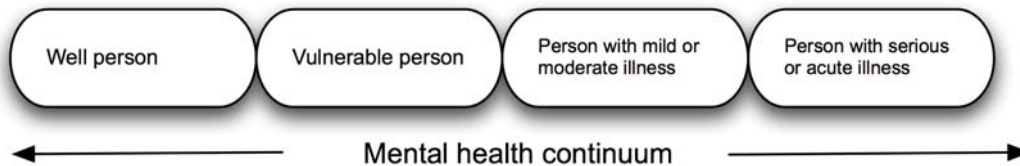
The mental health and addiction examples illustrate the extent to which the high level outcomes apply to many different people, and that the needs of people with mental health and addiction issues are similar to those we all share as citizens.

The Ministry of Health continues to work on the development of a national mental health outcomes framework. *Te Tahuu: Improving Mental Health* identifies a number of high-level outcomes for both people and services. In addition, the Ministry has worked on developing service user level outcome measures with a view to moving towards more outcome oriented service funding and delivery.

Mental health and addiction impacts on all Aucklanders, and if we are to lift the health of Aucklanders, we need to address the whole range of service needs. The challenge of developing meaningful and measurable outcomes and performance indicators is one that the mental health and addiction sector is actively engaged in, and strongly supports.

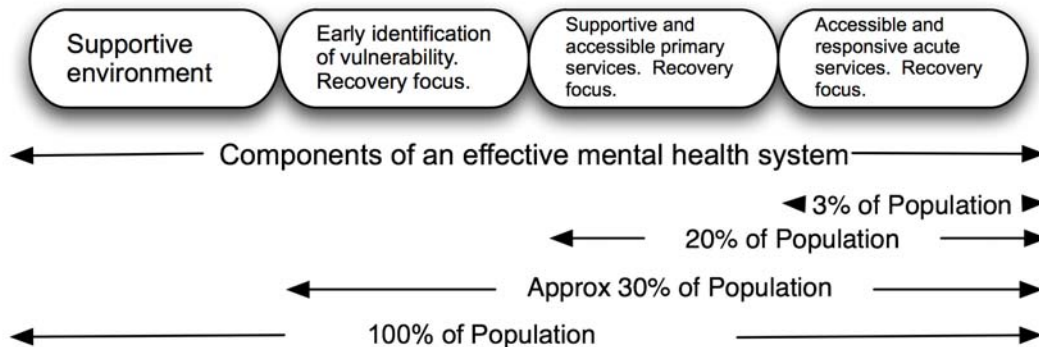
Our vision is to achieve environments and services that support mental wellness, reduce the progression to mental illness and enable sustained recovery.

To achieve this vision our focus is on improving outcomes across the continuum of wellness and illness and of developing a whole-system view of mental health needs and services.



A whole system view places the health consumer and their family/whanau at the centre of system design. A person with a mental health condition may experience different parts of the continuum at different points of their life.

The system needs a greater focus on early detection of illness, timely access to quality services and support for sustained recovery – at all points along the continuum.



Are our outcomes consistent with the priorities we are seeking to address?

ADHB developing goals for 2006 - 2011

To deliver improved mental health and addiction services across the continuum, we must work with a wide range of people and organisations, both within and beyond the health sector. Workshops and meetings with a wide range of people have contributed to a broader understanding of the challenges we face in the next five years. Solutions are available, and the solutions that arise from the process are ones that the participants can commit to.

The Service Development Group has considered the wide range of sector input and identified the following goals for developing a full continuum of mental health and addiction services.

A more detailed ADHB Mental Health Action Plan will be developed between July and December 2006.

Goal 1: Improve service delivery across the continuum

Key Actions:

- Improve collaboration across the primary-to-acute interface to support early identification of problems
- Improve service information and service access for the 20 percent of people who experience mild to moderate mental illness and their families/whanau
- Improve treatment and support within primary care to reduce progression to serious disease and support recovery

Outcomes:

- Early identification of mental health/addiction problems
- Reduce progression to serious disease
- Improve and sustain recovery
- Improving skill transfer from secondary to primary services

Action Example:

1. Develop support partnerships with primary mental health organisations to enhance clinical leadership and service delivery, provide opportunities for co-location, and link NGO and PHO service delivery
2. Improve the service interface for Older People (between Older Persons Health and Mental Health Services for Older People) with a focus on:
 - Population based health (including Mental Health) responsibilities
 - Need for support, irrespective of the diagnosis

Goal 2: Support choices that sustain mental health

Key Actions:

- Improve access to housing, income and education to improve recovery and reduce stressors that contribute to acute illness
- Improve the knowledge and capacity of families/whanau to support mental illness and sustain mental wellness

Outcomes:

- Improved living conditions
- Improved work opportunities
- Improved independence and choice
- Increased periods of sustained recovery
- Increased value of family support
- Improved self esteem and quality of life

Action Example:

1. Extend the current pilot that delivers the supportive landlord function to include the Eastern suburbs and if successful expand volumes
2. Fund an NGO support services collaborative model of delivery where support is delivered under one umbrella, by several organisations working together

Goal 3: Improve service responsiveness to population needs

Key Actions:

- Develop the capability of specific services to meet the needs of Maori, Pacific and Asian people
- Maori population:
 - ADHB provides quality mental health and addiction services that meet the unique cultural needs of tangata whaiora and their whanau
 - Maori Mental Health Workforce Development
 - Centre of Excellence for Maori Mental Health and Addiction Services
- Pacific population:
 - Pacific Mental Health Service to become a stand alone Community Mental Health Centre by 2010 - with an agreed service delivery model that addresses cultural and clinical competencies
 - Development of a Primary/Secondary and Specialist continuum of care for Pacific Clients and their families
 - Alignment of community support work and packages of care contract

Outcomes:

- Improved service access for specific groups
- Improved clinical outcomes for specific groups
- Develop new career pathways in Mental Health that reflect the needs of a diverse population

Action Examples:

1. Develop a Trans-cultural Resource Centre, serving as a resource to enhance mainstream service provision to the diverse communities and cultures of Auckland
2. Develop a plan between ADHB mental health services and Tamaki PHO for primary mental health and rongoa services for tangata whaiora and whanau, to be delivered from Whatua Kaimarie

Goal 4: Improve access to quality services**Key Actions:**

- Develop a framework that identifies clear desired mental health outcomes across the continuum and develops indicators that enable improved measurement of service and sector performance
- Improve the scope and level of evaluation of DHB and NGO programmes and support a learning-based environment through a service learning network
- Set up a 'health innovations' process
- Develop a health innovations fund that is designed to support and evaluate new service models
- Scope mental health DHB/NGO team approach
- Access to a single electronic file by DHB/NGO/PHO, with service user project management and design input
- Broaden outcomes to include employment, education and housing for mental health clients
- Improve data collection and utilisation

Outcomes:

- Develop climate of innovation and continuous quality improvement
- Improve care pathways
- Improve outcome focus and measures
- New areas of service development
- Use of data to improve targeting

Action Examples:

1. Encourage joint co-location of services (welfare, housing, mental health) in agency offices

2. Work with Regional Addictions Services to improve service coordination and delivery

Goal 5: Redesign services to achieve required outcomes despite predicted constraints on workforce availability

Key Actions:

- Develop sustainable service designs across the continuum that function in an era of restrained workforce availability
- Use of Audit or structured review to identify underperformance
- Develop quality accreditation
- Identify and develop new career paths and workforces able to support mental health outcomes

Outcomes:

- Services that are integrated across the continuum
- Quality services are maintained despite significant constraints on workforce availability
- Newly defined positions and career paths in mental health
- Review and restructure of existing services

Action Examples:

1. Expand the professional workforce – immigrant health expertise, tap existing expertise, and assist in further health career development
2. Partner with educational institutions – internships
3. Targeting older adults for health careers, such as Community Support Workers
4. Partnering with communities to identify workforce – Maori, young people, Pacific and migrants

Goal 6: Develop services for children and young people

Key Actions:

- Review and develop improved services for children and young people, including:
 - School services
 - Alcohol and drug integration
 - Services that better cater for different age groups
 - Children Of Parents with Mental Illness (COPMI)
 - Infant services

Outcomes:

- Improved identification of illness in childhood
- Improved post diagnosis education and service provision
- Improved support for high risk young people, leading to reduced suicide
- Improved outcomes for people with alcohol/drug/mental illness co-morbidities

Action Examples:

1. Implement a pilot youth focussed clinical service specifically to address the mental health and addiction needs of young people (including emancipated young people) by a combination of new resources and reallocation of existing resources
2. Trial a school based youth service through school/peer support/NGO partnership

Do our goals lead to the desired outcomes and address the established priorities and health needs?

Putting the plan into Action

Key Strategies

Achieving the goals that have been set for 2006 – 2011 will require a substantial change to many services. However, in many cases there is a strong foundation of existing services to build from – across DHB services, NGOs and primary care. While there are specific issues for each service, there are also some issues or themes that are important for all services in relation to improving mental health outcomes.

Critical to our ability to achieve the Blueprint outcomes is the need to increase access, which is potentially hampered by the issues of service responsiveness and availability of both replacement and additional workforce.

A second key issue is the need for meaningful engagement and consultation with mental health consumers around service focus, design and performance, and for this engagement to be embedded at all levels of delivery.

A third point is to acknowledge that health is a multi-faceted issue, and the health sector's contribution to improving the health of the population is not the only or even the most influential contribution. Therefore engagement with multiple sectors is required in order to establish what the critical issues are, how they can be addressed and to build solutions that will meet whole system Blueprint targets.

We propose three strategies to address the challenges we have identified, collaborate, engage, and build.

Collaborate

The challenge of leadership cannot be met in isolation; to lead is to work with others. The DHB must meet the challenge through modelling collaboration within the sector. Opportunities for collaboration are many, including inter-sectoral collaboration to tackle issues such as mentally healthy homes, and collaboration with the education sector to build and sustain the mental health and addictions workforce.

The existing Service Development Group, together with annual or six monthly sector workshops, allows the DHB to tap into the valued expertise that exists amongst our providers, service users, and others to ensure planned improvements happen, and future opportunities are taken up. Working together on shared problems ensures that all the parties are engaged in finding solutions.

Engage

Mental health and addiction services are often characterised as difficult to access, particularly by first time service users and their families. A strategy of engagement is proposed, through working with the primary sector, with different

cultures within our community, and with services that are seen as responsive to peoples needs rather than inaccessible.

Engagement is particularly crucial if we are to make headway in resolving issues of health disparity with the Maori community (and other under-represented communities such as those from the Pacific). The ADHB recognises that existing methods and strategies have not delivered the required improvements in Maori access to service, and the desired improvements in Maori health status.

Build

To meet current and future mental health and addictions needs within the Auckland population, successive governments have committed to investing money to meet Blueprint targets. We must use additional funding to build a sustainable workforce to meet those needs. Building will entail maintaining our current workforce, expanding the professional workforce, and broadening the workforce base.

Triple Strategy

The three strategies proposed provide a rationale for future service development, and a means of evaluating proposals and initiatives. However, the three strategies may prove most useful in a synergistic way, where the opportunities for applying each of them together are capitalised on.

Do our high level strategies provide a means of addressing the issues and needs we have identified?

Funding stream

The Northern Region has lagged behind the rest of the country in mental health funding for some time. An indication of the funding required to narrow that gap over the period 2005 -2010 was developed for the Regional Strategic Direction document.⁹ Increasing population pressure in the region contributes to the difficulty in closing the gap.

Year	05/06	05/06	05/06	06/07	06/07	06/07	07/08	07/08	07/08
	Baseline ¹⁰	PBFF	Blueprint	Baseline	PBFF	Blueprint	Baseline	PBFF	Blueprint
Child & youth	28.43	0.44	1.71	30.58	0.43	1.00	32.02	0.43	1.50
Older Persons	9.92	0.15	0.86	10.93	0.15	0.50	11.58	0.16	0.50
Addictions	23.46	0.36	1.71	25.54	0.36	1.20	27.10	0.37	1.00
Primary	-		0.86	0.86	0.01	0.30	1.17	0.02	0.00
General Adult	234.29	3.64	8.56	246.49	3.49	5.00	254.98	3.46	5.00
Infrastructure	0.16		10.00%			10.00%			10.00%
Total per year	296.26	4.59	13.70	314.39	4.45	8.00	326.84	4.43	8.00

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

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

Committing the increased funding as it becomes available has proved difficult at times, due to the unavailability of workforce issues noted earlier. ADHB has decided to defer the uptake of some Blueprint funding in the 2005/06 year, in order to fully commit existing funding. The deferred funding will be diverted to other DHBs in the region in the interim. However, as the closure of the Blueprint gap is a mechanism for ensuring populations get equitable access to mental

⁹ Northern Region Mental Health & Addictions Services Strategic Direction 2005-2010, NDSA & Network North Coalition 2004

¹⁰ Baseline is the amount of money available for a particular financial year, at the commencement of that year. Population is additional money allocated to meet projected growth in population (PBFF). It ranges from 1.55% to 1.30% over the period of the plan. Blueprint is money specifically allocated for additional mental health services. Therefore, Baseline (Year 1) + Population (Year 1) + Blueprint (Year 1) = Baseline (Year 2)

health and addiction services, future funding will be determined by the size of the gap then existing, so no long term detriment exists through deferral. ADHB will expect to receive additional funding from the regional pool, which moves it towards meeting Blueprint Access targets at a rate consistent with that of other DHBs within the region.

Scale of Secondary Service Development Required

Access to services is determined in part by the level of service availability. The following graph illustrates the difference in availability of services for adults, older adults and children and young people.

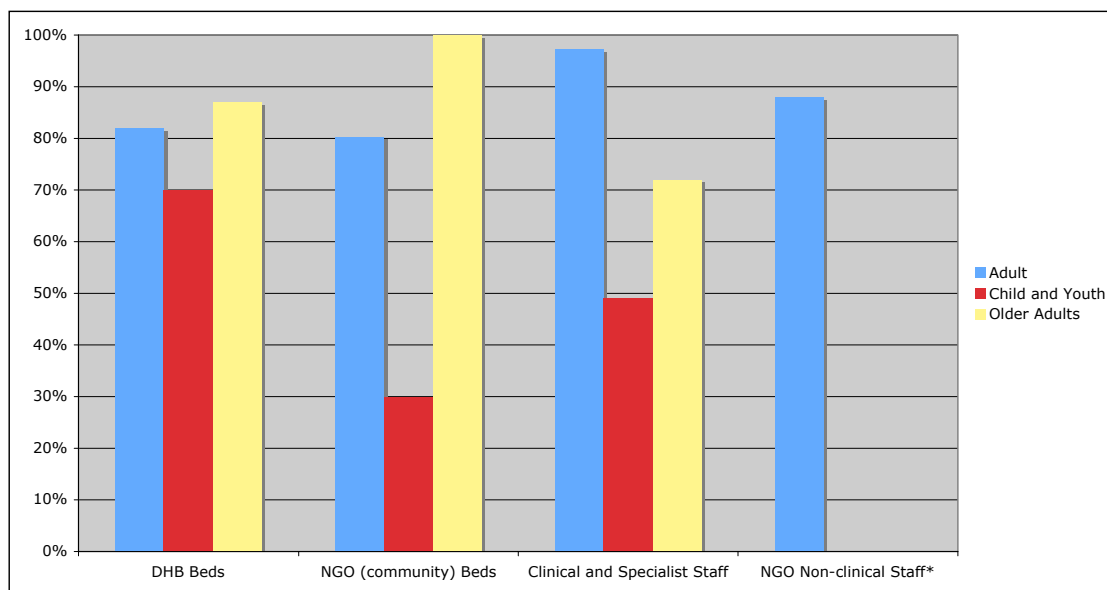


Figure 4: ADHB Delivery of Mental Health Service 2004/05¹¹

The first two sets of columns refer to hospital and community based beds, and the second to clinical and non-clinical staff. The bulk of the former are DHB employed. Funding in mental health and addiction services is accounted for on an input basis, with numbers of beds and numbers of full time equivalent staff making up the input measures. The number of NGO employed staff in the child/youth and older adult areas is very small, and is not distinguished from the clinical staff numbers in the current analysis, hence the lack of columns for those two areas.

The major challenge evident in the current level of service availability is in the area of child and youth services, where service availability is lowest in every division.

¹¹ There is no target for Older Adult community beds, 13.74 beds are provided.

Allocation approach

The use of additional funding can provide incentives to the sector participants to shape service and sector design in a particular direction. With this plan, we seek to enable the mental health and addiction services of the Auckland District to achieve the six goals set out earlier and to do this via an increase in whole sector:

- Leadership
- Responsiveness
- Sustainability

Through a funding focus that supports and rewards

- Collaboration
- Engagement
- Workforce building

In order to complete the development of a continuum of services that are client focused and recovery oriented, we will introduce additional services, and also look to improve the quality of both existing services and the service continuum. Where services gaps exist, we will look to bridging them, with existing services and new resources working together to remedy the gaps. The opportunities for developing enhanced services to meet the needs of Auckland diverse cultures and communities are considerable.

The proposed allocation approach supports greatly increased collaboration on the part of mental health and addictions services, as well as other areas of health and welfare. Do you think that such an approach is effective and fair? What would you suggest as an alternative?

How are we going to do it?

This plan sets out the areas on which we need to focus.

Sector **leadership** through the Service Development Group and the Local Stakeholder network

Collaboration, based on a shared view of the service developments that need to take place to deliver a full continuum of mental health and addiction services

We will develop:

A **responsive** sector, based on the outcomes framework of this plan, and cojoint measurement, which will enable both service users and the public of Auckland to evaluate its effectiveness

An effective **engagement** with primary care, service users, families/whanau, and communities to improve access to and participation in mental health and addiction services.

We will deliver:

Mental health and addictions services across a full continuum, **built** on present capability and future funding commitments, effectively meeting the needs of Auckland's population, and **sustainable** into the future.

Our vision is to achieve environments and services that support mental wellness, reduce mental illness and enable sustained recovery.

Our focus is on improving outcomes across the continuum of wellness and illness and of developing a whole-system view of mental health needs and services.

Implementing the plan and achieving the vision will require us to develop clearly detailed annual action plans, coordinating our activity, allocating our resources, and establishing the detailed measurements they require. We all have a role to play in Lifting the Mental Health of Aucklanders.

Additional Comments:

Please feel free to make any further comments you wish, either in the area below, or on additional paper.

Glossary

ADHB – Auckland District Health Board

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

Culture – the beliefs, customs, practices, and social behaviour of a particular nation or people, a group of people whose shared beliefs and practices identify the particular place, class, or time to which they belong

DHB – District Health Board

Ethnicity – belonging to a social group that has a common national or cultural tradition

Mental Illness – Any clinically significant behavioural psychological syndrome characterised by the presence of distressing symptoms or significant impairment of functioning

Mental Health Worker – A generic term including anyone who works within a mental health service

NGO – Non-governmental organisation, a term which is used to describe a contracted not for profit service provider or advocacy organisation

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

Service Provider – An organisation or other legal entity contracted by the Funder to deliver health and disability services

Service User – A person who uses mental health services. This term is often used interchangeably with consumer and/or tangata whaiora

Te Taha Hinengaro – Psychological health

Te Taha Tinana – Physical health

Te Taha Wairua – Spiritual health

Te Taha Whanau – the health of the family

Whanau – Kuia, koroua, pakeke, rangatahi, tamariki. The use of the term in this document is not limited to traditional definitions, but recognised the wide diversity of families represented within Maori communities

Whanau Ora – Maori families achieving their maximum health and wellbeing

Are there any other terms you would like to see defined in the glossary?