



ANZASW submission on Blueprint & MHASDP¹ review

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Aotearoa New Zealand Association of Social Workers (ANZASW) is the professional body for more than **4,000 social workers**, many of whom have day-to-day involvement with the mental health sector.

As a core skill, social workers have the capacity to deeply connect with people who are suffering. We have the unique identity of biculturalism as our defining characteristic. From this bicultural heart springs the desire to understand and respect tangata whaiora from all ethnic and demographic groups, regardless of their diversity. Social work is informed by the art of combining the disciplines of relationship-building and social science. It is a tradition that empowers people to take charge of their own lives in the context of their own values and aspirations. Social work looks at dimensions other than monetary to describe vulnerability. This includes the wider socio-economic and political conditions that marginalize people and families within their own communities. The very subtle skillsets of a professional social worker are often under-utilized in mental health and addiction services².

This submission represents our heartfelt views on challenges and issues that need to be addressed within the Blueprint II and MHADSP review. It has taken months to prepare and will be disseminated widely. We begin with informal comments and discourse themes about mental health and addiction services from the perspective of service-users, whānau and social workers within the system. This has identified overwhelming concerns about the effectiveness of care, quality of residential facilities, inability to access specialist services and lost opportunities for innovative community-based programme development. Tāmariki, rangatahi and Māori are clearly faring worst.

We also talk about the position of social workers within the MHA sector - our under-representation in workforce data, the obstacles that have hindered professional development, the blurring of boundaries that has evolved, over time, to undermine roles, responsibilities, relationships and capacity for advancement of unique skillsets.

ANZASW has invested in a comprehensive review of national systems for collecting, monitoring and reporting MHA dataset. This has identified a burdensome, ad-hoc, fragmented approach that lacks transparency and leadership and is incapable of informing the effectiveness of care, in its current form. The amount of data that is taken from tangata whaiora and not used to inform service delivery is shocking and, in our view, a shameful breach of the government's ethical responsibility. We believe the limitations of current data collection and inability to measure concepts of recovery, effectiveness and wellbeing, in any rigorous way, will seriously undermine capacity to demonstrate improvements in the MHA service delivery.

We have identified a number of themes for strategic development of the new service plan. In particular, we suggest alignment and synergy between the many goals, priorities and directions that are simultaneously influencing decision-making about service delivery. Of most importance is the need to continue implementation of Te Kōkiri actions that have not yet been achieved. We also

¹ Mental Health and Addiction Service Development Plan (MHASDP)

² Personal communication, ANZASW Social Justice Committee, 16 February 2012.

believe the government should be honest about the upheaval and realignment that will occur in the MHA sector over the next 3 years as they move towards implementation of the BSMC model of delivery in primary care. A vision of substantial investment in building the capacity of communities to provide innovative sustainable mental health and addiction services that meet local needs would be worth striving for. We also believe the Treaty of Waitangi is an important guiding principle for a sector that says it wants to improve the effectiveness of services for Māori. In addition, the equally compelling principles of trust, transparency and effectiveness still have relevance and have yet to be demonstrated in MHA systems and processes. We are particularly concerned about the effectiveness of a \$90 million dollar investment in pharmaceutical solutions. We also believe tangata whaiora have reason to be concerned about their loss of confidentiality and anonymity with the move to electronic note sharing.

ANZASW agrees with the 4 objectives that make up the scope for Blueprint II and anticipate the MHC's work on national indicators, measuring social inclusion, child and youth mental health and the meaning of recovery will provide a useful background for critical discussion. We are particularly interested in:

- resource packages for working across sectors and agencies to create a recovery-focused environment and hope this will address many of the concerns identified above, eg - how will NGOs and IFHCs work together? Will the BSMC model lead to the demise of NGOs and community groups? Where are the opportunities for multi-agency investment in essential community development of early intervention, prevention, recovery, day programmes, rehabilitation? Is there a need for targets to ensure community access and development of alternative models of care?
- support service designs that will maximise consumer/whānau and community contribution to MHA outcomes, eg – will whānau have opportunities to run locally based early intervention, prevention, rehabilitation programmes for at risk youths around the Whānau Ora model? How do whānau providers engage/collaborate with primary health care providers?

However, we think the Blueprint II scope should have the following additional objectives:

1. **Identify** resource paths for clarifying the linkages and professional boundaries within the MHA workforce and identifying targets the mix of BSMC skillsets , eg – how many social workers, support workers, cultural advisors, AOD workers, psychologists, psychiatric nurses, specialists are needed in each community provider? What are the boundaries for each professional groups in terms of expected roles, functions, skillsets.
2. **Clarify** the monitoring framework that will underpin the reporting of MHA data over the next 3 years.

This comprehensive submission has captured many concerns about New Zealand's \$3 billion investment in mental health and addiction services. The content contains numerous recommendations for development and improvement. Even though we have fallen outside the vaguely defined timeframes for public submissions, we hope the Ministry of Health and Mental Health Commission will take the time to seriously consider our views.

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Initial thoughts on Blueprint/MHASDP review ...

ANZASW agrees with routine review of key service principles and directions for mental health and addiction (MHA) services to ensure MoH/DHB planning, funding and service provision is aptly aligned with current trends, priorities, needs. We believe any change to the Blueprint and MHASDP must address shortcomings in current directions but also build on substantial investment in the platform of strategies that have driven the development of MHA services.

Blueprint I was underpinned by strong commitments to the Treaty of Waitangi, a recovery approach, eliminating discrimination, community-based service delivery and clarifying the requirements for national data collection. Notable changes in the mental health/AOD sector have included:

- strengthening the platform for national/regional leadership including establishment of the Mental Health Commission, Mental Health Directorate, Regional Mental Health Networks, separation of DHB funder/provider roles, involvement of service-users in decision-making and fine-tuning of the strategic framework, action or implementation plans, data collection protocols, key performance indicators and evidence-based guidelines for service delivery;
- introduction of essential service components with ring-fenced funding aligned to benchmarks/targets and projected needs of priority population groups (adults, child and youth, older people and AOD/forensic/specialist services) in terms of actual community mental health/support FTEs, number of inpatient/residential beds, day programme/ methadone places and access to prevention/specialist services;
- a more systematic approach to the collection of mental health data with capacity for ad-hoc analysis and integration of national datasets as well as the introduction of standardised tools for the measurement of outcomes;
- substantial increases in the overall budget for mental health/AOD service delivery with more flexible funding arrangements to facilitate collaboration across providers in the public, primary and community/NGO sector;
- expansion of the budget for community services with a threefold increase in NGO funding (currently receiving about 30% of the mental health budget);
- services are more user-friendly and more pro-active in listening/responding to needs, service-users are more involved in decision-making and there is more liaison with whānau;
- introduction of newer (atypical) medications and specialist skillsets within multi-disciplinary teams, eg - child and adolescent mental health, maternal mental health, early intervention, eating disorders, crises intervention;
- re-orientation of service delivery models around integration within the community, co-ordination of care around actual needs and mechanisms for sharing information and resources, eg – closing institutions, shifting from ‘beds’ to ‘packages/episodes of care’, seamless transfer from one provider to another as well as across regions and inpatient/community settings;
- improving access to temporary and emergency housing as well as community-based residential facilities for respite, transitional and long-term independent living;
- considerable strengthening of mental health/AOD workforce capacity³, particularly community/NGO support services, with introduction of the National Certificate in Mental Health (support work), implementation of workforce-specific development plans and more opportunities for tertiary study, training grants, scholarships, placement and mentoring;
- accelerated development of Māori workforce capacity and initiatives which aim to meet Māori MHA needs such as Māori representation in DHB decision-making about planning and service delivery, establishment of Te Rau Matatini (the Māori Mental Health Workforce Development Organisation), implementation of Kia Pūawai te Ararau (the Māori Māori Mental Health Workforce Development Strategic Plan) and Te Puawaiwhero (the 2nd Māori Mental Health

³ including implementation of several workforce development plans, eg Tuutahitia te Wero (the Mental Health Workforce Development Plan 2002-2005), Tauawhitia te Wero (the National Mental Health Workforce Development Plan 2006-2010) and the NGO Mental Health and Addiction Workforce Development Strategy 2006-2010.

and Addictions National Strategic Framework 2008-2015) and investment in Kaupapa Māori models of care;

- broadening the literature and the evidence-base for decision-making about the delivery of services for Māori; Pacific; Asian; Refugee, Migrant and Child & Adolescent mental health⁴;
- investment in strategies and initiatives to reduce stigma, eliminate discrimination, foster equal employment opportunities, encourage service use, promote early intervention and increase awareness self-help techniques/peer-support systems, eg Like Minds Like Mine, NZ Suicide Prevention Strategy, development of web-based resources.

Observations, comments, concerns ...

Implementation of the 1998 Blueprint and associated specifications⁵, has substantially improved many aspects of service delivery but there is still a way to go. Discussions with social workers, currently working in mental health/AOD settings, has identified a raft of observations, comments and concerns which are summarised below, as informal discourse themes:

1. Administrative burden is an obstacle to care – admission, assessment and reporting forms take too much time and have to be completed before the service can be provided – every minute that is spent completing templates and forms is one minute less with service-users and their families.

Easy, informal access to community drop-in centres and walk-in opportunities for mentorship, group discussion, peer support, training, work experience and participation in day programmes is vital for effective service delivery but increasingly difficult to fund.

2. Data collection requirements are continually expanding with no perceived benefits in terms of understanding causality, informing outcomes or improving the effectiveness of care⁶ - questions can seem intrusive and inappropriate, the data collection process has also been constructed around individual cases that do not capture our true workloads, like engagement with groups, communities and whānau/family.

Having the time and opportunity to form good relationships with whānau and communities is key to understanding local issues, creating local solutions and identifying at risk children/youths who may benefit from participation in prevention programmes.

3. Service-users are worried about the loss of privacy and confidentiality with electronic sharing and retention of files, many do not want their personal stories recorded if anonymity cannot be guaranteed.

There are times when social workers need to share information across a number of agencies, eg - when exploring opportunities for collaboration or there is concern about the safety and wellbeing of other members in the whānau/family – how can this be achieved without violating the anonymity and confidentiality of service users and their families?

4. Social workers prefer holistic, informal techniques and capacity to engage with families, communities and broader networks, if needed, such as the children of parents/care-givers with mental health and/or AOD challenges.

There is vast potential for engagement with community groups, including Māori land-owners, around the establishment of locally-based early intervention/prevention programmes for tangata whaiora and at risk youths – social workers are well placed to identify and negotiate the innovative, inter-sectoral solutions that need to resolve relatively minor obstacles and barriers such as setting up appropriate administration/decision-making systems.

⁴ More than 200 articles were published between 2004-2009, see NZ Mental Health Bibliography 2004-2009 available at www.tepou.co.nz on 20 September 2011

⁵ Such as the MHASDP, Te Kōkiri (2007), and the Mental Health and Addiction Action Plan (2010)

⁶ the most recent analysis of MHDW data was published in 2010 and reported on 2007/08 data

5. Social workers do not have enough flexibility to negotiate placements in prevention, early intervention and recovery initiatives for at risk youths within the wider community, irrespective of whether they are run by government, NGO, private or voluntary agencies - bureaucratic obstacles⁷ thwart and impede the implementation of entirely feasible training, employment, skills enhancement solutions.

Alternative education and Community Max have always been a magnet for at risk youths and would be an ideal vehicle for early intervention initiatives, this opportunity is undermined by restrictive eligibility criteria, temporary contracting arrangements, short-sighted leadership and a general lack of alignment with mental health/AOD pathways, objectives and strategies.

6. Whānau Ora⁸ is strengthening the platform for whānau involvement in the development and implementation of their own action plans, and strategies, for addressing mental health/AOD needs.

Whānau Ora focuses on the wellbeing of whānau - it is a whole of whānau approach that is underpinned by concepts of potential, responsibility and relationships - the potential for whānau to be self-determining, the belief that whānau can take responsibility for their own future and the importance of whānau being actively involved in relationships with other whānau members, service providers and government agencies that can assist the process of transformation.

7. Recovery is treated as if it is an individual process - it has been constructed around the achievement of personal goals and needs that are incongruent with the underlying philosophy of social inclusion, or the notion that participation in one's family and community is essential for wellbeing - recovery plans need a broader vision of positive engagement with vibrant, healthy whānau and communities.

... recovery is a journey as much as a destination ... it fosters inclusion within our communities, provides us with treatments and supports that work, gives us hope, treats us with equality and respect, enables us to use personal resourcefulness and helps us to find meaning in our distress (MHC "6 Ways to Use a Recovery Approach")

8. The best predictor of just about every mental health disorder is poverty, followed by social factors and isolation ... the enablers of recovery, resilience and whānau ora must, therefore, be embedded within policy frameworks that aim to improve living conditions and address the socio-economic inequities that have their origins in joblessness, homelessness and impoverished local communities.

Governments cannot deny their policies and economic reforms have trickle-down effects on our mental health and wellbeing – the demise of NZ industry was triggered by state asset sales, crippling overseas debt and free-trade agreements – this has created an inter-generational treadmill of poverty and hardship in which today's families are struggling to cope with dire shortages of affordable housing, exorbitant living costs and ferociously competitive job markets - it is not hard to understand why people living in these types of conditions are prone to anxiety, depression, hopelessness, helplessness and suicide.

9. Despite international credibility, as a discipline and model of care, New Zealand has little understanding or use of trauma-informed methodologies – clinicians seldom recognise, or take the time to gather information about, experience of trauma as a possible cause of illness - cross-overs in policies, narrowly interpreted referral guidelines, difficulties getting counselling, lack of expertise and the paucity of ACC-registered therapists have impeded the introduction and use of trauma therapies.

⁷ such as government policy, contract limitations, accreditation status, age restrictions, threshold requirements, DHB recognition/certification, the need for medical diagnosis/referral to access programmes

⁸ Led by a collaboration between Te Puni Kōkiri (TPK), Ministry of Social Development (MSD) and the Ministry of Health (MoH)

Dr John Read, professor of clinical psychology at Auckland University, has found the use of compulsion, seclusion, inappropriate diagnostic labelling, not inquiring about past abuse and pathologising or medicating psychological pain can exacerbate trauma ... “mental health services have become increasingly dominated by psychiatry’s medical model, which claims that feeling depressed, anxious or paranoid is primarily caused by genetic predispositions and chemical imbalances ...” (see Te Haererenga mo te Whakaoranga 1996-2006, pg 96 and Sydney Morning Herald, 15 September 2011).

11. Specialist involvement in mental health services always leads to medication and this is a reason why tangata whaiora do not seek help or return for care - it seems there are no alternatives and too many service-users end up on long-term medication plans, often with debilitating side-effects including speech impairment, facial ticks, kidney dysfunction, diabetes, extreme weight gain, loss of libido and potentially permanent CNS damage. The standard treatment for side-effects is more medication.

... clinicians say medication helps to restructure and stabilize thinking, thereby improving personal wellbeing and quality of life, but many service-users say it masks the problem and does not address the underlying cause ... “it hasn’t made it go away, it just means I don’t care ... it’s like my brain is numb” ... Cochrane reviews and meta-analysis of the evidence suggest anti-depressants are effective for less than 10 percent of the people who receive them and the widely used anti-psychotic Risperidone is no better than placebo.

12. Much of the social worker’s role in acute, residential and community mental health settings is about compliance – coaxing tangata whaiora to accept the need for medication, convincing them to keep taking it, wrapping support services and recovery plans around daily dosage and adherence regimes, picking up those who fall off the rails only to send them back to the same treatment plans - very few service-users have the courage or strength to try alternative techniques and the system does not support this approach.

On one hand our mental health system is actively fostering widespread dependence on addictive and mind-altering substances, albeit prescribed, but on the other hand we are investing millions of dollars in detoxification - what a paradox! ... it seems like the system is saying ... it’s OK to alter your mind with some substances but not others ... it’s OK to get addicted to some substances but not others and it’s OK to self-harm with medication-induced side-effects but you cannot bang your own head - what is the value, principle, underlying rationale of such mixed messages?

13. Social workers have doubts about the effectiveness of seclusion and compulsion in mental health services, the techniques are used too often, too quickly and decision-making about when to use them seems arbitrary. In 2007, Jan Dowland, ex-chair of the MHC, said seclusion would be eliminated as a technique for crisis intervention in acute inpatient care because it is not effective and influenced by too many extraneous variables such as unclear policy guidelines, overcrowding and the subjective judgements of inexperienced staff. New Zealand is known to use seclusion more often than other developed countries but it is alarming to find our use of it is increasing⁹. Around 1,200 New Zealanders, and 17% of mental health unit inpatients, are secluded each year, often more than once, and the vast majority are Māori males¹⁰. This is despite an international evidence-base which shows that seclusion and its various affiliates – including sensory deprivation, isolation, compulsion and restraint – is of little benefit, can add to inpatient trauma and should only be used in an extreme, crises. Community and inpatient use of compulsory treatment orders (CTOs) under sections 29-31 of the Mental Health Act are also on the rise and have increased by 20% since 2004¹¹. In 2010, 4626 tangata whaiora experienced compulsion in NZ mental health services and, once again, the vast majority are Māori males.

⁹ Mental Health Commission (2011) National Indicators 2011 – Measuring Mental Health and Addiction in New Zealand.

¹⁰ Ministry of Health (2011). Office of the Director of Mental Health Annual Report 2010. Wellington

¹¹ ibid

NZ mental health law has not kept pace with practice - the paucity of judicial commentary and lack of case law makes it difficult to address issues of legal transparency and accountability when seclusion and/or compulsion is enforced under the Mental Health Act. Both techniques are an intrusion of personal liberty and a violation of basic human rights – the service-user is excluded from participation in decision-making about their own care and their right to refuse medical treatment is over-ridden. Detention under the Mental Health Act can have a life-long impact on basic human rights such as the right to hold a driver's license and/or positions of responsibility. Consumers have voiced their dissatisfaction with the system and continue to challenge the grounds for detention despite little chance of success. In 2006, less than 5% of the cases which came before the Mental Health Review Tribunal were successful (Te Haererenga mo te Whakaoranga 1996-2006, chapter 11)

14. Social workers see compulsion in various forms - from subtle inducements to “voluntarily” take a pill (such as the promise of a movie) to twice-a-day check-ins, depot shots and outright coercion or force - when the tangata whaiora is held or strapped down and injected against their will.

It is totally misleading to suggest whānau actually have a decision-making partnership with psychiatrists when it comes to the use of compulsion – we were begging for the chance to try natural, spiritual or behavioural healing techniques but the psychiatrist wouldn't listen, once the order to medicate was given his staff acted immediately, there was nothing I could do to stop them holding my son down and injecting him with mind-altering, animal based, addictive products he didn't want or need, they wouldn't even wait for a kaumatua to come in and say a karakia. The only time we were genuinely asked to make a decision was at discharge when they wanted to know whether we preferred a Kaupapa Māori or mainstream support service (personal communication from a mother's experience of compulsion at Whanganui in June 2011).

15. The development of alternatives to medication was an original Blueprint goal but mental health services find it hard to change and little progress has been made. Tangata whaiora are not routinely given information about alternative models of care such as the various cognitive behavioural, problem-solving, inter-personal, trauma-informed, holistic, peer-support, Kaupapa Māori or home-based crises resolution techniques. More often than not, they are told medication is the first line of treatment and only option available in their region.

Consumers find it difficult to access information about alternative models of care and the specialist skillsets that are available in New Zealand - they need to know where the specialists are located, how they can be accessed and whether they are eligible for treatment or care.

16. Service users, and their families, often turn to social workers for information about alternative models of care but this doesn't happen until compliance has been established and they have been transferred to recovery support services. They usually hear about alternatives through word-of-mouth or the internet and want social workers to help them access the service. Information is difficult to source and often out-of-date.

Tangata whaiora do not have the option of referral to specialist-led, cognitive-behavioural programmes offered by public and private providers - such as Ashburn Clinic in Dunedin (New Zealand's only live-in rehabilitation clinic), Seagar-House Rauaroa in Auckland (which offers 2-years of intensive psychotherapy), Totara House in Christchurch (for early intervention in psychosis) or the sensory modulation alternatives to seclusion that were recently trialed at four DHBs (Capital & Coast, Midcentral, Counties Manukau and Auckland).

17. Medication often seems to do more harm than good, some providers are unwilling or unable to work with tangata whaiora who have been medicated and pharmaceutical interventions can interfere with the use of psychodynamic therapies in borderline personality disorders¹².

¹² See Bateman AW (2007) Mentalisation Based Therapy for Borderline Personality Disorders: Turning theory into practice available at <http://www.tepou.co.nz/story/2010/10/07/mentalisation---a-new-talking-therapy-approach-> on 22 November 2011.

Tangata whaiora are not encouraged to use any of the self-referral, peer-support initiatives that have been established by service-users throughout the country - even though the evidence suggests they are highly effective, eg - Psychiatric Survivors, Mind and Body Consultants, Hearing Voices Aotearoa Network, Centre 401, the Wellington Consumers Union, the Lighthouse, Warmline, Positive Thinking, Madpride and The Big Black Dog Message Board.

18. The barriers to alternative care are lack of information, restrictive entry criteria, geographic location (not available in their region), no residential facilities, long waiting lists, long waiting times, lack of providers, lack of funding, inadequate funding and DHB/clinician attitudes/ignorance, referral policies, refusal to accept/acknowledge validity/credibility and resistance to NGO involvement in the delivery of primary assessment, intervention services.

We cannot assume a one-size-fits-all approach when disseminating information resources. A range of media are needed to ensure tangata whaiora can access the information they want, when they need it. There is enormous demand for personal stories from a service-users point of view but web-based services (such as thelowdown.co.nz) are not suitable for everyone - the information can be too complex, too simplistic, too mainstream, too impersonal, too visible (you have to sign in), too difficult to access (must have computer, internet and be computer literate) and too generalised for age-group, region, actual needs.

19. Tangata whaiora do not make an informed choice about the type of care they receive and are not they told they have the right to set up an Advance Directive under the Code of Health and Disability Services Consumer Rights.

An Advance Directive provides an element of control over the treatment and interventions that are used during a future admission. A statement is made about treatment preferences during a crisis or episode in which the consumer is otherwise unable to communicate. For example, the consumer can talk about the treatments they want to receive (eg – no ECT/medication) and the places where they would prefer to receive services (eg – home/hospital). Psychiatrists can over-ride the directives but such a decision will be scrutinized and the psychiatrist will, therefore, need to have a transparent, compelling reason for doing so.

20. In mental health services, especially clinical settings, Kaupapa Māori models of care are an optional support service that may be factored into recovery plans once adherence to the treatment plan has been established. This negates the therapeutic potential of Kaupapa Māori healing techniques in which the timing, sequence and integrity of interventions is absolutely critical and must, at very least, precede the introduction of medication.

Acknowledgement of Te Tiriti o Waitangi is the starting point for improving the effectiveness of mental health services for Māori. If the underlying principles of partnership, participation and protection were genuinely implemented Kaupapa Māori would be a primary alternative to conventional care, instead of an optional support service, as it is currently construed.

21. In our day-to-day role, and involvement with communities, it is Māori children, youths and whānau who are carrying the burden of mental health and addiction issues in Aotearoa/New Zealand – Māori have more anxiety, depression, psychosis, bi-polar and stress-related disorders and more complex needs around social isolation, deprivation, co-morbidity and co-existing substance use, Māori are also more likely to be involved with the criminal justice system, more likely to live in extreme poverty and more likely to experience conflict, trauma, violence and abuse as well as the untimely loss of a family member to suicide¹³.

¹³ Families Commission (2009). Family Violence Statistics Report: Research Report # 04/09. Wellington

| Service Team | Māori | | | | | | non-Māori | | | | | |
|---|-------|-------|------|-------|-------|-------|-----------|-------|------|------|-------|-------|
| | DHB | | NGO | | total | | DHB | | NGO | | total | |
| | n | % | n | % | n | % | n | % | n | % | n | % |
| Alcohol and Drug Dual Diagnosis Team | 193 | 0.62 | 39 | 0.13 | 232 | 0.50 | 758 | 0.74 | 79 | 0.08 | 837 | 0.61 |
| Alcohol and Drug Kaupapa Maori Team | 1158 | 3.73 | 1299 | 4.18 | 2457 | 5.27 | 81 | 0.08 | 767 | 0.75 | 848 | 0.62 |
| Alcohol and Drug Team | 7143 | 23.01 | 2623 | 8.45 | 9766 | 20.96 | 19565 | 19.15 | 5123 | 5.02 | 24688 | 18.08 |
| Kaupapa Māori dual diagnosis mental health & AOD services | | | 246 | 0.79 | 246 | 0.53 | | | 51 | 0.05 | 51 | 0.04 |
| Children and youth, alcohol and drug services | 22 | 0.07 | 709 | 2.28 | 731 | 1.57 | 56 | 0.05 | 1024 | 1.00 | 1080 | 0.79 |
| | 8516 | 27.43 | 4916 | 15.83 | 13432 | 43.26 | 20460 | 20.03 | 7044 | 6.90 | 27504 | 26.92 |

Table 1: Comparison of AOD service-use by ethnicity, 2010/11 (ANZASW request for MHS data, extracted 25 Nov 2011)

22. Māori are over-represented in younger age-groups, have more difficulty accessing services and, those that do are less likely to get continuity of care. This is confirmed by MHS data (Figure 1) which shows that Māori are disproportionately represented in younger age-groups, particularly 10 to 34 years of age whereas non-Māori are over-represented at older age-groups. MHS data for 2008/11 also suggests over half of the prioritised Māori who came through mental health and AOD services were seen by more than one team.

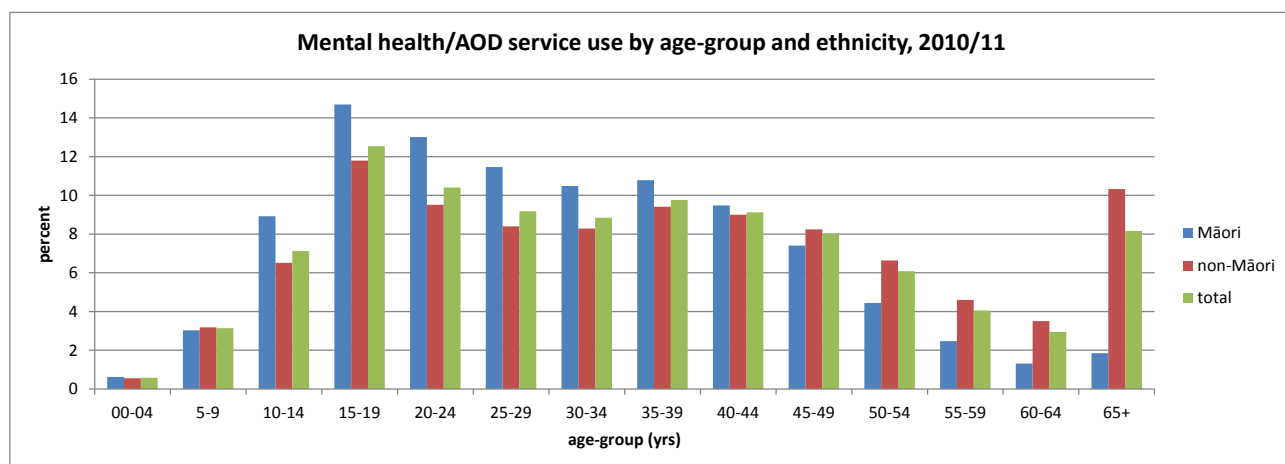


Figure 1: Service use by age-group and ethnicity, July 2010-June 2011 (ANZASW request for MHS data, extracted 25 Nov 2011)

23. Social workers are trained in bicultural practices, and our competence to work in a culturally appropriately manner is assessed every 5 years, yet we find ourselves immersed within a system where the vast majority of Māori service-users (85%) are treated by mainstream teams primarily located in DHB settings. In 2010/11, 67% of Māori services-users (n= 31,236) were treated by mainstream DHB teams and 18% (n = 8,384) were seen by mainstream NGO providers. Only 15% of Māori mental health/AOD service-users were, at any stage, seen by a Kaupapa Māori provider¹⁴.

| Service Team | Māori | | | | | |
|---|-------|--------|------|--------|-------|--------|
| | DHB | | NGO | | total | |
| | n | % | n | % | n | % |
| Alcohol and Drug Kaupapa Maori Team | 1158 | 2.4859 | 1299 | 2.7886 | 2457 | 5.2745 |
| Kaupapa Māori dual diagnosis mental health & alcohol and drug services | | | 322 | 0.6912 | 322 | 0.6912 |
| Kaupapa Maori Tamariki and Rangatahi (child and youth) mental health services | 494 | 1.0605 | 1256 | 2.6963 | 1750 | 3.7567 |
| Kaupapa Maori Team | 2462 | 5.2852 | 11 | 0.0236 | 2473 | 5.3088 |
| Māori service users seen by Kaupapa Māori Team | 4114 | 8.8315 | 2888 | 6.1997 | 7002 | 15.031 |
| Māori service users seen by mainstream teams | 31236 | 67.055 | 8345 | 17.914 | 39581 | 84.969 |
| number of Māori service users (may have seen more than one team) | | | | | 46583 | 100 |

Table 2: Māori use of Kaupapa Māori mental health and AOD services, 2010/11 (ANZASW request for MHS data, extracted on 25 November 2011)

24. Effective prevention and early intervention services are urgently needed in most regions, but whānau living in small town and rural areas are particularly disadvantaged. Time and again, we find that tangata whaiora (and/or their families) made several attempts to access an early intervention service but the system didn't provide the information that was needed, couldn't identify a local service and essentially waited for a crisis to occur before taking action.

¹⁴ See MHS data on service use for the 2010/11 year, extracted for Stephanie Palmer on 25 November 2011

Organisations like Depression Helpline, Lifeline, Youthline, Supporting Families in Mental Illness NZ, Emotions Anonymous and Balance NZ can be of little use in times of need – they can be difficult to contact (no 0800 number, will not accept texts or mobile calls), slow to respond or do not respond at all (even when they have said someone will call back), provide little practical advice and have no knowledge of support services outside main urban centres.

25. At risk children and youths need non-clinical, age-specific, culturally relevant, community-based opportunities to establish relationships with prevention and early intervention services that offer realistic pathways for education, life-skills, work experience, training and employment as well as access to appropriate peer-support, mentorship, CBT therapies, practical/self-help techniques, crisis intervention, information and support services.

With Māori still owning more than 20,000 land blocks averaging 55 acres in size (NZ Law Society Māori Land Update, June 2009) you'd think it wouldn't be hard to set up transformational initiatives which enabled at risk Māori youths and whānau to return to live on ancestral lands, eg – growing their own food, building their own homes and learning practical life-skills that would not only give them a sense of belonging but also make a valuable, measurable contribution to the whānau ora vision of employable skills and self-sustainable communities – but it is hard, indeed the many layers of obstacles seem insurmountable - no finance, no utilities, no decision-making structure, no "qualified" supervisors, no contact details for shareholders and who would lend an at risk whānau \$7-8K for materials to build their own whare anyway (even though repayments would be less than house rentals in the city) - then there is the problem of ancestral lands being on back-block "no-go" employment zones (which would make whānau ineligible for WINZ support if needed), local authorities would also impose their mono-cultural resource management views and exorbitant compliance fees ... and so the list goes on ... too many obstacles, too hard, never happens

26. Too many community-based programmes for at-risk youths are closed down before they have had the chance to reach their full potential, usually because of policy or strategy changes, eg – several programmes were lost when MSD/MoH/MoJ implemented their Funding for Outcomes strategy¹⁵ - from a social worker's perspective, such closures mean fewer providers offering services, fewer options for negotiating placements, fewer opportunities to strengthen communities and less capacity to grow early intervention programmes (which always take time to evolve) – more often than not, the programmes have their origins in grass-roots attempts to address glaring local needs - restructuring is meant to be about streamlining, strengthening and improving services but it seems the opposite often happens - the system becomes more complicated, more bureaucratic, less user-friendly, more difficult to access and less connected with actual needs, eg - to get a placement on programmes rangatahi have to come through Child & Adolescent Mental Health or MSD/Justice assessment and referral services.

Written evaluation (service-user satisfaction) forms do not capture the information that is needed to inform discussion about whānau perspectives on the quality of care they have received, other techniques are clearly more effective, eg - whānau are more likely to talk about positive and negative aspects of their experience in general conversation with each other. There is considerable dissatisfaction with the quality and timing of contact and interaction (too little, too infrequent, too rushed, not enough notice of meetings, no help with travel/costs). In anecdotal conversations, whānau say they are not being treated holistically, do not have the chance to explain background/history, are not able to access newer medications, discharged too quickly, not involved in decision-making, not told when medication/recovery plans are changed, not told about available resources, not able to access respite care and support services when needed and support workers not turning up when they said they would.

¹⁵ such as Whaimarama (Hamilton-Waikato), Te Hurihanga (Hamilton), Te Kohao Youth service (Hamilton), Te Rau o te Huia (Rotorua), Ngongotaha Hauora (Rotorua),

27. It is too difficult to get appropriate specialists involved in the assessment and treatment of children, rangatahi, young adults, older people, borderline personality disorders, anxiety, depression and trauma-related disorders, eating disorders, maternal mental health issues, forensic issues and AOD issues. There is huge variability in DHB capacity to deliver specialist services across the regions and whānau in rural areas and small towns are most disadvantaged.

When appropriate specialists are not available, or involved in care, problems of the mind, spirit and soul are treated as if they have a medical/physiological origin and cause, even when this approach is not warranted.

28. Upskilling and re-orienting the MHA workforce towards the use of cognitive behavioural techniques, peer support and talking therapies is taking too long¹⁶ but will be particularly beneficial for 50-60% of inpatient and community service users that have borderline personality disorders (bu HoNOS data)¹⁷.

Social workers, youth workers, support workers, ministers, healers, teachers, counsellors and community/whānau members have been doing talking therapy for years but many are not “qualified” or certified to provide this service – where is the evidence which shows that registered providers provide a better, more effective, service - the requirement to only use registered/accredited providers is undermining DHB capacity to ensure this service is able to be accessed in all regions, including small towns and rural communities.

29. We have found the prevalence and severity of mental illness and addiction is increasing but children, youths, Māori and the elderly are faring much worse than others. This perception is supported by HoNOS outcome data¹⁸, national survey data¹⁹ and a recent review of MHA services²⁰.

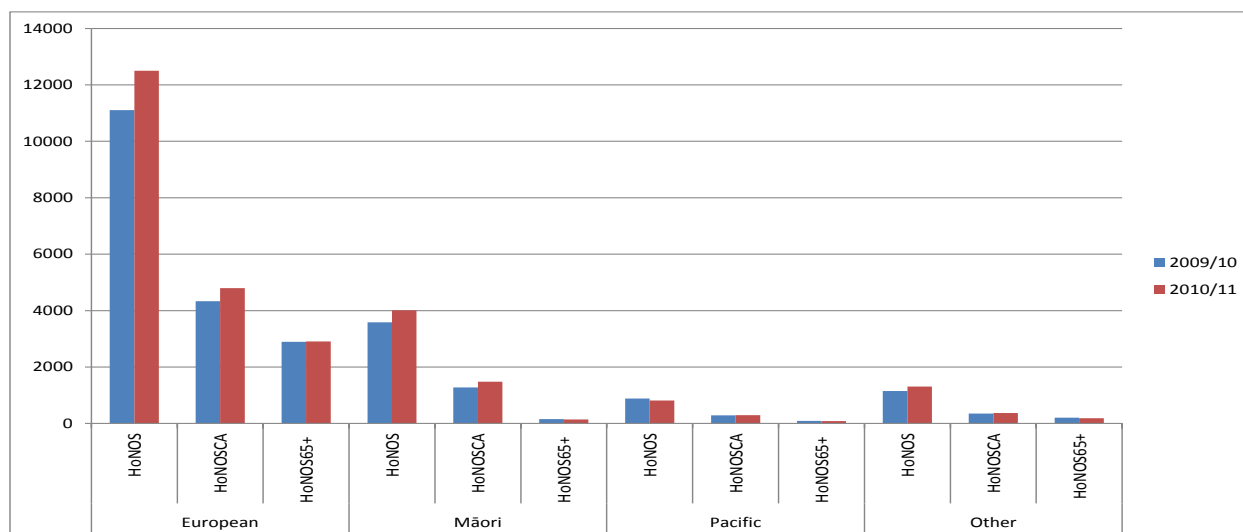


Figure 2: Significant items on age-related HoNOS scales by number of cases and ethnic group at admission to inpatient and community facilities for July 2009 – June 2010 and April 2010 – March 2011

¹⁶ the need for talking therapists was identified in 2007

¹⁷ see National PRIMHD Outcome Reports available at <http://www.tepou.co.nz/page/595-primhd-outcome-reports+national> on 30 September 2011.

¹⁸ PRIMHD Outcome reports April 2010 – March 2011, ibid

¹⁹ MHC (2011) National Indicators 2011 – Measuring mental health and addiction in NZ and MHC (2011) Measuring social inclusion – people with experience of mental distress and addiction Available from <http://www.mhc.govt.nz> on 5 October 2011.

²⁰ Health Workforce NZ (2011). Towards the next wave of mental health & addiction services and capability – Workforce Service Review Report, available on request from Health Workforce NZ, Wellington.

30. HoNOS admission data (above) shows the number of children and youth (HoNOSCA) and working age adults (HoNOS) who have clinically significant items has increased since 2009/10, this is a clear indicator of deteriorating mental health. By the mean number of clinically significant items (below), HoNOS65+ data suggests the mental health of our elderly, on admission to inpatient and community facilities, is also declining.

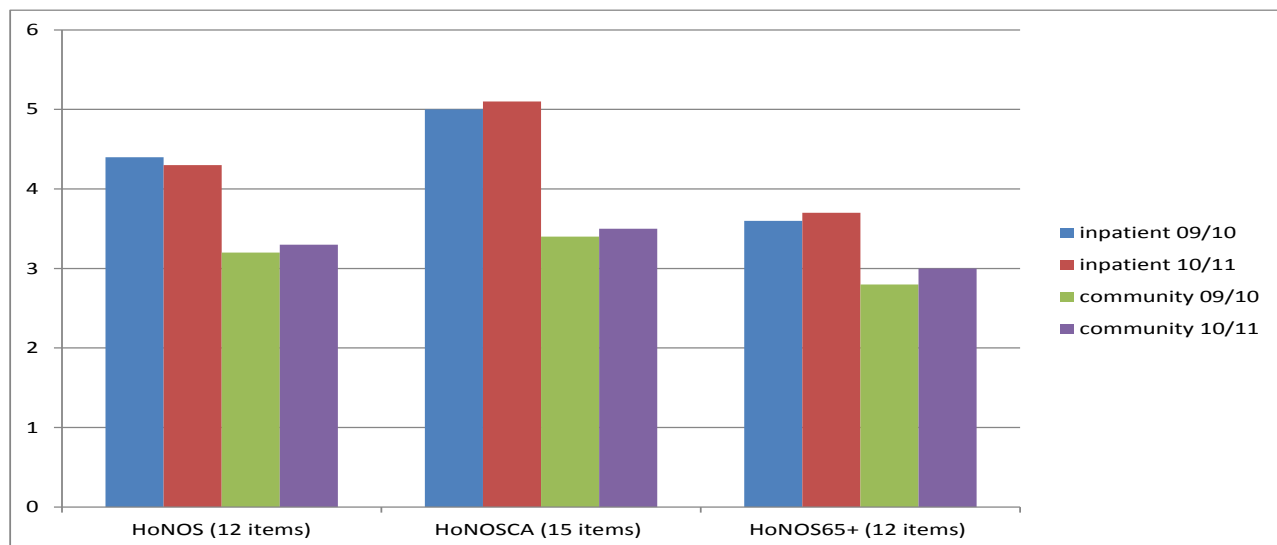


Figure 3: Mean number of significant items on age-related HoNOS scales by type of admission facility, July 2009-June 2010 and April 2010-March 2011

31. Consolidated data²¹ on the prevalence and impact of mental illness and addiction suggests the number of adults living with mild mental illness and symptoms of mental illness has more than doubled since 2003/04 – that's 500,000 to 1 million New Zealanders living with mental illness at any one time. Similarly, a recent MSD review has also shown that almost half (43%) of the mothers who came into contact with CYF in 2009/10 had symptoms of mental illness²².

The most common symptoms of mental illness are anxiety (14.8%), mood disorders (7.9%), substance use (3.5%) and eating disorders (0.5%) and those most at risk are young adults (9.4%), elderly (8%), Māori (10.8%) and Pāšifikā (12.9%). (Te Rau Hinengaro, 2006).

32. Health Workforce NZ²³ has estimated the number of children, adolescents, youths, adults, elderly and at risk families needing mental health and addiction services will increase by 300-500% over the next 10 years.

Adults who live with extreme poverty are three times more likely to experience anxiety and/or depression.

33. Social exclusion is known to be one of the biggest barriers to recovery but a multi-agency working group²⁴ has described what this might feel like, in terms of day-to-day life for tangata whaiora - people with symptoms of mental illness are more likely to feel isolated, less likely to be partnered, more likely to feel discriminated against, find it more difficult to express their identity, less likely to participate in leisure activities and experience alarming inequity in workplace and housing opportunities. People with symptoms of mental illness are 3 to 4 times less likely to be satisfied with their current living arrangements with Māori, Pasifika and those who are most deprived being least satisfied. Compared with all other groups, people with symptoms of mental illness also have the highest unemployment rates and lowest job satisfaction – only 44% have any type of employment, little more than a quarter are in full-time employment and 50-70% are dissatisfied with the jobs they have been given.

²¹ MHC (2011) *ibid*.

²² Centre for Social Research & Evaluation (2011). *Vulnerable children: numbers and risk factors*. Ministry of Social Development, Wellington.

²³ Health Workforce NZ (2011) *ibid*

²⁴ MHC (2011) *Measuring Social Inclusion* *ibid*.

When you first hear about Workwise you think it will be an organisation that understands how hard it is for us to get a job ... then you apply for one of their "real jobs for real pay" .. they have the same restrictions and attitudes as everyone else, they only help tangata whaiora who are currently being treated by a DHB clinician, they focus on relationships with employers not tangata whaiora, their main role is to screen for the few jobs they are given, they are not like a work broker or recruitment agency that matches skillsets with jobs and they are worse than WINZ because they pretend to be there for all of us but have instead used our situation to gain control of the resources and networks that would, or could, have helped us to get a job .. the experience is so degrading, once again we are rejected (personal communication, anonymous).

34. The standard and quality of residential facilities varies widely within and across regions and needs to be closely monitored, some providers seem to have little interest in the wellbeing of residents.

Independent living often translates into living alone in isolated, shabby flats and being locked into long-term rental arrangements without structure or contact with family, friends and the outside world. Social workers need the flexibility to meet individual needs which may sometimes mean daily, even twice-a-day, contact (rather than weekly, fortnightly or monthly), mechanisms for the provision of tangible support resources, longer than usual appointment times.

35. Respite and transitional residential facilities provide much needed short-term solutions for tangata whaiora awaiting specialist assessment, AOD placements and/or transfer to independent living but are under-utilised as potential sites for delivery of therapeutic techniques (such as immersion in Kaupapa Māori, massage, spiritual reflection, physical exercise, counselling, peer support, mentorship, talking therapies), some provide low-key training in basic life skills but mostly, it seems, residents are left to their own devices without structure or opportunities for participation in activities and programmes - 24 hours ticking time in respite and transitional settings can feel like forever.

The problem with rangatahi AOD placements and transitional arrangements is we don't have them for long enough!! We only get a set number of bed nights to work with them and then they go back to the whānau/community they came from - we need to keep those who would benefit from staying longer, at least until they have a job, or have learnt new coping strategies. They have to be strong enough to withstand the pressure to conform, they must know how to avoid returning to the same patterns of behaviour.

36. The decentralisation of psychiatric institutions has re-oriented services around integration within the community but 10 years of working this model has highlighted a yawning gap in the options for residential care - the current system offers short-term inpatient, respite and transitional facilities with supported transfer to community-based independent living – this model is appropriate for some but not others - there is an urgent need for longer-term rehabilitation facilities, these are the places tangata whaiora would go when they are not in need of acute, respite or medical care but not yet ready for transition - it would provide an opportunity for immersion in recovery-focused healing techniques such as talking therapy, peer-support, coping strategies, Kaupapa Māori and alternative models of care. The establishment of such facilities would bring New Zealand's mental health services into line with a global move towards government investment in healing retreats²⁵ and the rehabilitation philosophies that ostensibly underpin our vision of recovery.

²⁵ see <http://health.sedona-healing-retreats.com/>, <http://www.brookhavenretreat.com/cms/>, <http://www.rehabnz.co.nz/pages/drug-rehabilitation.html>, <http://www.ayurvedanz.com/events-and-retreats/retreats-in-india>

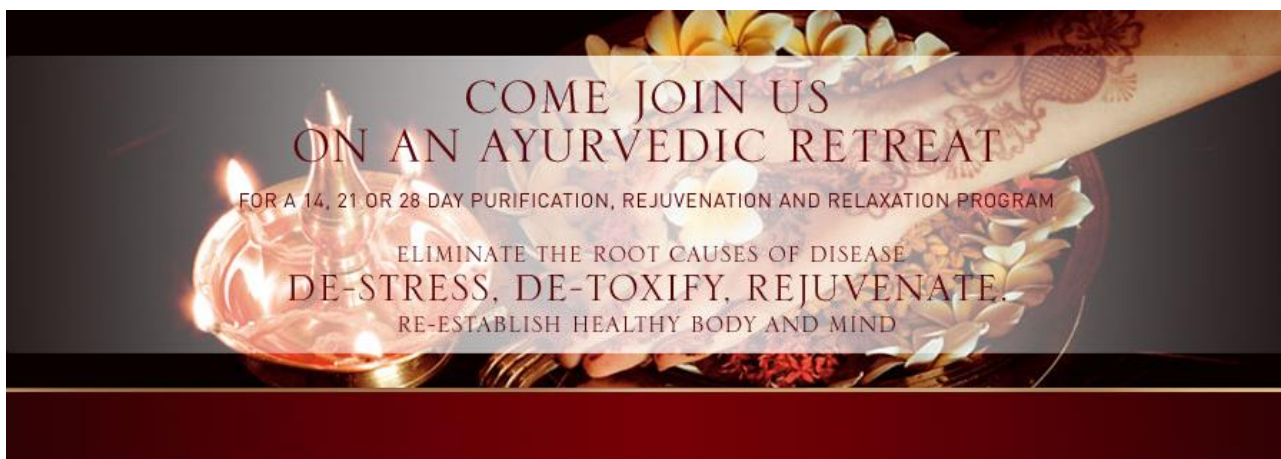


Figure 4: Would tangata whenua benefit from participation in this type of retreat?

37. The system never seems to have time ...

time to reflect
time to talk
time to understand you
time to understand me
time to remember we once had dreams
time to regain our strength
time to awaken the yearning to try
time to learn new ways of being
time to reconstruct our lives
time to form new relationships
time to hope
time to heal
time to
start again

38. Social workers do their best to ensure the system is meeting the needs of those who are struggling with mental health and AOD²⁶ issues but, sometimes ... we can't help sitting back and pondering the world we have created the values, the behaviours we are expected to accept ... the system in which we all have to find purpose, meaning, peace-of-mind ...

She was educated, she had done 2 years at med school, she looked after herself, ate all the right foods, didn't smoke or drink, exercised regularly, read all the books. She wanted to homebirth like her mother and grandmother did. They said she was overdue and her baby might die. They made her go to a hospital, induced her with prostaglandins then syntocinon and said it was an informed choice. They only let her labour for 10 hours and said they had to do a caesarean or baby might die. She couldn't hold breastfeed for days, she wasn't allowed to sleep with her because baby might die. Then the nurse came and said it was her choice but baby had to be vaccinated or she might die. Baby cried for days and broke out in a rash then the nurse came and did it again. She said crying was normal and gave her Pamol. When baby died the Police came and took baby away for 2 days. When she came back her little body had been cut open and her blood drained away. They said it had nothing to do with the caesarean or vaccines and kept samples of her DNA. I don't want to talk about it, I just want to be left alone. They locked me in a room and got a court order to make me take medication every day, they say it will help but that was years ago, nothing has changed.

39. What is "normal" again?

²⁶ the per capita alcohol consumption rate was taken from WHO (2011) Global Status Report on Alcohol and Health, available at http://www.who.int/substance_abuse/publications on 16 November 2011

40. The Māori worldview says everything we do and say and think creates a spiritual energy, wai rua – two types of energy or influence – dark and light, good and bad, positive and negative, beneficial and malevolent, right and wrong - the aim is to keep things in balance but what happens when the negative outweighs the positive, as it so often does in this world of ours– where does the negative energy go? Maybe tangata whaiora sometimes carry the burden/effect of our (collective) spiritual transgressions? Could mental illness and addiction have a spiritual cause? Do you believe in a spiritual realm? Do you think this could be possible?

Money is everything in this world - without it we have no options, no opportunities, no respect, no means of survival. Entertainers, investors and business magnates earn the most money, they are the billionaires, rewarded much more than our scholars, healers, children and elderly. Everything is a commodity - to be bought and sold in an endless quest for wealth - nothing is beyond exploitation, not even mother earth, children or the human body. Our world is dominated by hyper-consumerism, technology and medical interventions – we live in little boxes, fill them with possessions then strive for bigger, better, newer, faster - everyone is plugged into technology; most of us begin and end our lives in hospital, we are born by induction or caesarean, die with an autopsy and in between we are vaccinated, immersed in electromagnetic energy and lucky if we escape chemotherapy; our DNA is stored, exchanged, modified and mixed with that of the animals; our babies are genetically screened, terminated by the millions and conceived in a petri dish; our food is contaminated with pesticides, preservatives, hormones, antibiotics and additives; coke is cheaper than water and everything is wrapped in plastic; we have depleted our fish supplies, cut down all the forests, destroyed the ozone layer, polluted our waterways and surrounded ourselves with power lines, cell phone towers and urban sprawl; vast wastelands of our garbage are languishing in the ocean poisoning our own foodchain and most deaths are caused by cancers of our own making; the gap between rich and poor is widening, global job markets are shrinking, recession is entrenched and the cost of living is rising; most of us have to learn how to garden again and will never afford our own homes. All this, and more, in the name of innovation, public good, progress, success. Mental wellness is largely marked by our willingness to accept the rat race - 8 hours a day, 5 days week for 45+ years. In our downtime, we drink alcohol and smoke cigarettes, by the bucketful. Worldwide consumption is around 10 million cigarettes a minute and 6.13 litres of pure alcohol per person a year, with New Zealanders guzzling more than most. Alcohol, tobacco and substance use are hallmarks of the good life in middle-to-high income countries of the developed world.

Workforce development – the issues and challenges for social workers

A number of challenges currently undermine social workers' capacity to fully engage in the delivery of better, sooner, more convenient MHA services:

1. Under-representation in workforce data

Social workers have always been a vital workforce for tangata whaiora but this is not represented in workforce development profiles and plans.

Compared with other occupation groups - such as psychologists and nurses - the latest workforce development plan²⁷, suggests social workers comprise less than 4% of the MHA workforce and are least likely to be involved in delivery of services.

Table 6.1: Selected mental health and addiction occupational group workforce numbers, 2004

| Occupational Group | Total Number | Māori | Pacific |
|---|--------------|-------|---------|
| Addiction practitioners | 950 | 22.0% | 4.0% |
| Nurses (active registered) | 3052 | 13.2% | 2.7% |
| Support workers | 1423 | 33.0% | 8.2% |
| Psychiatrists and other medical practitioners working in mental health and addiction services | 528 | 3.0% | 0.4% |
| Psychologists | 1404 | 4.3% | 0.2% |
| Social workers | 311 | – | – |

Source: Tauawhitia te Wero. (See Table 1, page 5, for additional information.)

This statistic grossly under-estimates the role of social workers' in MHA services and is not supported by other data. A

| Fields of Practice | n | % |
|---------------------------------------|------|------|
| anger management | 209 | 5.1 |
| therapy / counselling / psychotherapy | 1893 | 46.0 |
| family / group therapy | 1062 | 25.8 |
| parenting | 857 | 20.8 |
| suicide prevention | 205 | 5.0 |
| maternal mental health | 179 | 4.4 |
| care & protection | 2869 | 69.8 |
| foster care / adoptions | 315 | 7.7 |
| family court | 111 | 2.7 |
| youth / adult justice | 641 | 15.6 |
| AOD | 1126 | 27.4 |
| mental health | 1401 | 34.1 |
| needs assessment | 848 | 20.6 |
| rehabilitation | 1027 | 25.0 |
| refugee resettlement | 79 | 1.9 |
| residential / alternate care | 709 | 17.2 |
| advocacy / mentoring / networking | 1868 | 45.4 |

Table 3: ANZASW membership by fields of practice, 2010/11

comparable analysis of the mental health workforce found up to 30% of staff in NGO and DHB settings were social workers²⁸. Others have shown that 30-40% of the children/adolescents who accessed mental health services in 2010 were seen by social workers²⁹. ANZASW data on fields of practice also suggests widespread involvement in service delivery (Table 3)³⁰. Of 4111 registered members in 2010, 1401 (34%) listed mental health in their fields of practice, 1027 (25%) were involved with rehabilitation and 1126 (27%) delivered alcohol and addiction services. In addition, 179 (4%) said they worked in maternal mental health, 848 (21%) were involved with needs assessment, 205 (5%) delivered suicide prevention services and 1893 (46%) listed therapy, counselling and psychotherapy as their main skillset.

ANZASW believes the under-representation of social workers' involvement in MHA services may be a reason why this professional group has not been targeted for training and workforce development.

²⁷ MoH (2005) Tauawhitia te Wero: Embracing the Challenge - National Mental Health and Addiction Workforce Development Plan 2006-2009.

²⁸ Tapsell, NA (2004) Workforce Profile II. An extended analysis of the mental health workforce. TRM 04/12, Te Rau Matatini, Palmerston North: Massey University.

²⁹ Werry Centre (2011) 2010 Stocktake of Infant, Child and Adolescent Mental Health & AOD Services available at <http://www.werrycentre.org.nz/?t=9> on 21 December 2011.

³⁰ members can select more than one field of practice

2. Participation in training and workforce development

Strategic plans, for training and development of the mental health and AOD sector, have continually emphasized the importance of relationship-building with professional bodies and groups. In 2005, for example, Tuutahitia te Wero³¹ highlighted the need to work alongside professional groups when developing and implementing strategies for:

- generic skills training
- targeted development of AOD, elderly mental health, community, primary mental health and forensic services
- co-ordinated development of the mental health workforce

Te Tāhuhu (2005) and Te Kōkiri (2006) have further acknowledged the importance of relationship-building with professional bodies to ensure:

- workforce training
- continuing professional development
- benchmarking standards of care
- building a mental health and addiction workforce that supports recovery, is culturally capable and committed to a culture of continuous quality improvement.

Over the last ten years, various agencies such as the Mental Health Directorate, DHBNZ, the Mental Health Commission, the now disestablished Health Workforce Advisory Committee and Regional Mental Health Networks have been building relationships with professional groups. Notable examples include the establishment of a Māori mental health workforce development organisation (Te Rau Matatini) and training incentives for support workers. Since 2009, Te Pou³² has been leading the implementation of Let's Get Real, an MoH-developed training programme for the MHA workforce. This programme aims to:

- ensure everyone working in the MHA sector has the knowledge, skills and attitudes that are needed for effective service delivery
- complement the competency assessment frameworks that have been developed by professional bodies
- provide a foundation for future workforce development activities

Let's Get Real is currently in a transition phase³³ but, by 2013, it is expected professional bodies will have integrated the framework within their policies, processes and systems for competency assessment and professional development. It is, therefore, surprising the Aotearoa/New Zealand Association of Social Workers (ANZASW), as the professional body for a significant MHA workforce³⁴, has not been involved in the development of Let's Get Real training opportunities for social workers. It would clearly be prudent for Te Pou and ANZASW to collaborate around this goal.

Collaboration between Te Pou (as the national centre for mental health workforce development) and ANZASW would be provide mutually beneficial opportunities for capacity building, dissemination of information, consolidation of data, identification of workforce needs, alignment of competency frameworks, measurement of outcomes and the development of strategies which ensure social workers are participating in relevant training programmes, such as:

- Skills Matter post-graduate scholarships
- Real Skills training modules for specialist skillsets - working with Māori, Pāšifikā, older people, child and adolescent services and addiction intervention
- interactive Climate MH e-learning professional development
- dialectical behavioural therapy training

³¹ the Mental Health Workforce Development Plan 2002-2005

³² the national centre for mental health research, information and workforce development

³³ MoH (2010) Lets Get Real Implementation Plan: Real skills for people working in mental health and addiction available at <http://www.health.govt.nz/publication/lets-get-real-implementation-plan-on-15-November-2011>.

³⁴ established in 1964

- national mental health leadership and management programmes
- training in talking therapies³⁵, sensory modulation, working with co-existing problems, trauma-informed care, peer support and Knowing the People Planning.

Strengthening social workers', as a workforce for delivery of MHA services, would clearly help to address the current shortage of therapists and specialists able to work with New Zealand's priority groups, such as children, adolescents, youth, mothers and infants, prisoners, refugees and other minority groups. It will also ensure social workers have the skills to work in a range of settings, including integrated, community-based, multi-disciplinary teams delivering "better, sooner, more convenient" MHA services.

3. Professional overlap – blurring of roles and responsibilities

The rapid rise of MHA support workers has posed a number of challenges for the social work profession, both internationally and in New Zealand. A recent survey of ANZASW membership has shown that many are concerned the roles and responsibilities of support workers are encroaching on social work scopes of practice. It is felt the government's investment in accelerated development of the support workforce, combined with lower rates of pay and less burdensome competency requirements, has marginalised and threatened the professional integrity of social workers. There is also a perception social workers are often overlooked, in favour of support workers, when applying for positions and little value is placed on the unique skills social workers bring to MHA services

Elsewhere in the world, a number of statutory and regulatory mechanisms have addressed the issue of professional overlap between social workers and support workers³⁶ roles and responsibilities. In Canada, for example, the Ontario Social Work and Social Service Work Act (1998) paved the way for establishment of an integrated regulatory body³⁷ which has clarified the respective scopes of practice³⁸, defined the boundaries in which each profession can operate (in relation to each other), determined the qualifications, or criteria, needed for registration to practice and taken responsibility for all aspects of professional development. The OCSWSSW acknowledges an inevitable overlap in the scopes of practice for social work and social service work but also identifies clear differences in the methods, knowledge-base which informs each profession's work and purpose or expected outcomes of engagement.

It is unclear whether current moves towards the mandatory registration of New Zealand social workers³⁹ will exacerbate or alleviate concerns about professional overlap. To inform this debate, ANZASW has canvassed views on expansion of their membership to include support workers, as in the Ontario model. Initial findings suggest the notion of alignment with support workers is controversial and unacceptable for some. Moreover, the feasibility of integration, at this late stage, may be unrealistic given the number of professional bodies that have already been established for support workers, particularly those working in mental health and addictions⁴⁰. However, social workers are not the only mental health workforce with boundary concerns. In 2005, the Strategic Framework for Mental Health Service Delivery (Te Tāhuhu) warned of changing professional roles, new disciplines emerging and transformation of established professions. This was a response to the impending involvement of primary health in assessment and treatment roles which have traditionally been held by psychiatrists, clinical psychologists and psychiatric nurses. Unlike our Canadian counterparts, New Zealand has been slow to identify and resolve the various professional boundary issues that are associated with expansion and specialisation of the MHA workforce.

³⁵ see the Te Pou (2009) Action Plan for We Need to Act Talking Therapies 2009-2011

³⁶ called social service workers

³⁷ The Ontario College of Social Workers and Social Service Workers (OCSWSSW), established in 2000

³⁸ See Ontario College of Social Workers and Social Service Workers Scopes of Practice available at <http://www.ocswssw.org> on 30 November 2011.

³⁹ See ANZASW submission to the Social Workers Registration Board (SWRB) available at <http://anzasw.org.nz/publications-2/submissions/> on 16 December 2011

⁴⁰ Including Pathways, Ara Taiohi, Support Workers Association of NZ (SWANZ), Age Concern and the Drug & Alcohol Practitioners Association Aotearoa/NZ (DAPAAANZ).

Data collection & measurement of outcomes

The 1998 Blueprint drew attention to an urgent need for systems and processes that would clarify the requirements for national data collection, enable the measurement of outcomes and monitoring of essential service components and ensure the development of an infrastructure that is able to drive innovation and effective service delivery. Similarly, the leadership challenges identified in Te Tāhuhu (2005) and related documents⁴¹ also emphasized the importance of a transparent and trustworthy system in which:

- there is evidence of a fundamental shift in the way services and society respond to mental illness, with a focus on quality not quantity;
- outcomes are measured in a meaningful way, eg – are the services making a positive difference/helping recovery? Are service-users benefitting?
- data is readily available and used to inform decision-making about service development as well as the quality and effectiveness of services;
- DHBs are demonstrating the value of their investments in MHA services, particularly the benefits for people who are severely affected;
- mental health workers and service users can access and use information to support and enhance recovery.

The last decade has, therefore, brought considerable expansion and refinement of the systems for collecting and reporting on MHA data but it is not clear whether the benefits gained, in terms of improving the quality of care, outweigh concerns about burden, ineffectiveness and risk. Particularly, tangata whaiora fears about their loss of anonymity and workforce perceptions about data collection burden being a barrier to care and not informing practice⁴². A brief review of the type and amount of data that is collected and way it is reported certainly suggests the system could be more effective⁴³.

Appendix 1 lists the seven (7) national datasets, comprising over 400 variables, which aim to assist and inform MoH/DHB/service provider processes for reporting, needs assessment, performance review, monitoring and decision-making about MHA services. In particular, the National Minimum Data Set (NMDS) was introduced in 1993 and contains 136 variables on hospital inpatient/outpatient services. The Mental Health Information National Collection (MHINC) was introduced in 2000 and gathers information on 65 variables which are meant to be submitted by any service that receives public funding for delivery of mental health services. The Mental Health Standard Measures of Assessment and Recovery Initiative (MH-SMART) was introduced in 2005 and is also completed by DHB funded inpatient and community-based services. MH-SMART aims to use mandated tools to measure outcomes across 5 domains but only one domain (clinical symptoms) is measured at present. Three (3) Health of the Nation Outcome Scales (HoNOS) are currently used to gather data about clinical symptoms, comprising 12-17 items, with each scale being administered 3-4 times⁴⁴.

DHBs and NGOs must also comply with the Nationwide Service Framework (NSF) minimum reporting requirements attached to contracts for the delivery of mental health services⁴⁵. The 65 variables are submitted monthly, quarterly, 6 monthly and/or annually across 13 service teams, 102 service types and 13 service settings. DHB performance against national health targets, policy priorities is also measured. In 2007, Key Performance Indicators for Mental Health and Addiction Services (KPIs)⁴⁶ were also introduced and the initial framework comprised 9 performance

⁴¹ such as Burdett, J. (2005). Mental Health Standards Measures of Assessment and Recovery (MH-SMART) Initiative – Implications for Service Users. Te Pou o te Whakaaro Nui, Wellington.

⁴² Fitzgerald, J., Thomas, P., Galyer, K. (2007). Evaluation of Waikato DHB Mental Health Services MH-SMART First Stage Implementation Project. The Psychology Centre, Waikato DHB.

⁴³ compiled from publicly available information

⁴⁴ Two additional HoNOS scales will be introduced in July 2012

⁴⁵ See Appendix 2

⁴⁶ see Appendix 3 for detail and See NDSA (2010) Key Performance Indicator Framework for New Zealand Mental Health and Addiction Services: Phase II – Live Test of the Framework, Review of the Test Phase and Supplementary

indicators and around 30 items that collectively aim to measure and monitor the quality of DHB-funded services. The most recent national dataset, Knowing the People Planning (KPP)⁴⁷, was introduced in 2010. The KPP framework comprises 10 key features (variables) and around 22 indicators which aim to measure the quality of mental health/AOD services from a service-users perspective. KPP is being rolled out nationally and will, no doubt, be mandated for MH-SMART measurement of the consumer outcomes domain.

Alongside the national datasets, DHBs and NGOs have internal systems for collecting data and monitoring or reporting on local/regional/site-specific processes of assessment, treatment, strategic planning, funding, quality assurance and professional competency assessment. Various services use the Alcohol & Drug Outcome Measure (ADOM), Recovery Star (a UK developed consumer outcomes tool that is based on 10 recovery themes) and Beck Depression Inventory (BPI). Tāku Reo, Tāku Mauri (12 domains, 86 items, 6 collection points) is another, recently developed, consumer outcome measure. Hua Oranga (4 domains, 36 items, 4 collection points) is being promoted, and used, as a tool for the measurement of Māori outcomes.

| reporting framework | description | number of variables | information reported | purpose |
|---|---|-----------------------------|---|--|
| Mental Health Services Data Mart (MHS v3) previously called the Mental Health Data Warehouse (MHDW) | MHDW started in 2000, MHS introduced in 2006, reconstructed monthly from MHINC database with additional data from the Primary Care Warehouses, NMDS and the National Health Index (NHI) | 81 | contains information about service-user demographics, use of mental health services, diagnosis and legal status | a high level database, able to be manipulated, aims to inform reporting, monitoring, research, recovery and collaborative approaches to care |
| Programme for the Integration of Mental Health Data (PRIMHD) | introduced in 2009, revised 2011 - integrates information from MHINC and MH-SMART | approx 80 tables and graphs | reports on HoNOS data by a range of MHINC variables - community and inpatient settings, reason for collection (assessment, admission, review, discharge), number of clinically significant items, ethnicity, team type, percentage of users with clinically significant items, clinical symptoms, index of severity | produces 3-6 monthly outcome reports, aims to link information on service provision with outcome measures |
| Office of the Director of Mental Health Annual Reports | introduced in 2005, draws on any relevant dataset | various | reports on the Office's activities, discusses indicators and trends of interest to the sector and general public, eg the 2010 reports on seclusion, compulsion, electroconvulsive therapy and suicide, does not look at causality | produced annually |

Table 4: National Reporting Frameworks – used by MoH/DHBs to monitor, assess, report on mental health data/outcomes

The information in national datasets is aggregated within three (3) reporting frameworks that, ostensibly, provide the main mechanisms for public reporting on MHA services (see Table 4)⁴⁸. Every month, the Mental Health Services Data Mart (MHS DM)⁴⁹ extracts data from the MHINC, NMDS, Primary Data Care Warehouse and National Health Index (NHI) datasets and reconstructs a series of tables on consumer demographics, service use and status. Abstracts from the MHS can also be accessed by researchers and health professionals to inform recovery, shared learning and collaborative approaches to care⁵⁰. In 2009, the MoH introduced their Programme for the Integration of Mental Health Data (PRIMHD) which combines information from the MHINC and MH-Smart datasets and produces 3-6 monthly reports on HoNOS data by a range of variables such as episodes of care, service team, data collection occasion and service setting. Since 2005, the Office of the Director of Mental Health has also produced an Annual Report which contains the information about performance, activities and expenditure as well as discussion about trends and indicators of particular relevance to the mental health sector and general public. In 2010, for example, the Annual Report presented and discussed data on the use of seclusion, compulsion and electroconvulsive therapy.

Indicators available at <http://www.ndsa.co.nz/LinkClick.aspx?fileticket=Hu3aASL4HUw%3D&tabid=95> on 20 December 2011

⁴⁷ see Appendix 4 for more detail

⁴⁸ general information on public hospital events, discharges and morbidity (from the NMDS database) is reported annually by the New Zealand Health Information Service (disestablished in 2008 but roles and responsibilities were transferred to the Ministry of Health)

⁴⁹ previously called the Mental Health Data Warehouse (MHDW)

⁵⁰ see the website portal and chatrooms available at <http://www.hiirc.org.nz>

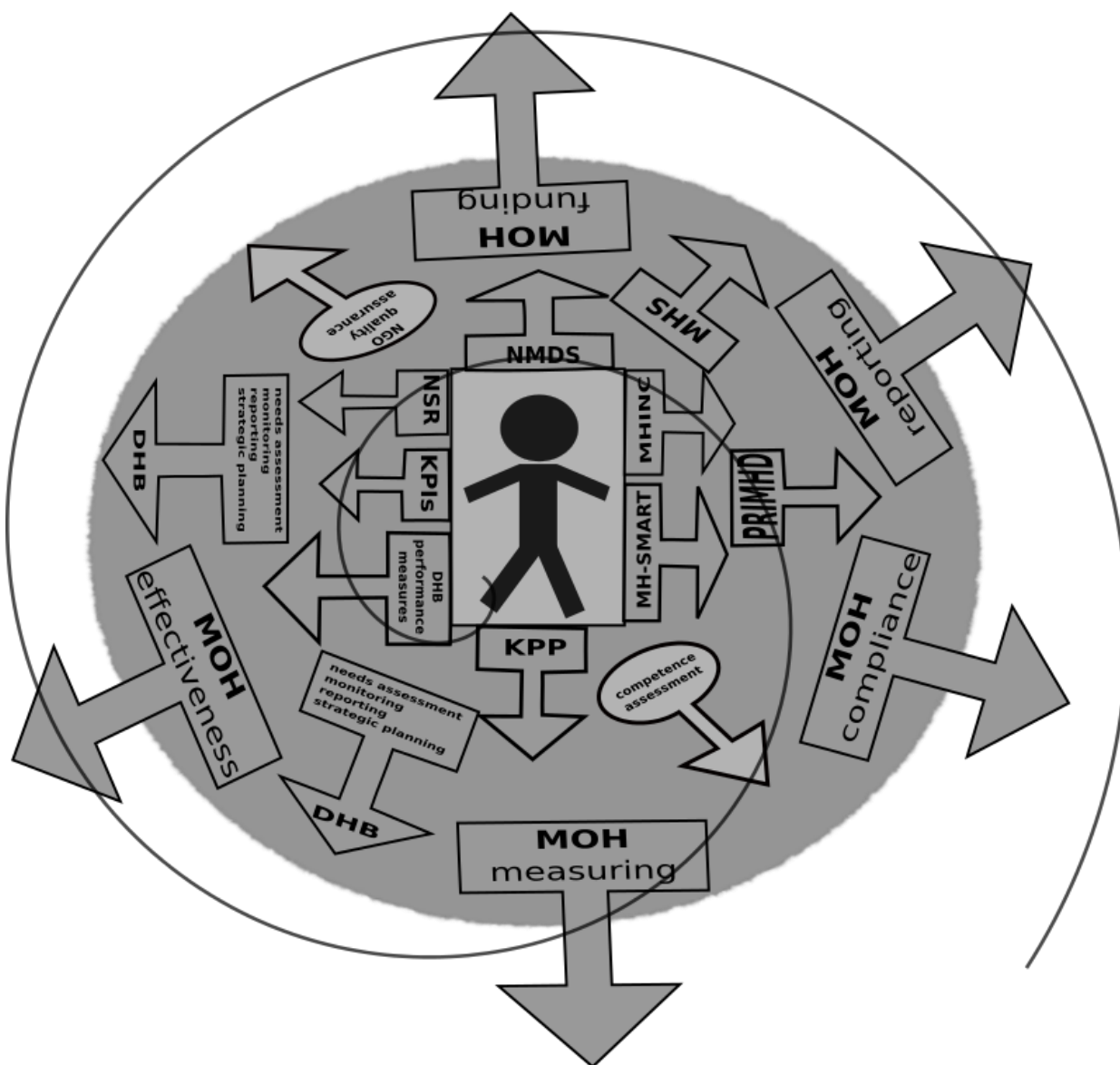


Figure 5: National mental health datasets that are taking, and/or aggregating, tangata whaiora data for monitoring, reporting, quality assurance and decision-making purposes⁵¹

Figure 3 illustrates the national datasets that currently take (vast amounts of) data from tangata whaiora but there is little evidence of the transparent and trustworthy reporting system that was promised in the 1998 Blueprint. Within the public arena, reporting on national mental health datasets seems ad hoc and sporadic with no obvious alignment to decision-making about the quality of service delivery or effectiveness of care. For example, the most recent MHS DM report was published in 2010 on 2007/08 data⁵², Office of the Director Annual Reports are selective and PRIMHD reports are presented as technical tables and graphs without explanation or analysis. To further explore this issue, Table 5 summarises the number and type of publications that have been produced by the Ministry of Health, Mental Health Commission and Te Pou⁵³ over the last 3 years⁵⁴. This shows the most common publications are workforce development/training tools (33%) followed by factsheets (14%), literature reviews (10%), guidelines (10%), evaluation (8%) and research (8%). Less than 4% of the documents produced by these organisations involved reporting on national datasets, monitoring of services (3%) or consolidation of indicators across sectors (1%).

⁵¹ additional data is collected by DHBs/NGOs and community service providers

⁵² available at [http://www.health.govt.nz/publications?page=1&f\[0\]=im_field_category%3A121](http://www.health.govt.nz/publications?page=1&f[0]=im_field_category%3A121) on 18 January 2012

⁵³ The MoH is primarily responsible for reporting on national mental health and addiction data but Te Pou and the MHC are able to access and report on data that is of relevance, under their respective terms of reference.

⁵⁴ see Appendices 5-7 for detail, excludes MHS DS, PRIMHD & Office of the Director Annual Reports

| | guidelines / standards | workforce development / training | position paper | strategic plans | action plans | literature review / discussion document / bibliography | reporting on national datasets/outcomes | consolidation of indicators (across sectors) | monitoring | research / pilot of new techniques | evaluation / review of service delivery | factsheet / information resource | total | % |
|--------------------------|------------------------|----------------------------------|----------------|-----------------|--------------|--|---|--|-------------|------------------------------------|---|----------------------------------|---------------|---------------|
| Ministry of Health | 6 | 3 | 0 | 0 | 3 | 0 | 2 | 0 | 0 | 0 | 2 | 5 | 21 | 12.35 |
| Mental Health Commission | 1 | 2 | 0 | 2 | 0 | 3 | 3 | 2 | 5 | 0 | 5 | 4 | 27 | 15.88 |
| Te Pou | 10 | 51 | 7 | 4 | 1 | 14 | 1 | 0 | 0 | 13 | 6 | 15 | 122 | 71.76 |
| total | 17 | 56 | 7 | 6 | 4 | 17 | 6 | 2 | 5 | 13 | 13 | 24 | 170 | 100.00 |
| % | 10.00 | 32.94 | 4.12 | 3.53 | 2.35 | 10.00 | 3.53 | 1.18 | 2.94 | 7.65 | 7.65 | 14.12 | 100.00 | |

Table 5: Number and type of mental health publications produced by key reporting agencies, 2009-2011⁵⁵

A closer look at the content of publications that have recently reported on national data⁵⁶ shows the Ministry of Health and Te Pou generally use basic descriptive techniques to summarise raw data on service use, and/or HoNOS outcomes, by demographic and provider characteristics. To demonstrate this point, Figure 4 duplicates an MoH diagram, on the information contained in their latest report on MHS data, which not only confirms the use of a descriptive approach but also signals problems with the integrity of data. Such findings suggest New Zealand's investment in workforce development and service delivery guidelines tends to be driven by research and literature reviews rather than policy recommendations which have come from the analysis of national data.

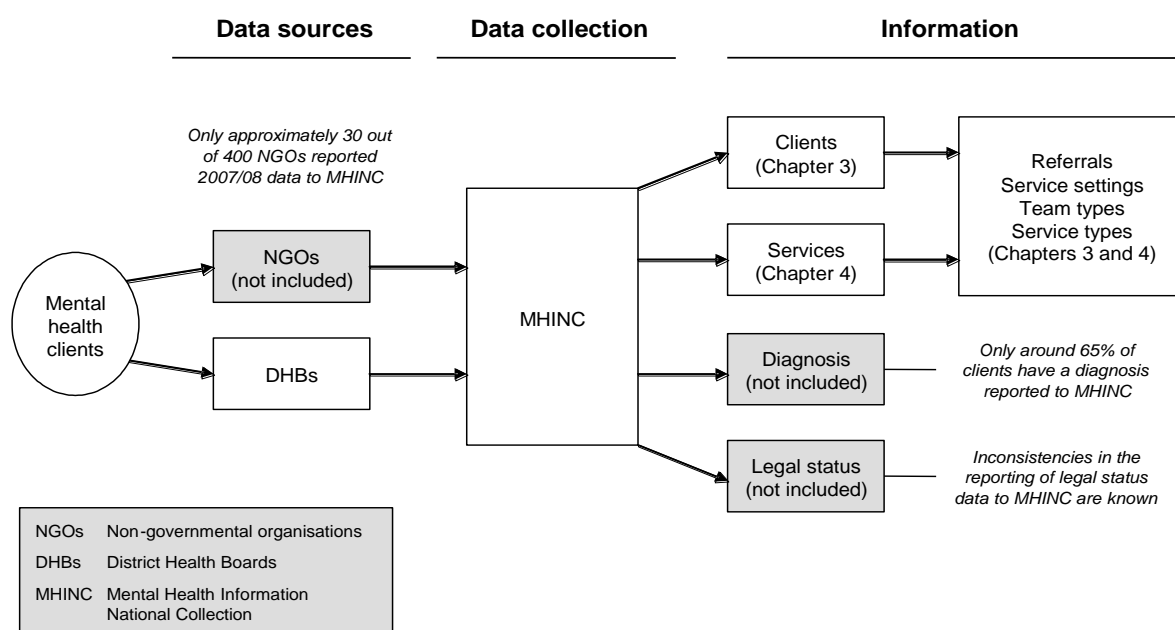


Figure 6: "Information in this publication" pg 2 MoH (2010) Mental Health Service Use in NZ 2007/08

In contrast, documents produced by the Mental Health Commission tend to work across multi-agency datasets and use a range of techniques (including sector visits and qualitative surveys) to supplement and report on national datasets, measure the effectiveness of services, monitor performance, develop indicators and identify benchmarks for conceptualising the impact of MHA issues from a whole of society perspective. In particular, *MHC (2011) Regional Performance to Blueprint Targets 2007/08, 2008/09 and 2009/10*⁵⁷ provides one of the few publicly available reports on DHB performance in the mental health sector (as defined by the 1998 Blueprint targets)

⁵⁵ numbers are not absolute, documents may have more than one classification

⁵⁶ see Appendix 8 for more detail

⁵⁷ available at <http://www.mhc.govt.nz/publications/regional-performance-blueprint-targets> on 24 January 2011

⁵⁸. This report demonstrates the efficacy of targets for monitoring and reporting on national and regional delivery of mental health services. For example, it shows:

- actual expenditure on Blueprint targets is difficult to track because of inadequacies in data collection and cross-overs in budget allocations, eg - primary mental health services and elderly services are not funded by the ring-fenced Blueprint budget, service model reconfigurations and inter-district flow are not captured;
- a national underspend of 20%, with most regions not reaching the target;
- the 14% increase in mental health funding since 2007/08 has largely been used to meet the increased cost of existing services instead of new services;
- adult mental health inpatient beds and community FTEs are below target and falling but more money is being channelled towards community support FTEs and residential beds;
- DHB spend on AOD services varies widely but community FTEs are at 94% of the national target, the number of beds and methadone places has increased and detoxification is generally happening in an NGO, rather than hospital settings;
- there is huge variability in child & youth services but community FTEs have decreased nationally and are well below target (73%), the number of day programmes is decreasing and has only reached 33% of the target and the number of beds is 40% below target;
- child and adolescent services should receive 26% of the mental health budget but they only received 12-14% in 2009/10;
- forensic beds are 22% below target and have decreased since 2008/09 but general expenditure on forensic services and community FTEs have exceeded the target in all regions except the South Island, this has largely been driven by new prisons;
- community FTEs for older people are 29% below target and day programmes for this group are 89% below target - Waikato, BoP and Tairāwhiti are the only regions with funded programmes, the number of beds is 17% below target;
- early intervention and prevention services are difficult to measure and DHBs are not reporting FTEs or expenditure, there is an urgent need for service specifications to inform DHB purchasing;
- specialist services (such as prevention services and those that meet the needs of mothers and babies, people with eating disorders, refugees) are under-developed and vary widely across DHBs, community FTEs are 45% below target and the number of beds has increased by a mere 0.5%, most DHBs have no specialist beds and Blueprint funding has mainly been used for GP consultations, mental health co-ordinators, primary health practitioner training in CBT, talking therapies, packages of care.

This is the type of analysis that needs to underpin Blueprint/MHASDP strategies for DHB monitoring, service development and performance review. However, it is disconcerting to note, the organisation that is most likely to engage in such analysis, the MHC, is about to be disestablished⁵⁹. New Zealand invests millions of dollars in the collection and maintenance of a mental health dataset that is clean, accessible, up-to-date and ready for use but there is little sign of the same commitment to analysis! The national datasets contain a wealth of information that should be regularly reported and contributing to an evidence-base that informs government decision-making about the effectiveness of services and strategies to improve delivery.

⁵⁸ previous MHC documents have contained some information about DHB performance, notably MHC (1998) Blueprint for Mental Health Services in NZ: the way things need to be and MHC (2006) Te Haererenga mo te Whakaoranga 1996-2006 – the journey of recovery for the Mental Health sector.

⁵⁹ see Tony Ryall (Hon) press release dated 11 August 2011 on disestablishment of the Mental Health Commission with functions transferred to the Health & Disability Commissioner (HDC).

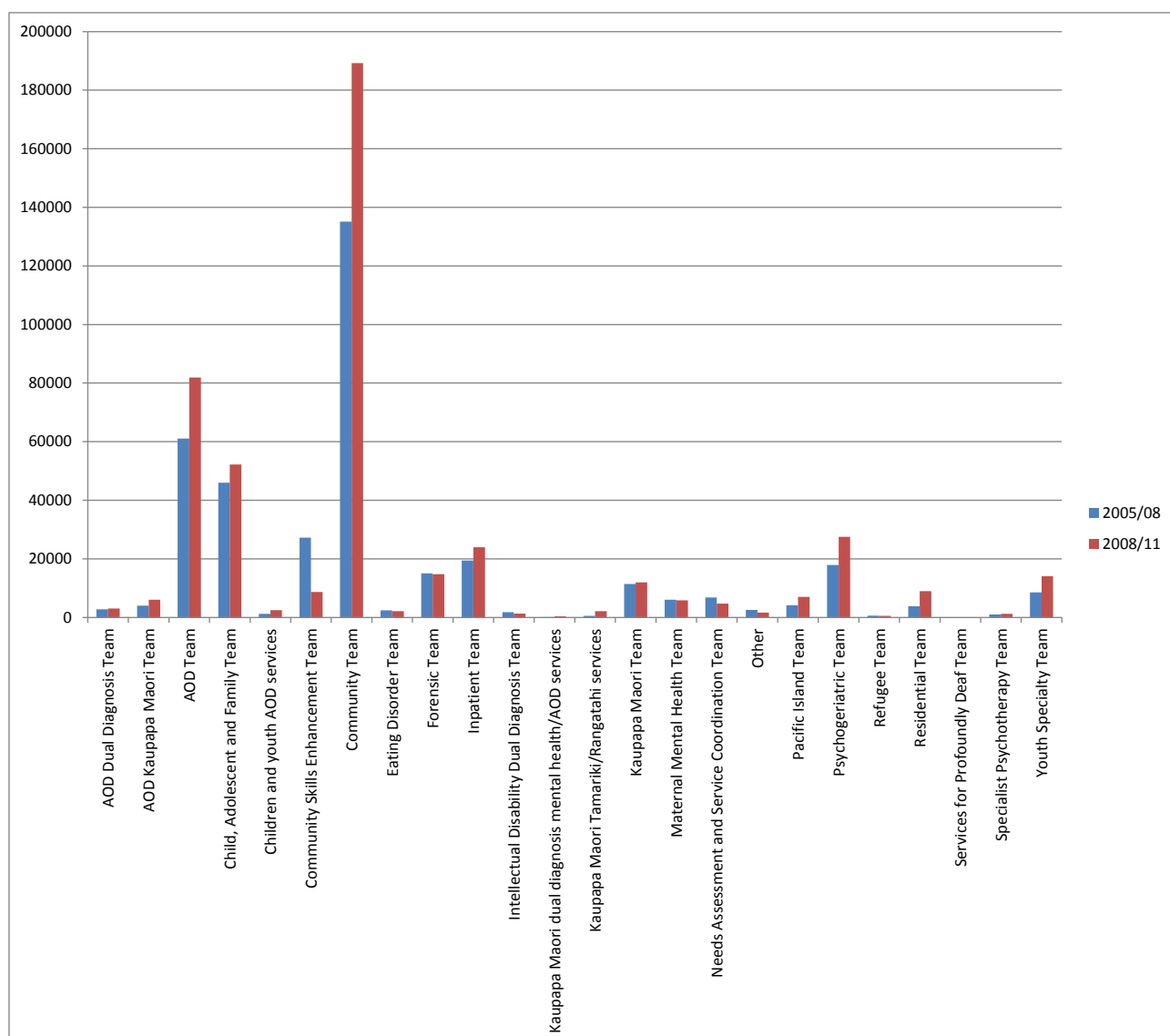


Figure 7: Triennial trends in total clients seen by service team, 2005/08 and 2008/11⁶⁰ (MHS data extracted for ANZASW on 16 December 2011)

In their *2010 Stocktake of Infant, Child & Adolescent Mental Health & AOD Services in New Zealand*⁶¹, the Werry Centre drew on national datasets to identify a 6% increase in the child and adolescent workforce between 2008-2010⁶² that was accompanied by a 9% increase in vacancies, 9% decrease in the Māori workforce, 26% decrease in the Pacific workforce and 20% increase in the number of children/adolescents (0-19 years) accessing services. Such findings are important and should be supplemented by analyses that assist decision-making about workforce development/service delivery priorities. Whilst preparing for this submission, for example, ANZASW requested MHS data on the ethnicity of service users by service team since 2005. General description of this simple dataset (Figures 1 and 7, Tables 2 and 6) has identified a number of trends that not only supplement the Werry Centre findings but also highlight the services that are under stress and ways in which Māori are accessing services, notably:

- Māori are disproportionately represented across most age-groups, specifically 10-14 years, 15-19 years, 20-24 years, 25-29 years, 30-34 years, 35-39 years and 40-45 years;
- most service users are seen by Community (40%) and AOD teams (17%), access to these services has increased by 30-40% since 2005/08;

⁶⁰ clients may have been seen by more than one team

⁶¹ available at <http://www.werrycentre.org.nz/?t=9> on 24 January 2012

⁶² largely clinical

- Child, Adolescent & Family Teams saw 11% of service-users in 2008/11 and there has been little change in the number of people accessing this service since 2005/08;
- 24% of mental health service users are 0-19 years of age, but only 15% were seen by Child & Youth services (of any type) in 2008/11;
- the number of Māori coming through Kaupapa Māori teams has increased by 26% since 2005/08 but the vast majority continue to be seen by mainstream services (86%), non-Māori use of Kaupapa Māori services has increased by 35%;
- capacity for Kaupapa Māori Tamariki/Rangatahi service delivery has had to expand rapidly in recent years - the number of non-Māori service-users has increased by 23% and Māori access has increased by 700% since 2005/08;
- non-Māori access to Child & Youth AOD services has increased by 48% since 2005/08 but the number of Māori accessing this service increased by 400%, Māori youths are twice as likely to be seen by AOD services;
- Kaupapa Māori Tamariki/Rangatahi and Child & Youth AOD teams saw less than 2% of mental health service users;
- 25% of Māori mental health service-users were seen by AOD services in 2008/11, compared with 19% of non-Māori and the number of Māori accessing AOD services (of any type) has increased by 54% since 2005/08;

| | 2005/08 | 2008/11 | ratio | % 2008/11 |
|---|---------------|---------------|-------------|---------------|
| AOD Dual Diagnosis Team | 2772 | 3079 | 1.11 | 0.65 |
| AOD Kaupapa Maori Team | 4020 | 6075 | 1.51 | 1.29 |
| AOD Team | 61076 | 81935 | 1.34 | 17.35 |
| Child, Adolescent and Family Team | 46002 | 52218 | 1.14 | 11.06 |
| Children and youth AOD services | 1239 | 2522 | 2.04 | 0.53 |
| Community Skills Enhancement Team | 27243 | 8705 | 0.32 | 1.84 |
| Community Team | 135136 | 189227 | 1.40 | 40.07 |
| Eating Disorder Team | 2458 | 2148 | 0.87 | 0.45 |
| Forensic Team | 15045 | 14803 | 0.98 | 3.13 |
| Inpatient Team | 19419 | 23972 | 1.23 | 5.08 |
| Intellectual Disability Dual Diagnosis Team | 1776 | 1292 | 0.73 | 0.27 |
| Kaupapa Maori dual diagnosis mental health/AOD services | 148 | 414 | 2.80 | 0.09 |
| Kaupapa Maori Tamariki/Rangatahi services | 553 | 2177 | 3.94 | 0.46 |
| Kaupapa Maori Team | 11439 | 12009 | 1.05 | 2.54 |
| Maternal Mental Health Team | 6035 | 5852 | 0.97 | 1.24 |
| Needs Assessment and Service Coordination Team | 6800 | 4728 | 0.70 | 1.00 |
| Other | 2556 | 1664 | 0.65 | 0.35 |
| Pacific Island Team | 4194 | 7037 | 1.68 | 1.49 |
| Psychogeriatric Team | 17872 | 27506 | 1.54 | 5.82 |
| Refugee Team | 625 | 539 | 0.86 | 0.11 |
| Residential Team | 3802 | 8984 | 2.36 | 1.90 |
| Services for Profoundly Deaf Team | 0 | 46 | n/a | 0.01 |
| Specialist Psychotherapy Team | 1006 | 1248 | 1.24 | 0.26 |
| Youth Specialty Team | 8533 | 14056 | 1.65 | 2.98 |
| total | 379749 | 472236 | 1.24 | 100.00 |

Table 6: Relative increase in total client numbers since 2005 and proportionate use of services during last triennial, 2008/11 (MHS data extracted for ANZASW on 16 December 2011)

Although HoNOS data (Figures 2 and 3) suggests the severity of illness is increasing, and community services are dealing with more complex cases, MHS data shows few have access to specialist services:

- the number of youths accessing specialist youth services has increased by 60% but less than 3% of service-users saw a Youth Specialist in 2008/11;
- access to Dual Diagnosis services has increased by 20% but less than 1% of service users were seen by these teams in 2008/11;
- access to Psychotherapy services has increased by 24% but 0.26% of service-users were seen by these teams in 2008/11;
- 1% of non-Māori and 0.77% of Māori service-users were seen by Maternal Mental Health specialists in 2008/11 and access is generally declining;
- less than 3% of service users had access to needs assessment, service co-ordination and skill enhancement teams in 2008/11;
- Forensic specialists saw 3% of service users in 20-08/11 but access is declining;
- 0.45% of service-users seen by specialist teams for Eating Disorders but access is declining;
- 10% of non-Māori mental health service-users are aged 65+, and their use of psychogeriatric services has increased by 55%, but only 7% of non-Māori service users had access to psychogeriatric specialist teams in 2008/11;
- Inpatient teams see 5% of service users and the number of people accessing this service has increased by 23%;
- Māori access to Inpatient services has increased by 47% compared with a 17% increase for non-Māori;
- roughly 2% of mental health service users are seen by Residential teams and the number of people coming through this service has doubled since 2005/08.

| | non-Māori | | | | Māori | | | |
|---|-----------|---------|-------|-----------|-----------|---------|-------|-----------|
| | 2005/2008 | 2008/11 | ratio | % 2008/11 | 2005/2008 | 2008/11 | ratio | % 2008/11 |
| Alcohol and Drug Kaupapa Maori Team | 604 | 1250 | 2.07 | 0.35 | 3416 | 4825 | 1.41 | 4.19 |
| Kaupapa Maori dual diagnosis mental health and AOD services | 45 | 77 | 1.71 | 0.02 | 103 | 337 | 3.27 | 0.29 |
| Kaupapa Maori Tamariki/Rangatahi (child and youth) services | 288 | 354 | 1.23 | 0.10 | 265 | 1823 | 6.88 | 1.58 |
| Kaupapa Maori Team | 2445 | 2901 | 1.19 | 0.81 | 8994 | 9108 | 1.01 | 7.90 |
| total seen by Kaupapa Māori Team | 3382 | 4582 | 1.35 | 1.28 | 12778 | 16093 | 1.26 | 13.96 |
| Alcohol and Drug Dual Diagnosis Team | 1995 | 2347 | 1.18 | 0.66 | 777 | 732 | 0.94 | 0.64 |
| Alcohol and Drug Kaupapa Maori Team | 604 | 1250 | 2.07 | 0.35 | 3416 | 4825 | 1.41 | 4.19 |
| Alcohol and Drug Team | 46759 | 59897 | 1.28 | 16.78 | 14317 | 22038 | 1.54 | 19.12 |
| Children and youth, alcohol and drug services | 972 | 1437 | 1.48 | 0.40 | 267 | 1085 | 4.06 | 0.94 |
| Kaupapa Maori dual diagnosis mental health and AOD services | 45 | 77 | 1.71 | 0.02 | 103 | 337 | 3.27 | 0.29 |
| Intellectual Disability Dual Diagnosis Team | 1594 | 1037 | 0.65 | 0.29 | 182 | 255 | 1.40 | 0.22 |
| total seen by AOD team | 51969 | 66045 | 1.27 | 18.50 | 19062 | 29272 | 1.54 | 25.40 |
| Kaupapa Maori dual diagnosis mental health and AOD services | 45 | 77 | 1.71 | 0.02 | 103 | 337 | 3.27 | 0.29 |
| Alcohol and Drug Dual Diagnosis Team | 1995 | 2347 | 1.18 | 0.66 | 777 | 732 | 0.94 | 0.64 |
| Intellectual Disability Dual Diagnosis Team | 1594 | 1037 | 0.65 | 0.29 | 182 | 255 | 1.40 | 0.22 |
| total seen by Dual Diagnosis Team | 2040 | 2424 | 1.19 | 0.68 | 880 | 1069 | 1.21 | 0.93 |
| Child, Adolescent and Family Team | 36234 | 40520 | 1.12 | 11.35 | 9768 | 11698 | 1.20 | 10.15 |
| Children and youth, alcohol and drug services | 972 | 1437 | 1.48 | 0.40 | 267 | 1085 | 4.06 | 0.94 |
| Kaupapa Maori Tamariki/Rangatahi (child and youth) services | 288 | 354 | 1.23 | 0.10 | 265 | 1823 | 6.88 | 1.58 |
| Youth Specialty Team | 6822 | 10861 | 1.59 | 3.04 | 1711 | 3195 | 1.87 | 2.77 |
| total seen by child/adolescent team | 44316 | 53172 | 1.20 | 14.90 | 12011 | 17801 | 1.48 | 15.44 |
| Specialist Psychotherapy Team | 918 | 1083 | 1.18 | 0.30 | 88 | 165 | 1.88 | 0.14 |
| Maternal Mental Health Team | 5143 | 4959 | 0.96 | 1.39 | 892 | 893 | 1.00 | 0.77 |
| Eating Disorder Team | 764 | 2042 | 2.67 | 0.57 | 1694 | 106 | 0.06 | 0.09 |
| Forensic Team | 9736 | 8718 | 0.90 | 2.44 | 5309 | 6085 | 1.15 | 5.28 |
| Intellectual Disability Dual Diagnosis Team | 1594 | 1037 | 0.65 | 0.29 | 182 | 255 | 1.40 | 0.22 |
| Psychogeriatric Team | 16866 | 26204 | 1.55 | 7.34 | 1006 | 1302 | 1.29 | 1.13 |
| Services for Profoundly Deaf Team | | 35 | | 0.01 | | 11 | | 0.01 |
| total seen by other specialist team | 35021 | 44078 | 1.26 | 12.35 | 9171 | 8817 | 0.96 | 7.65 |
| Needs Assessment and Service Coordination Team | 5292 | 3998 | 0.76 | 1.12 | 1508 | 730 | 0.48 | 0.63 |
| Community Skills Enhancement Team | 26177 | 6368 | 0.24 | 1.78 | 1066 | 2337 | 2.19 | 2.03 |
| total seen by skill enhancement teams | 31469 | 10366 | 0.33 | 2.90 | 2574 | 3067 | 1.19 | 2.66 |
| Community Team | 105799 | 150945 | 1.43 | 42.28 | 29337 | 38282 | 1.30 | 33.21 |
| Inpatient Team | 15034 | 17528 | 1.17 | 4.91 | 4385 | 6444 | 1.47 | 5.59 |
| Residential Team | 2820 | 6621 | 2.35 | 1.85 | 982 | 2363 | 2.41 | 2.05 |
| total seen by community, inpatient, residential teams | 123653 | 175094 | 1.42 | 49.05 | 34704 | 47089 | 1.36 | 40.85 |

Table 7: Triennial data on ethnicity of clients showing relative increase as ratio and proportionate use of services (data extracted from MHS DM for ANZASW on 16 December 2011)

This collection of findings highlights numerous shortcomings in current systems for analysing, monitoring and reporting the information contained in national mental health datasets. It is relevant to recall concerns expressed in the early 90s, when the Ministry of Health was extolling the virtues

of NHI-linked electronic health data collection, consumers feared this would result in vast amounts of their personal data being taken and stored without investment in proper analysis. It is alarming to find this is precisely what has happened. Now the government is advocating opening up this database so personal information can be shared across primary and mental health services⁶³ and tangata whaiora have reason to be concerned.

By their own Operational Standard⁶⁴, the Ministry of Health has an ethical obligation to use the information they are gathering to improve service delivery and their reasons for collecting data must be valid. In objective review, it is doubtful whether collecting and storing personal data for the sake of it, without appropriate analysis, would be considered valid. Under the ethical principle of Informed Consent, it is relevant to note, consumers of health and disability services (in this case tangata whaiora) have the right to decline consent for their information to be collected and, if relevant, withdraw their information from datasets. Given the paucity of analysis, lack of transparency and little evidence of alignment with decision-making about service delivery, this course of action would clearly be justified.

This submission has alluded to some of the ways in which the data that is currently stored in national mental health datasets could be analysed to inform decision-making about the effectiveness of service-delivery. Most notable is the need for routine:

- monitoring, description and reporting of national datasets by relevant demographic and service delivery variables, eg – age-group, sex, ethnicity, region, service setting, service team, clinical symptoms (HoNOS outcomes), episode of care, readmission rates;
- reporting the use of treatment techniques (such as seclusion, compulsion, sensory modulation, medication, talking therapy, other CBT) by relevant variables, eg - how many children/youths/ adults and elderly are on medication and why? what types/combinations/dosages of medication are prescribed and for how long?, are there ethnic/gender/age-group differences /inequities in the use of treatment techniques? How many tangata whaiora have access to talking therapy?
- monitoring residential facilities (respite, acute, transitional, independent) to standardise the quality of care, identify programme development opportunities and ensure participation in appropriate therapeutic/recovery focused/early intervention activities;
- identification of trends and changes in population group needs, the way in which services are being accessed or used and associated workforce capacity themes, eg – which populations have the greatest need?, which services are under stress?, what are the priorities for real-time investment in workforce capacity?

The need for a considered approach to the collection of mental health data, which ensures the factors associated with effective service delivery can be readily identified, has been continually emphasized in New Zealand's scientific literature and evidence-base. In 2009, for example, Dr Murray Patton, and experts appointed to the NZ Metabolic Working Group⁶⁵, developed guidelines for monitoring and recording information about the metabolic status of people prescribed anti-psychotic medication to reduce the likelihood of side-effects. In 2010, the University of Canterbury⁶⁶ reviewed the effectiveness of non-pharmacological interventions for people with dementia but had to exclude 73% of 364 eligible studies, from an initial pool of 4043 published articles, because the data was narrative and/or not able to be extracted. Similarly, the MHC's

⁶³ pg 4, MoH (2011) MHASDP Draft Paper for stakeholder engagement, 4 July 2011.

⁶⁴ see MoH (2006) Operational Standard for Ethics Committees, Wellington, Ministry of Health and NEAC (2006) Ethical Guidelines for Observational Research – Observational Research, Audits & Related Activities. Wellington, National Ethics Advisory Committee.

⁶⁵ see guidelines produced by Dr Murray Patton and the NZ Metabolic Working Group in 2009 available at <http://www.tepou.co.nz/library/research/141> available on 21 September 2011.

⁶⁶ Basu, A and Brinson, D. (2010). A Systematic Review of the Literature. The effectiveness of non-pharmacological interventions for behavioural and psychological symptom management for people with dementia in residential care settings. Health Services Assessment Collaboration. Christchurch. University of Canterbury.

recent attempt to identify national indicators for measuring mental health and addiction in New Zealand was limited by a lack of comparable data⁶⁷.

These studies draw attention to the need for national mental health data to be collected in a form that is useable, able to be compared with other datasets and amenable to more complex, multivariate (epidemiological) statistical techniques, eg – measures of association, regression, factor analysis. In other words, the data must be numeric which means string variables (those that contain letters) have to be coded or converted into a useable numeric form, preferably linear or binary. There are many examples of national mental health data that is not amenable to the types of analyses that would help to explore the effectiveness of care. Most salient is the data on use of medications, other treatment techniques, service providers, KPP outcomes and various DHB performance measures. Such findings highlight the pressing need for:

- scrutiny and refinement of national mental health datasets (including DHB performance measures) to reduce data collection burden, improve the reliability of data and ensure the information is still of relevance (valid), eg – remove or amend variables that are not analysed and/or do not provide useful information, add variables that would be of value (such as post-discharge HoNOS scores to capture change over time);
- a standardised set of questions that will inform the effectiveness of care, eg – which service teams/assessment processes/treatment techniques are associated with lower readmission rates, less use of seclusion/compulsion/medication, less need for support services, increased likelihood of employment, better consumer outcomes (sustained decline of clinical symptoms? improved Hua Oranga scores?) and service-user perceptions about the quality of care (an overall KPP score?) as well as their progress towards recovery (a single, multi-dimensional score?);
- coding/recoding/conversion of variables, if relevant;
- analysis of the information available within existing datasets to explore and identify the factors associated with effective care/better outcomes.

Investment in robust, transparent analysis of the information already contained in national mental health datasets is long overdue, and an achievable, cost effective strategy for not only informing decision-making about the effectiveness of care but also generating knowledge about some of the burning issues that have not been adequately addressed in New Zealand's evidence-base, eg.:

- When does medication enable/hinder recovery? what side-effects do most people experience and how are they treated? should medication be a first or last option? Does medication influence the efficacy of psychotherapy, CBT, other alternative techniques?
- How does medication impact on HoNOS outcomes? Is fewer clinical symptoms (less severity) at discharge associated with medication or actual recovery? Does alternative care have a similar influence on HoNOS outcomes?
- Which treatment techniques have better outcomes and for whom - alternative or conventional care, psychotherapy or pharmacology, seclusion or sensory modulation;
- What happens to the tangata whaiora that do not have access to specialist care? How are they treated? What if they decide conventional care has nothing to offer them? What happens to them? Where do they go? Do they recover?
- What happens to Māori in mainstream services and how does this differ from Kaupapa Māori models of care? Which service has better outcomes for Māori and their whānau?
- Has devolution to the primary sector improved the effectiveness of mental health services, if so, for whom? What impact has primary care had on tangata whaiora experience of assessment/treatment techniques?

Such investment will also provide real-time opportunities to identify and respond to prioritised population, service delivery and workforce capacity needs (such as the above 700% increase in the number of Māori accessing Kaupapa Māori Tamariki/Rangatahi services, 400% increase in Māori use of Child & Youth AOD services and little more than 1% of service users nationally having access to specialist psychotherapy services).

⁶⁷ MHC (2011) *ibid*.

The NEW service development plan (MHASDP)

Figure 8 presents a simple, but valid, diagram of the logic one would expect to underpin decision-making about New Zealand's **three billion dollar** (\$3bn) investment in MHA services each year⁶⁸. This suggests the development of service delivery plans is normally grounded in data analysis, knowledge about the effectiveness of care, identification of needs and strategic goals or priorities.

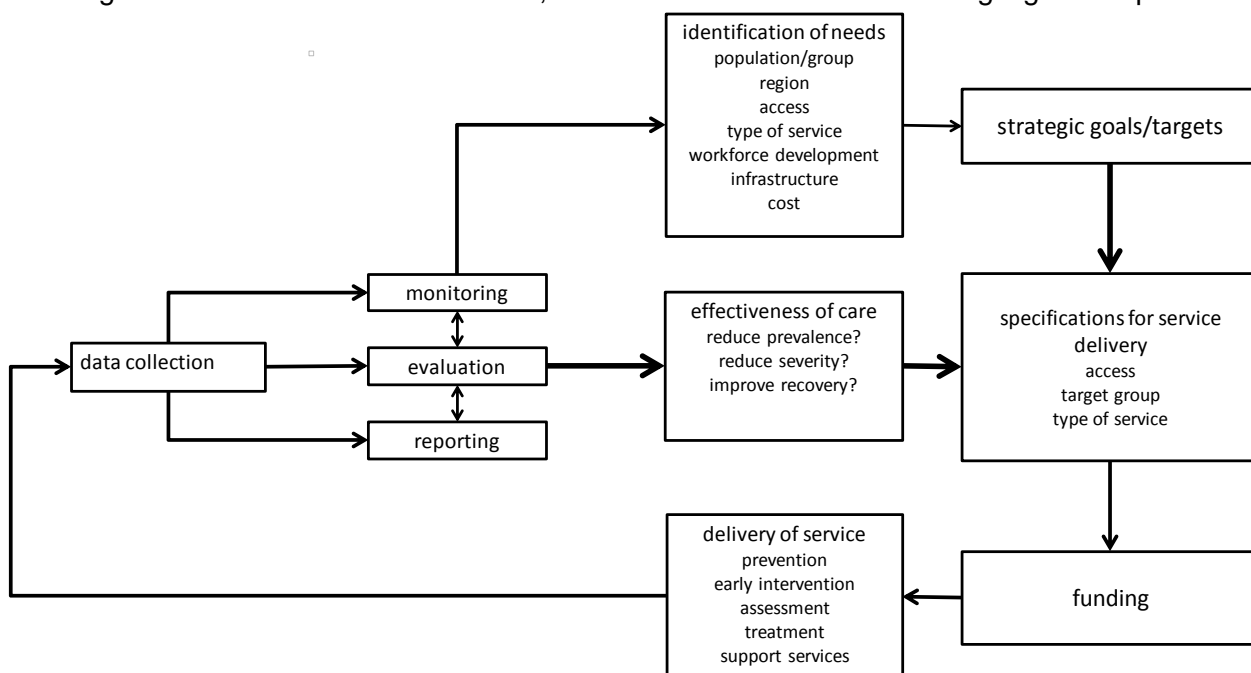


Figure 8: Decision-making logic for development of service delivery plans

Sadly, this is not the case in Aotearoa/NZ. Alongside inadequacies in the analysis and reporting of data, and subsequent lack of knowledge about effectiveness and needs, another defining feature of New Zealand's MHA sector is a confusing, hierarchical, labyrinth of strategies, frameworks, principles and plans⁶⁹. Alignment of the principles and strategic directions within MHASDP, Blueprint II and other relevant plans will help to clarify objectives and actions as well as improve capacity for monitoring, evaluating and reporting on a uniform, comparable set of outcomes.

Appendix 9 demonstrates the plethora of central government principles, goals, directions, performance indicators, critical success factors, focus areas, actions and milestones that are simultaneously vying to shape the delivery of MHA services in New Zealand right now. In particular, Te Tāhuhu (and its action plan Te Kōkiri) has 10 leadership challenges and 133 actions for resolution and/or implementation by 2015. Te Puāwaiwhero (2007) presents a consolidated vision about the specific goals and actions that would improve the effectiveness and cultural relevance of services for Māori. At the same time, the KPI framework for measuring DHB performance was launched. In 2009 the Nationwide Service Framework (NSF) was revised and quickly followed by the Mental Health & Addiction Action Plan (MHAAP) with its one year programme of 4 prioritised actions, 25 actions and 30 milestones for 2010-2011. Overriding all of this, are the Minister of Health's priorities of strengthening the health workforce, improving hospital productivity, speeding up implementation of their Primary Health Care Strategy⁷⁰ and value for money. It is of interest to look at the synergies within these strategies, prioritised actions, frameworks and indicators because this will identify the factors that are currently driving MHA service development and the parameters, therefore, for constructive engagement in MHASDP and Blueprint review.

⁶⁸ based on expenditure for the 2010/11 year, cited in MHC (2011) Developing Blueprint II available at www.mhc.govt.nz on 5 February 2012.

⁶⁹ The KPI framework for DHB MHA services was informed by 21 strategic plans and 14 policy documents all of which had been published by the Ministry of Health in the previous 6 years (see CMDHB (2007) Report on the KPI Framework).

⁷⁰ available at <http://www.nationalhealthboard.govt.nz/sites/all/files/BSMC%20ebooklet.pdf> on 4 February 2011

| Te Kōkiri (2005 - 2015) | Te Puāwaiwhero (2008-2015) | KPI Framework (2009) | Nationwide Service Framework (2011) | Mental Health & Addiction Action Plan (2010-2011) | MoH Health Policy Priorities (2011/12 & 2012/13) | Minister of Health's Priorities (2012/13) |
|-------------------------------------|--|-------------------------|---|---|--|---|
| 10 leadership challenges | 4 priorities | 9 indicators | 5 mandated services | 4 priority actions | 14 priorities | 4 priorities |
| promotion & prevention | effective & culturally relevant | effective | adult services | move health resources to increase access/improve outcomes | improve clinical leadership, self assessment | strengthen the health workforce |
| building mental health services | promotion & prevention | appropriate | infant, child, adolescent & youth specialist services | lift system performance to enhance wellbeing | implement Better, Sooner More Convenient primary health care | improve hospital productivity |
| responsiveness | early intervention & primary health care | efficient | addiction specialist services | tackle alcohol and other drug-related harm | Māori engagement in DHB decision making/development of strategies/ plans for Māori health gain | speed up implementation of the Primary Health Care Strategy |
| workforce & culture for recovery | specialist services | accessible | eating disorder specialist services | integration across government agencies | improve mainstream effectiveness | improve value for money |
| Māori mental health | | continuous | consumer leadership specialist services | | waiting times for chemotherapy treatment | |
| primary health care | | responsive | | | improve health status of people with severe mental illness through improved access | |
| addiction | | capable | | | improve mental health services use of crisis prevention planning | |
| funding mechanism for recovery | | safe | | | DHBs report AOD service waiting times and waiting lists | |
| transparency & trust | | sustainable | | | delivery of Te Kōkiri: The Mental Health and Addiction Plan | |
| working together | | | | | oral health DMFT Score at year 8 | |
| | | | | | children caries free at 5 years of age | |
| | | | | | utilisation of DHB funded dental services by adolescents | |
| | | | | | more children enrolled in DHB funded dental services | |
| | | | | | family violence prevention | |

Table 8: Synergies between strategic directions, NSF tier 1 services & MoH annual targets/priorities

The NSF is aligned with annual health targets⁷¹ (introduced in 2007/08) and policy priorities which together provide a powerful 3 tier mechanism for determining the health services DHBs deliver⁷². Health targets and policy priorities are associated with various “deliverables” that DHBs are contracted to provide⁷³. “Improving Mental Health Services” was a health target under the Labour government in 2007/08 but National has used a policy priorities approach. Table 8 suggests nine of the 14 current policy priorities⁷⁴ have a direct (4), or indirect (5), focus on MHA services. Prioritised actions in the fast-tracked MHAAP (Appendix 11) obviously provided a platform for testing and orienting service delivery towards new methods and techniques that are now being rolled-out nationally through policy priorities (Table 9), notably:

- electronic note sharing;
- GP telephone access to specialist mental health advice and use of electronic decision-support tools;
- delivery of mental health services through Integrated Family Health Centres⁷⁵ in primary care settings;
- use of Relapse Prevention Plans, KPIs and the KPP tool;
- positive parenting programmes as an intervention to improve mental health outcomes, eg - Incredible Years and Primary Care Triple P.

⁷¹ a set of national performance measures designed to improve performance and provide a focus for action available at <http://www.nationalhealthboard.govt.nz/our-priorities/health-targets> on 4 February 2012.

⁷² Tier 1 services (n=5) are mandatory whereas Tier 2(n=13) and Tier 3 services (n=106) are recommended or supplementary, decision-making about the delivery of Tier 2 and 3 services is at the discretion of DHBs

⁷³ See DHB non-financial Monitoring Framework and Performance Measures available at <http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/445> on 10 February 2012.

⁷⁴ It is unclear whether there are 14 or 20 policy priorities for the 2012/13 year - the NHB lists 14 health priorities for 2011/12 on their updated website <http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/456> but the 2012/13 Monitoring Framework & Performance Measures refers to 20 policy priorities.

⁷⁵ See Midlands Health Network (2011) Integrated Family Health Centres – Putting Patients at the Centre of Primary Health Care available at <http://www.waikatodhb.govt.nz/file/fileid/36268> on 10 February 2012

| Policy Priority | | reporting process | expectations | deliverables |
|-----------------|---|----------------------------|--|--|
| PP-01 | improving clinical leadership, self assessment | annual reports | foster clinical leadership, professional development, networking | evidence of progress |
| PP-02 | implementation of Better, Sooner More Convenient primary health care | quarterly progress report | people take greater responsibility for managing their own health/making healthy life choices; population-based approach to disease-prevention/health promotion; improve access to primary care for people with higher health needs (eg Māori, Pacific, low decile); manage the care for patients with chronic/long-term conditions | shift services from secondary to primary care settings, develop Integrated Family Health Centres, report on BSMC primary health care business cases and BSMC related data (eg service type, client use, number of referrals, waiting times) |
| PP-03 | Local Iwi/ Maori engagement and participation in DHB decision making, development of strategies and plans for Māori health gain | six monthly full reports | Māori are involved in decision-making/delivery of services; governance training; development of DHB Māori health plans | evidence of MoU's between DHB/Crown Māori Relationship Boards (MRBs), governance training for Māori DHB/MRB/PHO Board/Tumu Whakarae members, DHB Māori Health Plans showing needs, and national/regional/local health priorities |
| PP-04 | improving mainstream effectiveness | six monthly full reports | review pathways of care, reduce inequalities, improve effectiveness of care for Māori | report number of reviews undertaken in last 6 months, pathways and actions taken |
| PP-06 | improving the health status of people with severe mental illness through improved access | 6 monthly, agreed in DAP | engage in activities/programmes likely to improve access/health status of target group | report the number of children & youth (1-19yrs); young adults (20-24yrs) and older people (65+) seen by ethnicity |
| PP-07 | improving mental health services using crisis prevention planning | 6 monthly, agreed in DAP | use KPP or similar planning tool to develop relapse prevention plans, fewer people access service, fewer people need long-term care, address gaps in service delivery | report on adults in treatment for more than two years or more; children/youth in secondary care for 1 year or more years; the number/percentage of clients with up-to-date relapse prevention/treatment plans by ethnicity/group, describe RRP methods |
| PP-08 | DHBs report alcohol and drug service waiting times and waiting lists | 6 monthly, full report | reduce waiting times, address co-existing issues | identify services with longest waiting time & targets, report data by ethnicity/service type (inpatient detoxification, specialist prescribing, structured counselling, day programmes and residential rehabilitation) |
| PP-09 | delivery of Te Kōkiri: The Mental Health and Addiction Plan | annual, full report | implement Te Kōkiri | evidence of progress |
| PP-14 | Family Violence Prevention | annual confirmation report | reduce incidence, improve internal evaluation, develop policy, training, intersectoral partnerships/collaboration for referral/support services, be responsive to Māori | guidelines/action plans are implemented, co-ordinators are appointed |

Table 9: Policy priorities with a direct and/or indirect focus on mental health and addiction issues, 2012/13

The policy priorities have positioned DHBs to shift the delivery of mental health services from secondary to primary care; use new tools for planning and programme delivery; actively engage in critical self-review, collaboration and relationship building; focus on relapse prevention; implement guidelines for family violence prevention; address the needs of Māori, adults, children and youth; reduce waiting times and find innovative solutions to improve the effectiveness of care. Tier 1 (mandatory services) of the revised NSF has also ensured DHBs will nurture consumer leadership and continue to deliver general MHA services for adults as well as specialist services for addiction; eating disorders; infants, children, adolescent and youth. These directions meet some of the challenges outlined in Te Kōkiri⁷⁶, and the implementation of more actions is a policy priority (PP-09), but the enormity of this task within the context of constrained budgets, existing DHB workloads and lack of guidance on how this might be achieved makes further progress unlikely. If we assume alignment with Te Kōkiri is a service development goal, some of the more notable gaps in current specifications, and directions for MHASDP review, include:

- ✘ the new NSF has not broadened the range of services available, promoted recovery and ensured all service users have their needs met, particularly people diagnosed with personality disorders, first time psychosis, experience of trauma and rural communities (action 2.2);
- ✘ the specifications have not addressed the need to ensure primary care providers can improve access to psychological therapies, service user-led services, independent peer-led-services, community support services, recovery education and advocacy, home-based support services, family/whānau support services, community and home-based acute services and respite services (action 2.5);
- ✘ there are no specifications for demonstrating evidence of involvement in inter-sectoral activities that support recovery (action 2.7);

⁷⁶ Such as actions 1.4, 1.10, 6.6, 7.1, 7.12,

- ✘ the framework for child & youth mental and addiction service provision (New Futures)⁷⁷ has not been revised and updated to identify actions that would address the needs of youth, forensic services, severe behavioural disorders, responsibility for AOD services, maternal and infant mental health, children of parents/whānau with mental illness and low prevalence conditions (goal 2.10);
- ✘ the specifications have not broadened the range, quality and capacity of services available for people with high and complex needs, including recovery focused rehabilitation services (goal 2.18);
- ✘ there is no specification for recovery plans to be developed in collaboration with tangata whaiora and their family/whānau/support networks to address broader physical, spiritual, social and psychological needs (goal 3.2);
- ✘ there are no specifications for implementation of Te Puāwaiwhero actions, eg - 50% of Māori have access to Kaupapa Māori services (goal 5.1);
- ✘ there are no specifications for development of Māori focused cultural and clinical competency in mainstream services and ensuring Māori are able to access to traditional Māori therapies, whānau inclusive packages of care and treatments that are based on the wider concept of whānau ora, (goal 5.5);
- ✘ there are no KPIs for delivery of MHA services in primary settings (goal 6.2);
- ✘ there is no requirement for DHBs and primary providers to use a holistic approach when assessing and addressing the needs of people most severely affected by mental illness/AOD (goal 6.3)
- ✘ the new specifications have not broadened the range of services that are funded for substance use problems (goal 7.2)
- ✘ it is not clear how the revised NSF was informed by the NZ Survey of Mental Health & Wellbeing Epidemiology Study (if this was ever completed) to ensure a better match between service delivery and population needs (goal 9.3);
- ✘ there are no specifications for implementing the mental health components in multi-agency strategies, eg – Making Links, the Youth Offending Strategy, E Tipu E Rea, the Youth Development Strategy (goal 10.7).

A number of concerns about current directions in the specifications for service delivery should also inform MHASDP review, such as:

- ✘ the overall focus of service delivery has changed from recovery to relapse prevention plans, ie – the PP-07 deliverable is number/percentage of clients with relapse prevention plans;
- ✘ the deliverable for local iwi/Māori engagement and participation (PP-03) should not be restricted to MoUs with Māori Relationship Boards – this approach will exclude Māori whānau/hapū/communities who are not represented by MRBs and marginalize participation by equally transparent decision-making authorities, eg - Māori Authorities, Māori Land Trusts, Marae representatives;
- ✘ more information is also needed about the expected outcomes of local iwi/Māori engagement and participation (PP-07), if this the vehicle for MoUs about delivery of MHA services (eg Whānau Ora early intervention/rehabilitation/therapeutic programmes), it will be important to have deliverables that enable decisions to be made on a case-by-case basis with a range of suitable providers (eg – Māori Land Trusts, community groups, NGOs and other Māori Provider Organisations)
- ✘ there is considerable unease about the extensive list of Tier 2 and 3 supplementary services (see Appendices 9 and 10). The implication is these services are least likely to be funded, most likely to be down-sized or phased out and associated workforce development/capacity building is unlikely to be supported. The MHASDP needs to provide clear messages about the vision for these services, the value that is placed on the workforce(s) involved with delivery and the

⁷⁷ MoH (1998) New Futures available at [http://www.moh.govt.nz/moh.nsf/Files/newftres/\\$file/newftres.pdf](http://www.moh.govt.nz/moh.nsf/Files/newftres/$file/newftres.pdf) on 13 February 2012.

actions that will ensure equitable access to a range of services under the BSMC model of primary care;

- ✘ the supplementary (Tier 2 and 3) classifications have clearly undermined the likelihood of culturally appropriate, population-specific service delivery, in which Social Workers are widely involved, eg - community support, crisis respite, day programmes, early intervention, housing and recovery, needs assessment and co-ordination, wrap around packages of care, community based intensive recovery, specialist community services with accommodation and peer support services for adults, children, adolescents and youth.
- ✘ Service specifications do not value the therapeutic potential of Kaupapa Māori models of care as a viable alternative to mainstream techniques. Kaupapa Māori providers are among the Tier 2 and 3 supplementary services that are less likely to be funded and most likely to be phased out - including general MHA services, community based clinical and support services, consultation, liaison and advisory services, packages of care, Kaumatua services and Whānau Ora workers. As a supplementary support option, Kaupapa Māori will not have the opportunity to gather or demonstrate evidence of effective, responsive, appropriate MHA service delivery as defined by the KPI framework. In other words, the specifications have set Māori up to fail.
- ✘ the NSF has not allocated specific funding for MHA engagement in the fundamental process of liaison, relationship-building and establishment of linkages across key sectors/agencies/communities such as primary and secondary health, needs assessment and co-ordination; home and community support services; residential services; supported independent living services; habilitation/rehabilitation services; specialist support services; information and advisory services; local Māori/Pacific health providers, Māori/Pacific community groups, consumer support services and other government agencies (eg - Education, Justice, Police, MSD). Liaison and networking is key to the identification of innovative collaborative initiatives for improving the effectiveness of care;
- ✘ NSF exclusions have precluded sector involvement in the development and delivery of therapy and support services for people who have experience of trauma, which is a known, evidence-based, precursor to life-long mental illness and addiction, eg - sexual abuse, violence and anger, learning difficulties, anti-social behaviours, conduct disorders, parenting difficulties and relationship issues;
- ✘ the current specifications provide no guidance or direction on the need to strengthen and ensure equitable access alternative models of care such as specialist-led cognitive behavioural therapies, dialectical behavioural therapy, talking therapies, psychotherapy, mentalisation based therapy, peer support, service-user led services and other problem solving, inter-personal, holistic techniques;
- ✘ the specifications have not addressed the evidence-based need to eliminate the use of seclusion⁷⁸, in crisis intervention, and introduce more effective techniques, eg – sensory modulation, psychotherapy;
- ✘ specifications are also needed to minimise the use of compulsion (particularly for Māori males) and decrease regional variability in compulsory treatment orders;
- ✘ community leadership specialist services have Tier 1 status in the current NSF but there is a need for more information about scope and expected deliverables;
- ✘ development of the policy priorities, NSF, BSMC model of care, KPI framework, KPP tool and RRP content has been underpinned by the misleading assumption medical (pharmaceutical) techniques for MHA assessment and treatment will be effective for everyone;
- ✘ the KPI framework⁷⁹ lacks content validity and will not produce meaningful information about DHB performance in its current form, eg – inpatient change in the total HoNOS scale, 28 day acute readmission rates and employment/housing status are not the only measures of effective care; responsiveness is more than the number of complaints, contacts with family and service provider collaboration; seclusion rates are not a measure of safe service provision; the framework, in general, has not been designed to capture information about recovery and culturally appropriate models of care.

⁷⁸ The MHC identified this goal in 2007

⁷⁹ Appendix 3

Transparency of MHA service devolution to primary health care

In the public arena, there is an unacceptable dearth of information about the quality assurance process DHB's have to follow when devolving MHA services to primary health care. The lack of transparency has given rise to speculation about an ad-hoc, experimental approach that is left to DHB discretion. Stakeholders, service providers, professional bodies and the MHA workforce have numerous questions which need to be addressed in the MHASDP, Blueprint II or some other public accessible forum. For example:

- ✚ It is unclear whether, or how, MHA primary health care providers will be assessed, or screened, for competence, appropriateness and suitability to provide community-based MHA services, eg – how will DHBs know whether they have the skillsets, linkages and cultural competence to not only provide an acceptable service but also engage with tangata whaiora? One recent study has shown that GPs find it difficult to detect depression in elderly Māori⁸⁰. Will primary health care providers be assessed at all? How will this information influence decision-making about the MHA services they are contracted to provide?
- ✚ On pg 14 of Mental Health & Addiction Services for Older People and Dementia Services⁸¹, published in June 2011, the Ministry of Health presents a seven-tiered model of care (see Appendix 12) for IFHCs. Is this what the BSMC model of MHA service delivery in primary care will look like?
- ✚ What skillsets will the multi-disciplinary team have in MHA primary health care? Will there be a psychologist, psychiatric nurse, social worker and support worker in every team? Who will clarify and define the professional boundaries between these roles? What other health professionals/allied health professionals might be involved? Will every team have a kaumatua and cultural advisor? What is the difference between a delegated care manager and mental health co-ordinator? Who can apply for these jobs?
- ✚ The use of e-therapies, electronic self-help tools and diagnostic aides in MHA primary care is innovative, cost efficient and time-saving but will not be suitable for everyone. Social Workers are concerned such techniques will become standard care and be quickly linked to additional time-saving techniques (from the GPs perspective) such as electronic prescription of medication needs. IFHC development has been underpinned by promises of “more personalised care” and “better access” but those who have lobbied for community-based MHA services never envisaged face-to-face contact (with a human being) would be replaced by electronic self-help and diagnostic techniques. Where is the evidence which shows that this is what tangata whaiora need? The use of electronic techniques in MHA care needs to be closely monitored – is this information being collected? Is there a quality assurance process? Who is responsible for reporting? Will access be the only indicator of effectiveness? Will outcomes be monitored?
- ✚ What are the protocols for electronic note sharing? Do tangata whaiora have to give consent? Will service providers retain a copy after transfer? Can tangata whaiora opt-out of the system? Can tangata whaiora ask for their information to be deleted? Will tangata whaiora be notified when their file is transferred to another provider? Will tangata whaiora have any control at all? What happens in the case of death or Power of Attorney? Can tangata whaiora make an Advance Directive about access and use of their personal information? How will the confidentiality, anonymity and privacy of tangata whaiora be protected?
- ✚ Will MHA primary health care providers be involved in the development and delivery of community-based MHA support services including residential facilities and programmes for prevention, early intervention, recovery, rehabilitation? Who will ensure these services are available in every community? How will this be aligned with the BSMC model of MHA service delivery? Will primary health care be expected to collaborate with established providers of MHA support services? Will new collaborations be formed? How will this process be supported? managed? monitored? Will DHBs or PHOs be accountable for the quality of service delivery?

⁸⁰ MoH (2011). Mental Health and Addiction Services for Older People and Dementia Services: Guideline for district health boards on an integrated approach to mental health and addiction services for older people and dementia services for people of any age. Wellington: Ministry of Health.

⁸¹ MoH (2011) *ibid*

- ✚ NGOs, Charitable Trusts, Christian Services, Māori Health Providers and other community groups are established providers of community-based MHA support services. These organisations have been building their capacity, expertise, workforce, quality assurance systems for many years. This is a strength that shouldn't be lost! Will these organisation have to collaborate with primary health care? What will the contracting arrangements look like?
- ✚ The MoH has recently published guidelines on setting up DHB collaborations for regional services planning⁸² but there is no publicly available information about the establishment of collaborations across PHOs, IFHCs, BSMC primary health care services, NGOs, MHOs and other community providers. This information is urgently needed.
- ✚ Will the shift to primary health care lead to the demise of NGO/Kaupapa Māori/Pacific/Community providers of appropriate MHA clinical and support services? Should they be concerned about their future? Will they compete for these services? Is it more likely the contracts for these services will be given to primary health care providers?
- ✚ Who will have responsibility for collecting, monitoring and reporting on BSMC models of MHA service delivery? How will the information be collected? Will MHA service delivery in primary settings be captured in NMDS, MHS and DHB performance monitoring systems? What KPIs will be in place? Will primary health care providers be using HoNOS, KPP, RRP, Hua Oranga tools? Will they have discretion to use other tools if they wish, eg Becks Depression Index? Recovery Star? Who will analyse this data and report on the effectiveness of care? Have the problems with capturing data from NGOs/DHBs under the old system been sorted yet? How will the bureaucracy cope with this additional layer of complexity?

Guiding principles

The MHC discussion document on Blueprint II⁸³ provides the most up-to-date (publicly available) information on the new service development plan, albeit in draft form. This suggests the primary goal for service development, over the next 3 years, is likely to be:

“To improve rates of recovery for those already accessing services while providing better access to effective services to improve mental health and wellbeing for a wider range of people”

Given the limitations of current data collection, specifically the inability to measure concepts of recovery, effectiveness and wellbeing, in an acceptable and rigorous way, it will be impossible to achieve this goal. We think the government should instead be honest about the upheaval and realignment that will occur in the MHA sector over the next 3 years. A vision of substantial investment in building the capacity of communities to provide innovative sustainable mental health and addiction services that meet local needs would seem to be a more realistic goal, and one that is worth striving for.

We also believe the Treaty of Waitangi is an important guiding principle for a sector that says it wants to improve the effectiveness of services for Māori. In addition, there are the equally compelling principles of trust, transparency and effectiveness which would have to be the holy grail of MHA service delivery that we are striving for.

As stated above, we think it is important to ensure alignment and synergy between the principles, objectives, priorities, aims and leadership challenges that are simultaneously influencing developments in the mental health sector, irrespective of which political party happens to be in government. Over time, this would have to be the most cost-efficient way of identifying needs, building an evidence-base and demonstrating progress towards guiding principles and strategic goals that will truly help tangata whaiora on their journey of recovery. For this reason, we urge the need to continue implementation of Te Kōkiri actions in the new service development plan.

⁸² MoH (2012) Regional Services Planning - How district health boards are working together to deliver better health services available at <http://nationalhealthboard.govt.nz/sites/all/files/Regional%20%20Services%20Planning.pdf> on 13 February 2012.

⁸³ MHC (2011) Developing Blueprint II

Blueprint II Review

In general, ANZASW supports the directions MHC has identified for Blueprint II. Having engaged in this rather comprehensive review of underlying challenges, we believe Blueprint II could clarify some of the grey areas that may shackle progress in the MHA sector over the next few years. We submit a few comments for consideration.

The last thing tangata whaiora need is another long, drawn out vision of nebulous goals and aspirations that may never be achieved. It is disappointing, for example, that years of working towards Blueprint objectives never produced a measureable definition of recovery that could now be used as a KPI for monitoring DHB (and primary care) performance. Similarly, the goals of eliminating seclusion, alternative models of care and establishing a trustworthy, transparent system for monitoring and reporting MHA data were never achieved. The amount of time (and money) it takes to upskill the workforce and develop useable outcome measures is interminable⁸⁴. Within the context of a broader 10-year vision, we think Blueprint II should provide hard-hitting messages about the developments that need to be achieved within 1, 2 and 3 year timeframes.

We agree with the 4 objectives that make up the scope for Blueprint II and anticipate the MHC's work on national indicators, measuring social inclusion, child and youth mental health and the meaning of recovery will provide the background for critical discussion. We are particularly interested in:

- resource packages for working across sectors and agencies to create a recovery-focused environment and hope this will address many of the concerns identified above, eg - how will NGOs and IFHCs work together? Will the BSMC model lead to the demise of NGOs and community groups? Where are the opportunities for multi-agency investment in essential community development of early intervention, prevention, recovery, day programmes, rehabilitation? Is there a need for targets to ensure community access and development of alternative models of care?
- support service designs that will maximise consumer/whānau and community contribution to MHA outcomes, eg – will whānau have opportunities to run locally based early intervention, prevention, rehabilitation programmes for at risk youths around the Whānau Ora model? How do whānau providers engage/collaborate with primary health care providers?

However, we think the Blueprint II scope should have 2 additional objectives.

1. **Identify** resource paths for clarifying the linkages and professional boundaries within the MHA workforce and identifying targets the mix of BSMC skillsets , eg – how many social workers, support workers, cultural advisors, AOD workers, psychologists, psychiatric nurses, specialists are needed in each community provider? What are the boundaries for each professional groups in terms of expected roles, functions, skillsets.
2. **Clarify** the monitoring framework that will underpin the reporting of MHA data over the next 3 years.

The latter objective is about improving trust and transparency, it aims to avoid the ad-hoc, fragmented approach to monitoring and reporting that has been evident in recent years. Over the last decade, for example, MHC has had responsibility for monitoring implementation of the Blueprint and MoH/Health Services has been responsible for reporting MHA data but neither was bound by a transparent, collaborative work programme that aimed to maximise the opportunities for whole of sector monitoring, reporting and development of an evidence-base. To make matters worse, there were no obvious linkages between those who were involved with monitoring/reporting and those who were developing outcome measures and performance indicators. This is why we have KPI and KPP frameworks that need further development.

We are fearful, the current system has already been structured around a similar fragmented approach. On one hand, MHC dis-establishment information says MHC functions (which will no doubt include monitoring Blueprint II implementation) will be transferred to the Health & Quality

⁸⁴For example, work on a Māori outcome measure began in 2000, the KPP tool has been in use since 2003 and the need for workforce training in talking therapies and cognitive behavioural therapy was identified 10 years ago.

Safety Commission (HQSC)⁸⁵. Across the entire health sector, the HQSC has been charged with the challenging task of driving improvement in quality and safety, identifying data sets and key indicators to inform and monitor improvements, reporting publicly on safety and quality including performance against national indicators and disseminating knowledge. Then, on the other hand, the Terms of Reference for the National Health Board (NHB) suggest they will be responsible for

“funding, monitoring and planning Bringing together the various activities with strategic planning and funding of future capacity (Information Technology) so they can be better integrated and driven by future service requirements ...”⁸⁶

Several other agencies and groups are also involved in the collection, analysis, dissemination of national mental health and addiction data, notably MoH Sector Services (which oversees the work of National Systems & Collection and Data & Statistics) and the National Health IT Board is responsible for systems implementation and advice, including development of Shared Care and IFHCs functions and capability. For these reasons, we believe there is an urgent need for the Blueprint II scope to pose the questions no-one else is asking, eg:

- ✘ HOW these various agencies will work together (collaborate) to ensure robust reporting and analysis of MHA data across the whole sector (eg - DHBs, PHOs, NGOs, BSMC primary health care)?
- ✘ WHO is developing a collaborative work programme and will it capture transition data?
- ✘ WHAT are the resource options and mechanisms in terms of MHA sector funding/planning?
- ✘ WHAT are the short/long term actions, priorities starting with for the next 3 years.

Within the body of this submission, ANZASW has identified a raft of MHA quality and safety actions/priorities that would strengthen trust, improve transparency and build the evidence base on effectiveness of care, eg:

- ✘ improve validity of the KPI framework, or create new KPIs (for use in both DHBs and BSMC settings)
- ✘ develop a (numeric) measure of recovery, eg - a single score
- ✘ report on the use of medications by clinical symptoms, service team and reasons for admission
- ✘ report outcomes by reason for admission, treatment and service team
- ✘ identify more complex, multivariate techniques that would inform the effectiveness of care, eg – comparison of recovery profiles by medication and alternative care, identify when medication works and for whom
- ✘ report contextual information about onset/cause/reason for admission by treatment techniques;
- ✘ capture post-discharge HoNOS scores to measure effectiveness of treatment techniques over time
- ✘ check validity of satisfaction survey, develop new data collection techniques, eg – get whānau to talk about their experience, preferred treatment options
- ✘ gather evidence on the effectiveness of Kaupapa Māori models of care as an alternative to mainstream (medical) models of care.

⁸⁵

⁸⁶ NHB Terms of Reference available at <http://www.nationalhealthboard.govt.nz/about-us/terms-of-reference-on-17-November-2012>.

Appendix 1:

National Data Collection Systems – Mental Health

| database | description | number of variables | type of information collected/reported | purpose |
|---|---|--|--|---|
| National Minimum Data Set (NMDS v7.2) | introduced in 1993 (backloaded to 1988), revised 1997/98, rolled out 2000 - collects DHB hospital inpatient/outpatient information | 136 | agency, facility type, diagnosis, clinical treatment/procedure, legal status, description of health event (eg length of stay, personal details, DRG code), health provider | MOH reporting |
| Mental Health Information National Collection (MHINC v3.8) | piloted 1997, introduced 2000, collected from all publicly funded services, eg community, residential, NGOs; data is loaded to MHDW twice a month | 65 | client information, reporting period, service setting, units of service, agency name/type, diagnosis type/date, clinical code/type/code, admission/discharge, team code, healthcare user (eg DOB, ethnicity, NHI, sex), referral source/tpe/code, service provider code/team/agency/dates, admission, event type, facility, team type/details | reporting via MHDW |
| Mental Health Standard Measures of Assessment and Recovery Initiative (MH-SMART) | introduced 2005-06, collected by DHB funded services, uses mandated tools to measure outcomes across 5 domains (clinical symptoms, functioning, consumer outcomes, AOD outcomes, Māori outcomes); Health of the Nation Outcome Scale (HoNOS) is the only mandated tool at present, measures clinical symptoms | HoNOS 18-65 yrs (12 items), HoNOSCA 4-17 yrs (17 items), HoNOS65+ (12 items) | 4 data collection points (assessment, admission, review, discharge), clinical symptoms = overactive, aggressive, disruptive, agitated behaviour; non-accidental self-injury; problem drinking/drug taking; cognitive problems; physical illness/disability; hallucinations/delusions; depressed mood; other mental/behavioural problems; relationship problems, problems with daily living, living conditions, occupation and activities | gathers baseline data for PRIMHD, aims to measure change over time (outcomes), 2 additional scales to introduced in July 2011 (HoNOS Secure & HoNOS LD |
| DHB Reporting Requirements for Mental Health Services, part of the Nationwide Service Framework (NSR) | attached to DHB/NGO contracts/service specs, collected before and after PRIMHD reporting | 57 variables across 13 service teams, 102 service types ¹ and 13 service settings ² | # of face-to-face contacts/liaison/group sessions with client/family, # of training sessions/placements/needs assessment, # of clients, FTEs, length of stay, # of beds used/available, # of admissions/readmissions/transfers/suicides/discharges, # of staff changes, # of self/involuntary discharges, # of referrals back to GP, # of people on waiting list, average length of time on waiting list | data is reported monthly, quarterly, 6 monthly and annually - informs DHB performance, Regional Strategic Plans, health needs assessment, planning, funding |
| DHB Performance Measures | DHB performance (including funded NGOs) is measured against national health targets, policy priorities, system integration and ownership | 48 variables | contains 5-22 measures that gather information on the performance of mental health services, eg - clinical leadership, iwi engagement, improving mainstream services for Māori, improving health status of people with severe mental illness, improving mental health services using crisis intervention planning, reporting on AOD service waiting times, delivery of Te Kōkiri | reports on % achievement of targets and evidence-based reports on mechanisms, processes, relationships, achievements |
| DHB KPI Framework | introduced in 2007, all DHB funded services required to gather data | 9 performance indicators, 21 variables, approx. 36 items (compiled from analysis of aggregated data, scoring across scales, etc) | are services effective, appropriate, efficient, accessible, continuous, responsive, capable, safe, sustainable | aims to inform DHB performance |
| Knowing the People Planning (KPP) | introduced 2010/2011, all DHBs required to use it, measures outcomes from service-user perspective | 10 key elements, roughly 22 indicators | prompt access to services when needed, treatment leading to discharge and self-management, personal assessment and treatment plans, relapse prevention plans, continuity of care, health treatment and advice, social support, service accountability, co-ordination of services, service evaluation | gathers information on service-user experience, aims to inform DHB service delivery |

¹ service team by number of service types = Adult (27); Infant, Child, Adolescent (18); Eating Disorders (6); Consumer Led (6); Kaupapa Māori (5); Pacific (4); Family & Whānau (2); Addiction (12); Forensic (7); Youth Forensic (2); Maternal (5); Asian, Migrant, Refugee (4); Older People (4)

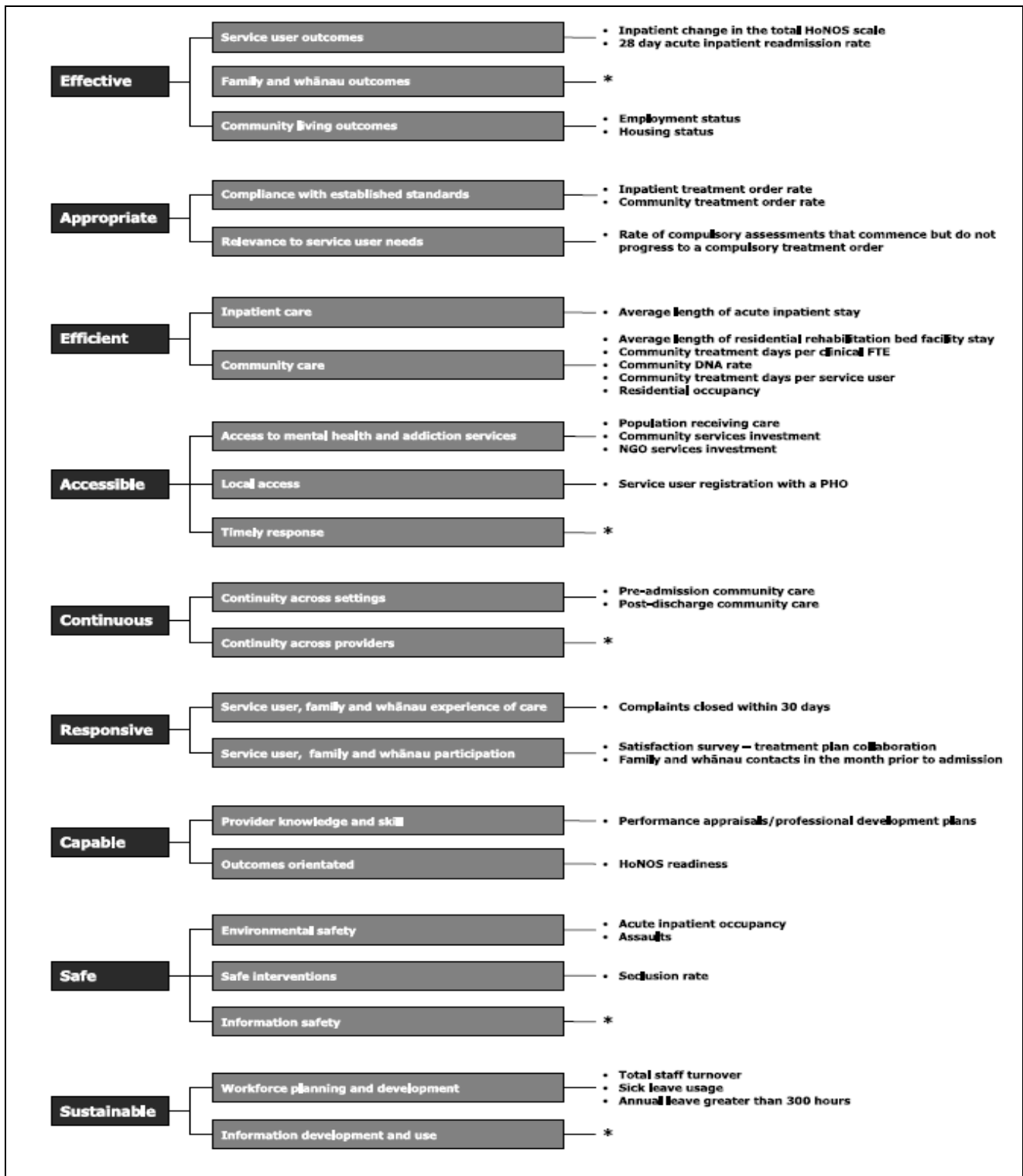
² service settings = general community, inpatient services, community based support services with housing/accom, general hospital liaison, day programmes, methadone treatment, dedicated methadone services, community acute/respite, dedicated day programme services, peer support, drug & alcohol with accom, NASC, Māori Advisory Service

Appendix 2:

Nationwide Service Framework - Reporting Requirements

| indicator | measure |
|---|--|
| 1 Admissions | number of beds/clients |
| 2 Available Beds | total number available |
| 3 Available Bed Days | total inpatient beds available |
| 4 Available Budget | total budget for reporting period |
| 5 Average Length of Stay | average days between admission/discharge (inpatient), first/final contact (community services) |
| 6 Average Length of Time on Waiting List (Methadone Treatment) | average number of days on waiting list |
| 7 Bed Days | total number of beds available/occupied each day |
| 8 Clinical FTE | total full time employed health professionals |
| 9 Completed Support Needs Assessments | total completed during the reporting period |
| 10 Consultation/Liaison Contacts | total number of phone/face-to-face discussions with a health professional |
| 11 Consultation/Liaison Training Sessions | number of education/training sessions for people working outside service (eg GPs) |
| 12 Current Client | total number |
| 13 Day | number of 24 hour days |
| 14 Day Attendance | total number of attendances by non-inpatient consumers |
| 15 Day Places Available | on each programme |
| 16 Day Programme | number of clients |
| 17 Expenditure (Promotion/Prevention) | total money spent |
| 18 Expenditure with a breakdown of service utilisation | total spent on community/acute/respice services |
| 19 Face-to-Face Contacts (Groups) | number of group sessions with individuals/family |
| 20 First Face-to-Face Contacts (Individual/Family) | number of initial contacts for episode |
| 21 Follow-up Face-to-Face contacts (individual/family) | all face-to-face contacts after initial contact |
| 22 FTE | total FTEs/40 hours per week |
| 23 General Hospital Beds | total beds in region on last day of period |
| 24 Group Session | total group sessions with a psychotherapy/skill development/education programme (>2hrs/2 people) |
| 25 Group Session Delivered | total number for period |
| 26 Hui Held | total number for period |
| 27 Hui Narrative Report | number of trainees supported/individual training packages provided |
| 28 Hui Participants | total number of attendees |
| 29 Hui Narrative Report (details) | summarised report - purpose/location/participants |
| 30 Inpatient Admissions | number of admissions |
| 31 Involuntary Discharges Commenced | total number discharged by other agency eg Justice (not self or service) |
| 32 Kaumatua & Kuia FTE Staff | total number in this role |
| 33 Longest time on Waiting List | most days for any one person |
| 34 Māori Advisory FTE Staff | total FTE |
| 35 Māori Training Posts FTE Staff | total FTE |
| 36 Methadone Places Available | number of places available on treatment programme at one time point in period |
| 37 Monthly Expenditure for Flexi-Fund | summarised report on utilisation of fund |
| 38 Number of FTE Staff (Senior Management) | total FTE |
| 39 Number of FTE staff (Junior Medical) | total FTE |
| 40 Number of FTE staff (Nursing & Allied) | total FTE |
| 41 Number of FTE staff (Cultural) | total FTE |
| 42 Number of FTE staff (Māori Mental Health Worker) | total FTE |
| 43 Number of FTE Staff (Medical) | total FTE |
| 44 Number of FTE staff (Nursing) | total FTE |
| 45 Number of FTE staff (Occupational Therapy) | total FTE |
| 46 Number of FTE staff (Other) | total FTE |
| 47 Number of FTE staff (Psychology) | total FTE |
| 48 Number of FTE staff (Social Work) | total FTE |
| 49 non-Clinical FTE | total FTE |
| 50 Occupied Bed Days | sum of occupied beds each day |
| 51 People Currently on Waiting List (Methadone Treatment Programme) | total number who have been assessed as eligible but not admitted |
| 52 People Receiving Methadone (GP prescribing under Specialist) | total number on last day of reporting period |
| 53 People Receiving Methadone (GP case-management) | total number on last day of reporting period |
| 54 People Receiving Methadone (Specialist case management) | total number on last day of reporting period |
| 55 People Referred Back from GP | number of people referred for specialist methadone service by GP |
| 56 People Supported by this Service (end of reporting period) | total number at end of reporting period |
| 57 People Supported by this Service (during reporting period) | total number during period |
| 58 Planned Discharges | total number discharged |
| 59 Programmes Delivered | total number of mental health promotion programmes delivered |
| 60 Re-Admissions | total unplanned re-admissions to same inpatient mental health service |
| 61 Senior Medical FTE | total FTE |
| 62 Suicide of Current Clients | total number during period |
| 63 Transfers to an Inpatient Unit/Off-Site Respite | total transferred from accommodation service to inpatient unit or crisis respite |
| 64 Unplanned Discharges - Self-Initiated | total number during period |
| 65 Unplanned Discharges - Service Initiated | total number during period |

Appendix 3: DHB Key Performance Indicators



*no data gathered

Appendix 4:

10 Key Features of Knowing the People Planning (KPP) A Service-User Outcomes Framework

1. **Prompt access to services when needed**
Service users, their families and whanau are enabled to maintain contact with the service provider.
Each service user has a relapse prevention plan focused on maintaining good health and prompt service access if needed.
2. **Treatment leading to discharge and self-management**
How does treatment support personal growth?
Service users/clinicians mutually agree on aims for the episode of care, including the timescale leading to discharge.
Services show a commitment to the aim of recovery and enabling service users to be as independent as possible.
3. **Personal assessment and treatment plans**
There is a mutually agreed plan for the episode of care, including the milestones for accomplishment.
Each service user has a personal assessment and treatment plan which is reviewed with them at regular intervals.
Is medication appropriate, have needs changed?
4. **Relapse prevention plans**
Crisis response and relapse prevention is planned for.
Service users are educated in how to recognise when things might be going wrong.
Crisis services are alert and responsive to the specific needs of registered service users.
5. **Continuity of care**
There is continuous contact during episodes of care.
Clinicians make contact with service users whether or not they attend appointments.
6. **Health treatment and advice**
Contact is established with a supportive general practitioner (GP) service for routine psychiatric medication along with attention to physical health problems.
7. **Social support**
Assistance is provided in dealing with social problems, housing, income, work and any needs assessment.
Occupation, education, accommodation and social contact needs are reviewed as key aspects of the process of recovery.
8. **Service accountability**
The service is ensuring a consistent approach across all the service elements used.
There is one care plan for all health and social support services.
9. **Coordination of services**
The service focus encompasses both clinical needs and related social needs.
The mental health service is recognised by all health and social agencies as the focal point for service coordination.
10. **Service evaluation**
The service learns from the experience of clients.
Service performance is routinely evaluated against the 10 key features.

Appendix 5: MoH Mental Health Publications 2009-2011

| Ministry of Health Mental Health Publications (2009-2011) | | guidelines / standards | workforce development / training | Position Paper | strategic plans | action plans | literature review / discussion document / bibliography | reporting on national datasets / outcomes | analysis of social indicators (across sectors) | monitoring | research / pilot of new techniques | evaluation / review of service delivery | factsheet / information resource |
|---|--|------------------------|----------------------------------|----------------|-----------------|--------------|--|---|--|------------|------------------------------------|---|----------------------------------|
| 2011 | Reporting Suicide - a resource for the media | 1 | | | | | | | | | | | |
| | Youth Forensic Services Development | 1 | | | | | | | | | | | |
| | Suicide Prevention Action Plan | | | | | 1 | | | | | | | |
| | Mental Health & Addiction Services for Older People | 1 | | | | | | | | | | | |
| | Mental Health & Addiction Services Action Plan (to Nov 2011) | | | | | 1 | | | | | | | |
| | | | | | | | | | | | | | |
| 2010 | Suicide Facts: Deaths & Intentional Self-Harm Hospitalisations 2008 | | | | | | | | | | | | 1 |
| | Interventions & Treatment for Problematic Use of Methamphetamines & other Amphetamine-Type Stimulants | 1 | | | | | | | | | | | |
| | National Opioid Substitution Treatment Providers Training Programme | | 1 | | | | | | | | | | |
| | NZ Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Dependence 2010 | 1 | | | | | | | | | | | |
| | Te Ariari o te Oranga - the assessment and management of people with co-existing mental health and drug problems | | 1 | | | | | | | | | | |
| | Service Delivery for People with Co-existing Mental Health & Addiction Problems - Integrated Solutions 2010 | | 1 | | | | | | | | | | |
| | What Happens to Your Mental Health & Addiction Information | | | | | | | | | | | | 1 |
| | Lets Get Real - Implementation Plan | | | | | 1 | | | | | | | |
| | After Suicide: Practical Information for People Bereaved by Suicide | | | | | | | | | | | | 1 |
| | Seclusion Under the Mental Health (Compulsory Assessment and Treatment) Act 1992 | 1 | | | | | | | | | | | |
| 2009 | Suicide Facts: Deaths & Intentional Self-Harm Hospitalisations 2007 | | | | | | | 1 | | | | | |
| | Coping with Financial Stress: Looking after yourself and your family/whānau during tough economic times | | | | | | | | | | | | 1 |
| | NZ Suicide Prevention Plan 2008-12: Report on Progress Year One | | | | | | | | | | | 1 | |
| | Evaluation of Primary Mental Health Initiatives: Summary Report | | | | | | | | | | | 1 | |
| | Intentional Self-Harm Hospitalisations 2007 (Provisional) | | | | | | | 1 | | | | | |
| | Electro-convulsive Therapy (ECT): What you and your family and whānau need to know | | | | | | | | | | | | 1 |
| | Mental Health Service Use in NZ - 2005/06 and 2006/07 | | | | | | | | | | | | |
| total | | 6 | 3 | 0 | 0 | 3 | 0 | 2 | 0 | 0 | 0 | 2 | 5 |

Appendix 6: MHC Mental Health Publications (2009-2011)

| Mental Health Commission Publications (2009-2011) | | guidelines / standards | workforce development / training | Position Paper | strategic plans | action plans | literature review / discussion document / bibliography | reporting on national datasets / outcomes | analysis of indicators (across sectors) | monitoring | research / pilot of new techniques | evaluation / review of service delivery | factsheet / information resource |
|---|--|------------------------|----------------------------------|----------------|-----------------|--------------|--|---|---|------------|------------------------------------|---|----------------------------------|
| 2011 | Family, Whānau Booklet December 2011 | | | | | | | | | | | | 1 |
| | Annual Report for the year ended 30 June 2011 | | | | | | | 1 | | 1 | | 1 | |
| | Recovery Meanings & Measures: A scan of the literature | | | | | | 1 | | | | | | |
| | Blueprint II Concept Paper | | | | 1 | | | | | | | | |
| | Developing a New Blueprint for the Mental Health & Addiction Centre | | | | 1 | | | | | | | | |
| | Measuring Social Inclusion - people with experience of mental illness & addiction | | | | | | | | 1 | | | | |
| | A literature review - prevention and possibilities, a focus on children & youth | | | | | | 1 | | | | | | |
| | Power of Peer Support Services | | 1 | | | | | | | | | | |
| | Child and Youth Mental Health & Addiction, 2011 | | | | | | | 1 | | | | | |
| | District Sector Visits Review Summary | | | | | | | | | 1 | | | |
| | National Indicators 2011 - measuring mental health & addiction in NZ | | | | | | | | 1 | | | | |
| | Regional Performance to Blueprint Targets 2007/08, 2008/09 and 2009/10 | | | | | | | 1 | | 1 | | | |
| | About Us, Consumer Newsletter | | | | | | | | | | | | 1 |
| | Peer Support Practice in Aotearoa, NZ | | | | | | | | | | | 1 | |
| | Clinical Assessment of Infants & Youths with Mental Health Problems | 1 | | | | | | | | | | | |
| 2010 | Annual Report 2010 | | | | | | | | | 1 | | | |
| | Acute Services: Local Ideas to Improve Integration | | | | | | | | | | | 1 | |
| | Future Workforce Development Needs | | 1 | | | | | | | | | | |
| | Mental Health & Addiction Funding - mechanisms to support recovery | | | | | | | | | | | 1 | |
| | Services Under Challenge: critical success factors in meeting high and complex needs of people in mental health care | | | | | | | | | | | 1 | |
| 2009 | Annual Report for the year ended June 2009 | | | | | | | | | 1 | | | |
| | Mental Health & Social Inclusion Concepts & Measurement | | | | | | 1 | | | | | | |
| | Family Inclusion in Mental Health & Addiction Services for Children & Young People | | | | | | | | | | | | 1 |
| | The Legal Framework for Family Inclusion in Child, Youth & Adolescent Mental Health & Addiction Services | | | | | | | | | | | | 1 |
| total | | 1 | 2 | 0 | 2 | 0 | 3 | 3 | 2 | 5 | 0 | 5 | 4 |

Appendix 7:

Te Pou Mental Health Publications (2009-2011)

| Te Pou Mental Health Publications (2009-2011) | | guidelines / standards | workforce development / training | Position Paper | strategic plans | action plans | literature review / discussion document / bibliography | reporting on national datasets / outcomes | analysis of social indicators (across sectors) | monitoring | research / pilot of new techniques | evaluation / review of service delivery | factsheet / information resource |
|---|--|------------------------|----------------------------------|----------------|-----------------|--------------|--|---|--|------------|------------------------------------|---|----------------------------------|
| 2011 | Primary Mental Health Research Update | | 1 | | | | 1 | | | | | | |
| | International Initiative for Mental Health Leadership (IIMHL) Talk About their Experiences | | | | | | | | | | | | 1 |
| | Sensory Modulation in Acute Mental Health Wards - a qualitative study of staff and service user perspectives | | | | | | | | | | 1 | | |
| | Lets Get Real Implementation (various) | | 4 | | | | | | | | | | |
| | Distribution of Grants funding (various) | | 4 | | | | | | | | | | |
| | AODM Implementation Project | | | | | | | | | | 1 | | |
| | Va' Oration Epilogue | | | | | | | | | | | | 1 |
| | World Congress of Psychiatry Presentations 2011 | | | | | | | | | | | | 1 |
| | Skills Matter 2012 Programme Service Specifications | | 1 | | | | | | | | | | |
| | Kato Fetu Stocktake - Research Agenda Update | | | | 1 | | | | | | | | |
| | Older Adults in NZ - Population, Health, Service Use, Workforce Needs | | | | 1 | | | 1 | | | | 1 | |
| | Media Influences on Suicidal Behaviour (various) | | | | | | | | | | 1 | | |
| | Sensory Modulation in Mental Health Clinical Settings - Literature Review | | | | | | 1 | | | | | | |
| | Outcome Leaders Day | | | | | | | | | | | | 1 |
| | Factsheets - Sensory Modulation; Service Responsiveness to Asian, Migrant, Refugee Populations | | | | | | | | | | | | 4 |
| | Using HoNOS(SCA) in Multi-disciplinary teams | | 1 | | | | | | | | | | |
| | Knowing the People Planning Toolkit | | 1 | | | | | | | | | | |
| | Position Papers - Values Based Practice, Lets Get Real & Health & Disability Service Standards | | | 1 | | | | | | | | | |
| | Examples of Mental Health Resources for Disaster Planning & Responsiveness across IIMHL Countries | | 1 | | | | | | | | | | |
| | Building Evidence for Better Practice in Support of Asian Mental Wellbeing | | | | | | | | | | | | |
| | Research Updates - Refugee & Migrant Responsiveness, Asian Mental Health, Primary Mental Health, Talking Therapies | | 5 | 1 | | | 5 | | | | | | |
| | Tools & Resources - Co-existing Problems | | 1 | | | | | | | | | | |
| | Developing Culturally Responsive Services for Working with Refugee Youth & Mental Health Concerns | | | | | | | | | | 1 | | |
| | The Delivery of Sensory Modulation by Persons other than Registered Nurses, Occupation Therapists, Psychologists or Social Workers | | | 1 | | | | | | | | | |
| | Mental Health Outcomes Information Collection Protocol v2 | | 1 | | | | | | | | | | |
| | Professional Supervision for Mental Health Clinicians in Primary Health Care | | | | | | | | | | | | 1 |
| | NZ Mental Health & Addiction Workforce Surveys | | | | | | 1 | | | | | | |
| | Trauma Informed Care Workshop Resources | | 1 | | | | | | | | | | |
| | Professional Supervision Guides for Leaders & Managers, Nursing Supervisees, Nursing Supervisors | | 4 | | | | | | | | | | |
| 2010 | Factsheets - Sensory Modulation for Funders & Planners; Grow, Engage, Lead, Inform; | | | | | | | | | | | | 2 |
| | Knowing the People Planning Update - Analysis | | | | | | | | | | | 1 | |
| | Walk the Walk and Talk the Talk - a summary of peer-support activities in IIMHL countries | | 1 | | | | | | | | | | |
| | Impact of Sensory Modulation in Acute Wards on Reducing the Use of Seclusion | | | | | | | | | | | 1 | |
| | Talking Therapies for - People with Problematic Substance Use; Māori; Asian People; Older People; Pasifika People | | 5 | | | | | | | | | | |
| | Five Year Vision for Lets Get Real | | | | 1 | | | | | | | | |
| | Lets Get Real - Service User Perspectives | | | | | | | | | | | | 1 |
| | Service User Workforce Survey - Where are we at? | | | | | | | | | | | 1 | |
| | Therapies for Refugees, Asylum Seekers & New Migrants | | 3 | 3 | | | | | | | | | |
| | Sensory Modulation Introduction Package | | 1 | | | | | | | | | | |
| | Evaluation of the NZGG Self-Harm & Suicide Prevention Collaborative | | | | | | | | | | | 1 | |
| | Feasibility of evaluating DPT for Self-Harming Adolescents - a small RCT | | | | | | | | | | 1 | | |
| | PRIMHD Referral Relationship to Outcome Collections | | | | | | 1 | | | | | | |
| | Understanding Families & Suicide Risk | | | | | | | | | | 1 | | |
| | Reporting Suicide in NZ Media - Content and Case Study Analysis | | | | | | | | | | 1 | | |
| | Youth '07 - the health & wellbeing of secondary school students in NZ | | | | | | | | | | 1 | | |
| | Evaluation & Feedback Report for Te Rangatahi Parae High School Programme | | | | | | | | | | 1 | | |
| | Professional Supervision Training: a pilot evaluation in Northland DHB | | | | | | | | | | 1 | | |
| | NZ Mental Health Research Bibliography 2004-2009 | | | | | | 1 | | | | | | |
| | Supporting People Supporting Change (Lets Get Real) | | 1 | | | | | | | | | | |
| | Mental Health and Addiction Service Evaluator Handbook | | 1 | | | | | | | | | | |
| | Position Paper - Using Lets Get Real to Support the Co-Existing Problems Project | | 1 | | | | | | | | | | |
| | Performance Indicators for Mental Health & Addiction Information - Descriptor (Lets Get Real) | | 1 | | | | | | | | | | |
| | DBT - An outline for the future directions and development of NZ | | | 1 | | | | | | | | | |
| | The Outcomes Training Model & Guide (train the trainer) | | 1 | | | | | | | | | | |
| | Skills Matter Student Survey | | | | | | | | | | | 1 | |
| | I AM - a guide for nurturing hope, resilience, happiness Pasifika style | | 1 | | | | | | | | | | |
| | A person centred clinical outcome pathway | | | | | | 1 | | | | | | |
| | Outcome measurement in NZ - book chapter | | | | | | 1 | | | | | | |
| 2009 | Outcome graph builder - HoNOS scales | | 1 | | | | | | | | | | |
| | Mental Health & Recession - the Impact of Unemployment on Mental Health | | | | | | | | | | 1 | | |
| | Coping After a Tsunami - Information Sheet | | | | | | | | | | | | 1 |
| | Takū Reo, Takū Mauri Tool | | | | | | | | | | 1 | | |
| | Lets Get Real Learning Modules - Working with Māori; Working with Service Users; Challenging Stigma & Discrimination; Values & Attitudes; Working with Communities; Working with Service Users; Law, Policy & Practice | | 7 | | | | | | | | | | |
| | Lets Get Real - All tools and templates | | 1 | | | | | | | | | | |
| | Lets Get Real - Guide for Managers & Leaders | | 1 | | | | | | | | | | |
| | Lets Get Real Tools - Human Resources, Education, Team Planning | | 3 | | | | | | | | | | |
| | Lets Get Real Plus Seitapu - Working with Pacific Peoples | | 1 | | | | | | | | | | |
| | Lets Get Real Overview | | 1 | | | | | | | | | | |
| | A Guide to Talking Therapies in NZ | | | | | | 1 | | | | | | |
| | Past, Present & Future - Vision Paper | | | | | | | | | | | | |
| | Kato Fetu - Setting a Pacific Mental Health & Addiction Research Agenda | | | | 1 | | | | | | | | |
| | National Outcomes Forum 2009 | | | | | | | | | | | | 1 |
| | Dialectical Behaviour Training - an outline for the future direction and development of NZ | | | | | | 1 | | | | | | |
| | Talking Therapies - We Need to Act | | | 1 | | | | | | | 1 | | |
| | Mental Health Classification Outcomes Study | | | 1 | | | | | | | | | |
| | From Data to Information - Data Use Guidelines for Standard Measures Collected in the NZ Mental Health System | | 1 | | | | | | | | | | |
| | How Do You Rate Me - Information about HoNOS for people who use mental health services | | | | | | | | | | | | 1 |
| | Action Plan for We Need to Act Talking Therapies 2008-2011 | | | | | 1 | | | | | | | |
| | National Guidelines for Professional Supervision of Mental Health & Addiction Nurses | | 1 | | | | | | | | | | |
| | Preliminary Work towards Validating a Draft Outcome Measure for Use in the Alcohol & Drug Sector (AODM) | | | 1 | | | | | | | | | |
| total | | 10 | 51 | 7 | 4 | 1 | 14 | 1 | 0 | 0 | 13 | 6 | 15 |

Appendix 8:

Content of Publications Reporting on National Datasets

| | Title | Use of national datasets/monitoring techniques |
|--------|---|---|
| Te Pou | PRIMHD | HoNOS outcomes (x3) by validity, total score, number of clinically significant items, number/percentage of clinically significant sub-scores, clinically significant individual items and index of severity by service team, reason for collecting, ethnicity, setting |
| | Older Adults in NZ - Population, Health, Service Use, Workforce Needs | current trends, service-use by DHB, age-group projections, ethnicity, workforce participation, socio-demographic characteristics (income, home ownership, living situation), care-givers (hospital, residential), life-expectancy, alcohol and drug use/dependency, morbidity, mental health diagnoses , co-morbidity, health care use, other social issues, workforce needs/issues, interventions |
| MoH | Suicide Facts: Deaths & Intentional Self-Harm Hospitalisations 2007 | suicide deaths and intentional self-harm by age, sex, ethnicity, deprivation, DHBs - provides rates, international comparisons, trends |
| | Annual Reports | monitoring report on activities, release prevention plans, sector visits, sector meetings, mental health networks, district inspectors, special/restricted patients, report of the Mental Health Tribunal; statistics on special topics, eg - compulsory assessment and applications for compulsory treatment orders, compulsory treatment orders, seclusion, electroconvulsive therapy, reportable deaths, suicide, detention and committals under the Alcoholism and Drug Addiction Act, opioid substitution treatment services |
| | Mental Health Service Use in New Zealand 2007/08 | clients by number seen, ethnic group, sex, bed nights, contacts, team types, age-group, referral source, number of episodes, length of stay, service setting |
| MHC | Annual Report for the year ended 30 June 2011 | introduced new way of reporting on activities - measured progress towards target (%) on outcomes (3) and monitoring of outputs (advocacy, collaboration, monitoring) by impact measures |
| | Measuring Social Inclusion - people with experience of mental illness & addiction | uses social inclusion framework to consolidation of Multi-Agency Group (MAG) information, use of social inclusion framework, looks at incidence across whole of society, compares/presents baseline information for people with no/mild/moderate-severe experience of mental health and addiction, supplements national datasets with surveys/information from Multi-Agency Group (MAG) - mental illness/addiction, relationships, health, civic participation, safety, cultural identity, leisure and recreation, knowledge and skills, employment, standard of living, transport |
| | Child and Youth Mental Health & Addiction, 2011 | depression, hazardous drinking, suicidal thoughts & behaviour, hospital rates for intentional self-harm, suicide rates, mental health service use, referral rates by 12-month prevalence, age, ethnicity, deprivation |
| | District Sector Visits Review Summary, February 2011 | pilot of supplementary technique for monitoring the effectiveness of services, involved face-to-face interviews with consumers, online surveys, rohe visits, site-specific recommendations and 6-month follow up, information about mental health and addiction services for Māori/Pasifika supplemented with additional site (rohe) visits, summary report contains 28 concerns/recommendations to improve process, methods, preparation & reporting techniques |
| | National Indicators 2011 - measuring mental health & addiction in NZ | aims to provide a framework for measuring mental health and addiction status across the whole of society (not just service-uses), consolidates data on 3 domains x 15 indicators, ie - mental health of the population (life satisfaction, psychological distress, potentially hazardous drinking, harmful effects of alcohol and drug use, suicide); health service delivery (access to services, unmet need for help, seclusion, input into treatment, family participation); social inclusion (isolation, perceived discrimination, employed and satisfied with job, standard of living, housing satisfaction) |
| | Regional Performance to Blueprint Targets 2007/08, 2008/09 and 2009/10 | comprehensive analysis of national data that informs regional performance on 1998 Blueprint targets, ie - funding and number of FTEs, community beds, placements, day programmes, beds, services by targeted service team (adult, AOD, child & youth, forensic services, older people, specialist services), contains recommendations and discussion about policy implications, workforce and service development themes, strategies for improving the effectiveness of services |
| | Annual Reports for the years ended June 2009, 2009 | general description of activities, introduction of pilot techniques for improving monitoring, integrated care, collaboration with primary health, acute services and the effectiveness of services for Māori/Pasifika; identifies sector priorities (legislation and human rights, infant & toddler mental health, Māori health, collaboration with primary care, development of peer-led services/resources); |

Appendix 9: Key Strategies/Service Specifications 1996-2015

| 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| Looking Forward: Strategic Directions for Mental Health Services 2 key goals: to decrease the prevalence of mental illness and mental health problems within the community; to increase the health status of and reduce the impact of mental disorders on consumers, their families, caregivers, and the general community. 14 principles: empower consumers, enable people to fully participate, better specifications for services, Māori involvement, consistent safety standards, cultural safety, access, best possible outcomes, personal dignity, minimises disruption to personal lives, sensitivity of services, cost-effective, integrated, rights of people 5 strategic directions: comprehensive, community based services; Māori involvement in planning, development, delivery; improve the quality of care; balance personal rights with protection of the public; develop a national AOD policy | | | | | | | | | | | | | | | | | | | |
| Moving Forward: The National Mental Health Plan for More & Better Services 2 goals: decrease prevalence, increase health status (from Looking Forward) 7 strategic directions: more services, better services, balancing personal rights with protection of public, developing/implementing national drug policy, develop infrastructure, strengthen promotion/prevention, 17 guiding principles/service objectives (30 targets): empower consumers, enable people to fully participate, better specifications for services, Māori involvement, consistent safety standards, cultural safety, access, best possible outcomes, personal dignity, minimises disruption to personal lives, sensitivity of services, cost-effective, integrated, rights of people, increase consumer control over services, create supportive social environment, work across sectors 15 national objectives (22 national targets) National Mental Health Standards aim: to implement the principles of Looking Forward 20 standards: tangata whenua, Pacific people, cultural awareness, children & young people, rights, safety, consumer record & documentation, privacy & confidentiality, consumer participation, family & carer participation, prevention and early intervention, leadership & management, access, entry, consumer assessment, quality care & treatment, community support options, discharge planning, follow-up & re-entry, promoting mental health & community acceptance | | | | | | | | | | | | | | | | | | | |
| Blueprint: How Things Need to Be - service developments required for implementation of Moving Forward scope: to monitor implementation of the National Mental Health Strategy, to reduce discrimination against people with mental illness, to strengthen the mental health workforce aims: define recovery, reduce discrimination, clarify roles & responsibilities, describe essential service components/service needs for priority groups 17 guiding principles: (taken from Moving Forward) 7 priority groups: adults, children and youth, older people, Māori, Pacific people, families, other special groups 10 essential services: local level, regional specialist, AOD, younger people, older people, forensic, prevention, Māori, Pacific, co-ordination, infrastructure 11 resource guidelines (beds/places, packages of care, FTEs, access targets, ring-fenced funding): inpatient, residential, community mental health, community support, advisory services, access to newer anti-psychotic medication, detoxification, residential AOD, community AOD, methadone treatment, mental illness prevention 10 critical success factors for Māori: outcome measures for Māori, culturally relevant treatment practices, Māori access, whānau participation, skilled Māori workforce, effective consumer advocacy, relevant quality assurance, co-ordination/collaboration/integration, sustainable provider development, services targeted to needs | | | | | | | | | | | | | | | | | | | |
| A National Strategic Framework for Alcohol & Drug Services (policy direction for Moving Forward) 5 guiding principles: effectiveness, cost, equity, Māori health, acceptability 8 strategic directions: national consistency & prioritisation, service priorities, implementation issues, ensuring high quality treatment services, service availability & access (specialists, referrals, aftercare), consumer participation, research & development, capacity building 5 priorities: Māori responsiveness, Pacific responsiveness, specialist child/youth services, specialist services for complex/co-existing needs, workforce development 8 priority groups (in order of priority): Māori, Pacific, Children & Youth, Co-existing Disorders, Offenders, Opioid Dependent, Women, Older People 137 recommendations | | | | | | | | | | | | | | | | | | | |
| Te Puawhātanga: Māori Mental Health National Strategic Framework aim: to build on Looking Forward, Moving Forward & the Blueprint 5 goals: comprehensive clinical, cultural & support services; active participation in planning & delivery; 50% of Māori have option of access KM services; 50% increase in Māori workforce; inter-sectoral co-operation 50 objectives (within 3 years) | | | | | | | | | | | | | | | | | | | |
| Te Tāhuhu (2005-2015) Improving Mental Health: The Second NZ Mental Health & Addiction Plan 2 principles: effective service delivery, build a culture for recovery 2 aims: outcome statements for 3 specific groups (all New Zealanders, tangata whaiora and those who support them); identify the 10 main leadership challenges 10 Leadership Challenges: promotion & prevention, building mental health services, responsiveness, workforce & culture for recovery, Māori mental health, primary health care, addiction, funding mechanisms for recovery, transparency & trust, working together 33 focus areas (over next 3 years) | | | | | | | | | | | | | | | | | | | |
| Te Kōkiri: Action Plan for Te Tāhuhu (2006-2015) 3 aims: achieve Te Tāhuhu objectives, describe specific actions, stakeholders, responsibilities, short (1-3yrs)/medium (3-5yrs)/long-term goals (5-10 y) 8 underlying principles: working collaboratively and co-operatively, service users, lead their own recovery, Mōtū to oversee implementation, DHs responsible for effective planning, funding, management, must be able to demonstrate progress; NGOs & wider sector responsible for a range of services, innovation, leadership, PHOs to improve responsiveness, provide a range of services, provide innovation & leadership; professional groups responsible for workforce training, cultural and clinical standards, continuing professional development 10 leadership challenges: as outlined in Te Tāhuhu 133 actions implemented over 3, 5, 10 years | | | | | | | | | | | | | | | | | | | |
| Te Puāwaiwhero (2008-2015): the Second Māori Mental Health National Strategic Framework overall aim: Whānau Ora 2 directions: population based, target severely affected 3 key principles: prioritise Māori, build on gains, responsive to Māori 4 priorities: effective & culturally relevant, promotion & prevention, early intervention & primary health care, specialist services 40+ actions: (from Te Kōkiri) Key Performance Indicators for Mental Health & Addiction Services (2007), Phase II (2010) 9 performance objectives: effective, appropriate, efficient, accessible, continuous, responsive, capable, safe, sustainable 30 performance indicators: effective (change in HoNOS, inpatient days, employment/housing status), appropriate (inpatient/community treatment order, compulsory assessments that do not progress to order), efficient (average length of stay/treatment), accessible (population receiving care, community/NGO investment, registration with PHO), continuous (pre-admission/post discharge community care), responsive (complaints, satisfaction survey, whānau contacts), capable (performance appraisal, professional development plans, HoNOS readiness), safe (acute inpatient occupancy, assaults, seclusion), sustainable (staff turnover, sick leave, annual leave) | | | | | | | | | | | | | | | | | | | |
| Nationwide Service Framework Strategic Direction: Te Tāhuhu (2005-2015), Te Puāwaiwhero (2008-2015) 3 tier service delivery: mandatory, recommended, supplementary 9 directions: service definition, service objectives, service users, access, service components, service linkages, exclusions, quality requirements, purchase units & reporting requirements (defined in data dictionary, reviewed annually) 13 service objectives: responsive, Māori Health/responsive to Māori, responsive to Family/Whānau, recovery focused, foster resilience, encourage natural supports, promote independence, informed choice, reduce inequalities, promote seamless/integrated services, develop organisational governance, develop workforce, value lived experience 5 mandatory mental health and addiction services (tier 1): adult, infant, child, adolescent & youth specialist; addiction specialist services; eating disorders specialist; consumer leadership specialist 13 recommended services (tier 2): adult mental health; infant, child, adolescent & youth dual diagnosis; health of older people mental health & addiction; asian, migrant and refugee mental health & addiction support service; Kaupapa Māori mental health & addiction; Pacific mental health & addiction; addiction services; eating disorders; family & whānau; forensic mental health; perinatal mental health; youth forensic; consumer leadership 106 supplementary services (tier 3): adult (see Appendix 10) | | | | | | | | | | | | | | | | | | | |
| Mental Health & Addiction Action Plan (2010-2011) 3 goals: accessible, responsive, well-coordinated 4 prioritised actions: moving health resources to increase access/improve outcomes; lifting system performance to enhance wellbeing; tackling alcohol and other drug-related harm; integration across government agencies 19 aims 25 actions 30 milestones | | | | | | | | | | | | | | | | | | | |

Appendix 10:

Nationwide Service Framework - Tier 3 Services (supplementary)

| | |
|-----------------------------------|---|
| Adult | <p>acute inpatient</p> <p>intensive care inpatient beds</p> <p>crisis respite</p> <p>alcohol & other drug consultation & liaison</p> <p>addiction community based AOD service</p> <p>crisis intervention service</p> <p>acute home based treatment</p> <p>acute package of care</p> <p>sub-acute/extended care inpatient beds</p> <p>general hospital liaison service</p> <p>community clinical mental health</p> <p>early intervention for people with first-time psychosis</p> <p>mobile intensive treatment service</p> <p>service for profoundly hearing impaired</p> <p>community-based service for mental health with intellectual disability</p> <p>co-existing disorders</p> <p>community co-existing disorders (with accommodation)</p> <p>community day programme</p> <p>adult planned respite</p> <p>needs assessment and service co-ordination</p> <p>adult package of care</p> <p>community support services</p> <p>day activity and living skills</p> <p>vocational support service</p> <p>housing co-ordination service</p> <p>housing and recovery services - daytime and awake night service</p> <p>housing and recovery services - daytime/responsive night support</p> <p>support landlord service</p> |
| Infant, Child, Adolescent & Youth | <p>child, adolescent & youth inpatient beds</p> <p>acute home-based treatment</p> <p>packages of care</p> <p>acute crisis intervention</p> <p>crisis respite</p> <p>community mental health</p> <p>day treatment</p> <p>child, adolescent & youth intensive clinical support</p> <p>child, adolescent & youth mental health community care (with accommodation)</p> <p>child, adolescent & youth alcohol and other drug community service</p> <p>child, adolescent and youth community AOD (with accommodation)</p> <p>community-based child, adolescent and youth co-existing disorders</p> <p>needs assessment and service co-ordination services</p> <p>child, adolescent & youth planned respite co-existing disorders</p> <p>children, adolescents & youth of parents with mental health/AOD disorders</p> <p>child, adolescent and youth community-based day activity service</p> <p>community support service home-based support, support for independence</p> <p>package of care (wrap around)</p> <p>early intervention for child, adolescent, youth with first-time psychosis</p> |
| Addiction Services | <p>AOD community support service</p> <p>AOD consultation and liaison</p> <p>AOD acute package of care</p> <p>day treatment programme</p> <p>managed withdrawal home community service</p> <p>managed withdrawal inpatient</p> <p>community based AOD service</p> <p>early intervention AOD service</p> <p>community support services</p> <p>day treatment programme</p> <p>community support service with accommodation</p> <p>early intervention</p> <p>opiod substitution treatment</p> <p>intensive AOD service with accommodation</p> |
| Kaupapa Māori Mental Health | <p>Kaupapa Māori community based clinical and support service</p> <p>Kaupapa Māori consultation liaison and advisory service</p> <p>Kaupapa Māori Kaumatua roles</p> <p>Kaupapa Māori package of care</p> <p>Kaupapa Māori Whānau Ora worker service</p> |

NSR Tier 3 Services (cont'd)

| | |
|--|---|
| Pacific Health | Pacific senior cultural advisory service Pacific cultural navigator service Pacific community-based clinical and support service Pacific family advisory service |
| Health of Older People | acute inpatient services demential behavioural support advisory service specialist community services sub-acute or extended care services |
| Eating Disorders | inpatient, intensive treatment and consultative consultative service within a specialist eating disorder clinical outpatient services community services DHB liaison specialist eating disorders with accommodation |
| Forensic | medium secure service community based intensive services for recovery community service minimum secure service prison service court liaison service extended term secure service |
| Youth Forensic Inpatient Service | inpatient services specialist community services |
| Perinatal Mental Health Infant Inpatient | perinatal mental health infant inpatient service respite service perinatal specialist community services infant mental health specialist community service with accommodation |
| Asian, Migrant & Refugee Support | refugee mental health AOD cultural community support work service cultural support co-ordination service specialist services |
| Family & Whānau | support, education, information and advocacy services advisory services |
| Consumer Leadership | consumer advocacy service consumer leadership, consultancy mental health & addiction consumer resource & information phone service peer support services for adults peer support services for children, adolescent & youth |

Appendix 11: Mental Health & Addiction Plan 2010-2011

| Prioritised Actions | Actions |
|--|---|
| 1 Moving health resources to increase access to mental health and addiction services and improve outcomes | |
| seamless integrated service delivery through electronic note sharing | 3 pilots completed by 30 June 2011 |
| primary health care providers deliver more effective care, GPs have immediate telephone access to specialist mental health advice | 3 pilot completed by 30 June 2011 |
| services delivered locally through integrated family health services | 2 pilots completed by 30 June 2011 |
| increased funding for primary health care providers to deliver additional services | 2,000 additional packages of care by Dec 2010 |
| primary health care providers use standard electronic decision-support tool when working with people who have depression | 10% of GPs using this tool by Dec 2010, 90% by June 2011 |
| more use of Relapse Prevention Plans | 95% of DHB long term patients using RPPs by 30 June 2011 |
| use of Knowing the People Planning (KPP) tools for people requiring long-term assistance | 5 DHBs using KPP or similar planning tool by 30 June 2011 |
| 2 Lifting system performance to enhance our communities' mental health and wellbeing | |
| additional funding for eating disorder services | 5 hospital beds, 9 residential beds, 19 staff by 1 December 2010 |
| establishing regional advisory services for dementia and behavioural problems | 4 regional advisory services established by 31 December 2010 |
| DHBs and NGOs benchmark/measure performance using national key performance indicators (KPIs) | 80% of DHBs using KPIs to measure performance for adult population, Māori, and other vulnerable populations by 30 June 2011 |
| development of a new mental health and addiction service development plan | by 30 November 2011 |
| better information about the effectiveness of mental health and addiction services | publication of a set of outcome measures, Health of the Nation (HoNOS) and KPI use by 80% of DHBs by 30 November 2011 |
| 3 Tackling alcohol and other drug-related harm | |
| better access to methamphetamine-related services | 60 residential treatment beds and 20 additional social detoxification beds by 30 June 2011 |
| people with methamphetamine-related receive nationally consistent services | all frontline workers using Working with Amphetamines User Guidelines by 30 November 2010 |
| developing a modern legislative framework for people with alcohol and drug-related issues | policy proposals for legislative change submitted to the Government by 30 November 2010 |
| providing additional alcohol and drug treatment programmes for young offenders | 100 new community youth AOD treatment places by October 2010, another 100 places by October 2011 |
| 4 Integrating efforts across government for better mental health outcomes | |
| more vulnerable families/whānau have access to effective positive parenting programmes in primary care setting to reduce childrens behavioural, emotional and mental health problems | 30 primary care practitioners trained to use Primary Care Triple P - Positive Parenting Programme, 1500 families of 3-7 year olds have received information on positive parenting strategies, 3415 families receive self-help resources by 30 November 2011 |
| more families/whānau of children with conduct/behavioural problems have access to child & adolescent mental health services | 60 child & youth mental health workers trained in the Incredible Years programme, 400 families have participated in the IY programme, 80 participating families have received additional support by 30 November 2011 |
| Māori can access culturally appropriate parenting programmes which reduce behavioural, emotional and mental health problems | by 30 November 2011 a training provider is contracted to develop an evidence-based programme, one demonstration site is operating and the programme has been delivered to 50 families/whānau |

Appendix 12:

The 7-tiered model of Integrated Family Health Care

| Tier level | Focus | Patients to whom focus applies | Health care provider |
|------------|--|---|--|
| Tier 1 | Mental health promotion and disease prevention | People with no mental disorder or dementia | Primary health care (managing) Health promotion providers Local community councils |
| Tier 2 | Targeted mental health prevention and promotion for at-risk groups | People presenting with risk factors for mental disorders and dementia without behavioural and psychological symptoms of dementia (BPSD) | Primary health care (managing) Health promotion providers Disability support and service providers |
| Tier 3 | Assessment, early intervention and treatment | People with mild mental disorders or mild BPSD | Primary health care (managing) Disability support and service providers Health of Older People (HOP) services |
| Tier 4 | Assessment, early intervention, treatment and case management | People with moderate mental disorders or moderate BPSD | Shared care: primary health care providers and specialist services, with support from disability service providers and/or HOP services |
| Tier 5 | Assessment, treatment and case management | People with complex mental disorders or BPSD with complications such as aggression or agitation | Specialist services Case management by community MHOP services in collaboration with aged residential care (ARC) facility and/or disability service providers and/or HOP services |
| Tier 6 | Assessment, treatment and case management | People with severe mental disorders or severe BPSD | Specialist services (specific acute mental health unit or dementia unit within ARC facility) with support from disability service providers and/or HOP services |
| Tier 7 | Assessment, treatment and case management | People with extreme mental disorders | Specialist services (specialist unit with intensive care) with support from HOP services |

Source: Ministry of Health (2011). *Mental Health Services for Mental Health and Addiction Services for Older People and Dementia Services. Guideline for District Health Boards on an Integrated Approach to mental health and addiction services for older people and dementia services for people of any age*. Wellington, Ministry of Health.