

# He Nuka Mo Nga Taitamariki

A national workplan for  
child and youth  
mental health services

Kia Tu Kia Puawai  
Mental Health Group  
Health Funding Authority  
Wellington

2000

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Tena koutou katoa

The Health Funding Authority Mental Health Group is pleased to release this workplan which outlines the pathway for developing mental health and alcohol and drug services for children/ nga tamariki and youth/rangatahi who have serious mental disorders.

The benchmarks for mental health services are determined by government and although current services fall short of these, we are optimistic that this workplan can achieve substantial improvements over future years. Any new money received by the HFA for child/tamaiti and youth/rangatahi services will therefore be allocated in line with this document.

The plan sets some objectives for future service development and within this prioritises tamariki and rangatahi Maori, Pacific children and youth, and children/nga tamariki and youth/rangatahi with severe problems and high need and their families, whanau and caregivers.

Through the plan we aim to achieve some national consistency in the provision of specialist services throughout the country and to get a greater range of services for the children/nga tamariki and young people/rangatahi with high need.

Most importantly, the plan communicates a vision of the need for expanded services in line with our vision statement and our whakatauaki Kia Tu Kia Puawai.

When developing the plan we talked to young people/rangatahi who use mental health services and to the parents of children/nga tamariki with severe mental health problems. We also received substantial help from members of a small reference group made up of people with expertise in child/tamaiti and youth/rangatahi mental health, and from others who advised on the Maori content of the document.

Sincere thanks go to all the young people/rangatahi, families and whanau and others throughout the sector who their shared expertise, ideas and visions for improved child/tamaiti and youth/rangatahi mental health. We would also like to acknowledge in particular the work of Julie Helean, other Health Funding Authority Mental Health Group team members, and Barbara Arnold, Ministry of Health, in developing this workplan.

We are aware that this workplan will not address all areas of unmet need. We have attempted simply to show the first important steps to address the deficits, knowing that these steps are good foundations for future progress of what is an exciting and fast developing sector. We hope that this work is particularly useful for the District Health Boards as a guide to priorities for new and improved services.

E noho mai ra



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# He Taonga He Tamaiti

Ko tenei te aroha ki a koutou nga taitamariki.

Ma te Atua koutou e manaaki e tiaki i nga wa katoa.

Tena koutou katoa

## He Whakatauaki

### Kia Tu Kia Puawai

The whakatauaki Kia Tu Kia Puawai was suggested by Professor Mason Durie to guide the work of the Mental Health Group of the Health Funding Authority (HFA). Based on the work of Durie, specifically Te Whare Tapa Wha and Puahou principles, Kia Tu Kia Puawai reflects the vision of the Mental Health Group for mental wellbeing and mental health promotion to improve the health status of Maori.

Kia Tu Kia Puawai is a Maori model that draws on Maori concepts of health, values, practices and institutions to promote whanau and hapu mental health, advocates for whanau links, and seeks to restore a positive self and collective Maori identity.

Kia Tu Kia Puawai is interpreted as "stand tall with confidence" and reflects a longer term goal to achieve mental health and wellbeing in individuals, communities and the population as a whole.

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# Executive Summary

This workplan arises in response to the Ministry of Health requirements for the HFA to develop a national workplan to address the service gap for those children/tamariki and young people/rangatahi with severe mental health problems. It sits within the strategic and policy framework already determined by the Ministry of Health and the Mental Health Commission (MHC).

Several people who work directly with children/nga tamariki and young people/rangatahi helped the HFA draft this workplan by identifying best practice approaches to child/tamaiti and youth/rangatahi mental health, identifying the kinds of services and programmes needed across the country, and determining priority areas to focus on in the shorter term.

The key objectives of the workplan are:

- 1 to maintain a vision for child/tamaiti and youth/rangatahi mental health which encompasses mental wellbeing and acknowledges that a full spectrum of health promotion and problem prevention activities need to sit alongside treatment and recovery work. This vision is symbolised in the whakatauaki Kia Tu Kia Puawai (stand tall with confidence) and is detailed in the document of the same name.
- 2 to improve services including consultation and liaison for the 3 percent of children/nga tamariki and youth/rangatahi with serious mental illness and their families/whanau, and to ensure that there is future growth of services in line with the benchmarks determined by Government.
- 3 to ensure that disparities in the range of services available in each region are addressed to improve national consistency and equity of access to services.
- 4 to prioritise the establishment and expansion of appropriate services for tamariki and rangatahi Maori and their whanau. This is linked in with existing plans to invest in workforce development for Maori and to ensure Maori approaches to mental health are adopted.
- 5 to establish an improved range of appropriate services for Pacific children and young people along with a workforce able to provide specialist and support services for Pacific communities.
- 6 to increase, strengthen and better coordinate the child/tamaiti and youth/rangatahi mental health workforce, including a focus on human resource management issues and training.
- 7 to promote integrated, safe and high quality services for children/nga tamariki and young people/rangatahi through inter-agency, cross-sector and District Health Board (DHB) collaboration.

This workplan recognises the considerable demand for treatment services on the one hand and strategies to reduce further illness on the other. There are obvious tensions in this relationship arising from limits to the resources available. The most immediate focus for future funding will be on increasing services to benchmark levels ie, the 3 percent of the population with the most severe mental health problems. In doing this resources will be directed to areas where there is good evidence that interventions work, and to developing and enhancing treatment approaches that are appropriate to Maori.

There is a substantial shortfall in funds available to bring services up to benchmark levels. Some improvements will be made by reallocating existing funds to the identified priority areas. The Government has however committed to a full implementation of the MHC *Blueprint*. This workplan outlines the first stage of that implementation for the child and youth services and can be implemented from year 2000/01 as additional money becomes available.

In planning future services for children/nga tamariki and young people/rangatahi, the various sub-populations requiring specialist services have been identified and prioritised. Additional funding for child/tamaiti and youth/rangatahi mental health services will be directed in the first instance to those groups identified as high priority. In many cases the investments will need to be in developing a workforce and a skill base before services can be provided. This is especially true for the Maori and Pacific mental health workforce.

The groups which are prioritised for future service development are:

- Priority one: Nga tamariki and rangatahi Maori with mental health problems, and their whanau
- Priority two: Pacific children and youth with mental health problems, and their extended families
- Priority three: Children/nga tamariki and young people/rangatahi with severe problems and multiple need and families/whanau/caregivers
- Priority four: Other areas of high need (rural, alcohol and drug dependency, suicide prevention, destigmatisation work)

Workforce development is the key to developing services, and many of the inconsistencies currently being experienced can be directly related to shortfalls in expertise or in staff numbers. This document focuses strongly on training, staff development, developing new providers and resolving some issues associated with human resource development. Workforce will be progressed by actions which increase and strengthen the workforce and which better coordinate the delivery of child and youth mental health training. These are included in detail in the workforce section.

In addition to specialist service expansion, dedicated health promotion and illness prevention services, including those approaches most appropriate to Maori, are required. Secondary prevention services will be provided through specialist services which concentrate on those children and youth who are most at risk of mental illness including self harm and suicide.

While this document focuses on specialist mental health services, a full range of services is required for those people under 20 years and their families. Considerable intersector and interagency work is required over the next three years to identify the appropriate funding streams for the broad range of promotion and prevention services that children and young people require. In the short term, targeted promotion and prevention projects in line with Kia Tu Kia Puawai will continue on a pilot basis.

The following table indicates the additional resources required over the next three years to bring services closer to the benchmarks determined by Government.

Funding needs to increase at a rate of approximately \$10 million each year to implement the service developments outlined in this report. Investments made in line with this plan would bring child and youth full time positions up to 64.8 percent of benchmarks, and beds or care packages up to 57.3 percent of benchmarks by the year 2002/03.

**Table 1:** Cumulative new resources required – 2000/01 to 2002/03

Resource Type	00/01 Volumes	01/02 Volumes	02/03 Volumes
Beds or care packages	13.9	27.8	41.7
Community FTEs	64.8	129.6	194.4
Day programmes	13.4	26.8	40.2
<b>Total</b>	<b>92.1</b>	<b>184.2</b>	<b>276.3</b>

NB: This table shows the cumulative volume increase required in addition to the 1999/00 contracted volumes.

**Table 2:** New resources required – 2000/01 to 2002/03

Resource Type	00/01 \$M	01/02 \$M	02/03 \$M	Total \$M
Beds or care packages	2.738	5.489	8.255	<b>16.482</b>
FTEs	5.211	10.449	15.712	<b>31.372</b>
Day programmes	1.139	2.284	3.434	<b>6.857</b>
<b>Subtotal</b>	<b>9.088</b>	<b>18.222</b>	<b>27.401</b>	<b>54.711</b>
Workforce development	0.385	1.195	1.495	<b>3.075</b>
<b>Total</b>	<b>\$9.473</b>	<b>\$19.417</b>	<b>\$28.896</b>	<b>\$57.786</b>

As new funding becomes available, it will be allocated to the priority areas within child/tamaiti and youth/rangatahi of Maori, Pacific and those with severe problems and high need. In addition, each DHB will have unique regional needs not detailed in this workplan. Future developments will therefore need to balance the need for improved national consistency in the range of services available while retaining the flexibility to respond to community needs.

These plans do not address all the problems identified. The view presented is that growth in the short term is best aimed at priority areas and those areas which create a solid base for further expansion. In addition, related workstreams will be progressed which contribute to the sector eg, improved data collection (regarding service usage) and analysis, quality improvement systems, service monitoring, and evaluations of service outcomes.

# 1 Background

This workplan is a response to the Ministry of Health requirements for the HFA to develop a national workplan to address the service gap for those children/tamariki and young people/rangatahi with severe mental health problems.

The background policy and strategic work on child/tamaiti and youth/rangatahi mental health was completed by the Ministry of Health (MoH) and the Mental Health Commission (MHC) and is covered in previous documents:

- *Looking Forward* (MoH 1994)
- McGeorge Report to the Ministry of Health (MoH 1995)
- Making Links Working Party, 1996
- *Moving Forward* (MoH 1997a)
- *Blueprint for Mental Health Services in New Zealand* (MHC 1998)
- *New Futures* (MoH 1998)
- *In Our Hands, Kia Piki te Ora o Te Taitamariki: New Zealand Youth Suicide Prevention Strategy* (Ministry of Youth Affairs, MoH, Te Puni Kokiri 1998)
- *Specialist Mental Health Services for Children and Youth* (MHC 1999).

While acknowledging the breadth of mental health need in the community – from public health prevention programmes to intensive inpatient care – this document focuses on the needs of the 3 percent of child/tamaiti and youth/rangatahi population with serious and severe mental health disorders. The range of specialist child/tamaiti and youth/rangatahi mental health services is outlined in the *Blueprint for Mental Health Services* (MHC 1998) with benchmarks set for each of the key types of service. Details of these services and access levels are included in the final section of this plan.

## 1.1 Development of the workplan

The Government has a commitment to the implementation of the Mental Health Commission *Blueprint*. This national workplan focuses on closing the gaps which have been identified in mental health service provision for children/nga tamariki, youth/rangatahi and their families as new money becomes available. This plan has been developed by the Mental Health Group of the HFA in consultation with the Ministry of Health. A small external reference group was formed to assist with advice, including people to contribute specific advice on the Maori content. Representatives were chosen from the following areas: Maori Women's Welfare League, Commissioner for Children's Office, the national child and youth mental health sector network, a youth coordinator and the Royal Australian and New Zealand College of Psychiatrists, Faculty of Child and Adolescent Psychiatry. The Mental Health Commission also contributed information and advice.

Children/nga tamariki, young people/rangatahi, and families/whanau were also involved in the development of this workplan. They participated via focus groups throughout the country, identifying gaps in services, barriers preventing access to services and priorities for future funding.

The planning process began by identifying best practice approaches to child/tamaiti and youth/rangatahi mental health, including models of health, guiding values, principles and identifying the range of options available for improving mental health. A second step involved focusing on the specific services needed for the short to medium term. A three-year time frame was chosen for the plan, recognising that the health sector is undergoing restructuring that involves the merging of the HFA with the Ministry of Health and the creation of DHBs.

## 1.2 The Treaty of Waitangi

Any discussion of partnership between Maori and a Crown entity has to start with the Treaty of Waitangi. The relationship between Maori and the Crown is based on the underlying premise of the Treaty itself, that Maori continue to live in Aotearoa as Maori.

The relationship between Maori and the Crown in the health and disability sector has formed around three key principles:

- **Partnership:** a relationship between Maori and the Crown of good faith, mutual respect and understanding, and shared decision-making. Partnership is balanced by the principles of kawanatanga.
- **Participation:** the Crown and Maori will work together to ensure Maori (including whanau, hapu, iwi, and communities) participate at all levels of the health and disability sector. This includes the development of Maori provider and Kaupapa Maori mental health services.
- **Protection:** the Crown actively contributes to improving the health status of Maori and ensures equal access to mental health services.

## 1.3 A vision of mental health for children/nga tamariki and young people/rangatahi

The whakataauaki *Kia Tu Kia Puawai* (stand tall with confidence) has guided the work of the HFA Mental Health Group since 1999 and reflects a great desire within the mental health sector to achieve positive mental health and wellbeing across the population as a whole. The vision represents the intention to achieve a broad spectrum of mental health services including early intervention, prevention and health promotion activities.

The document *Kia Tu Kia Puawai* (HFA 1999) outlines the vision and preferred approach of the Mental Health Group to mental health and wellbeing for tamariki, rangatahi and whanau. *Kia Tu Kia Puawai* is based on the work of Professor Mason Durie, specifically Te Whare Tapa Wha and Puahou principles and draws on Maori concepts, values, practices and institutions to promote whanau and hapu mental health. This model, while focused on Maori, does identify aspects of Maori health that may have applicability to the wider population of children/nga tamariki, youth/rangatahi and families/whanau in Aotearoa/New Zealand eg, family involvement and the holistic approach to health and wellbeing presented in the 1986 Ottawa Charter (World Health Organization 1986).

## 1.4 Preventing mental health problems

The vision of the Mental Health Group of the HFA is of mental health in its broadest sense. It acknowledges that children/nga tamariki, youth/rangatahi and their families/whanau will require access to a comprehensive range of services including health promotion, problem prevention, treatment and ongoing support for recovery. In this respect, specialist mental health services are one component of a full spectrum of activities which keep young people well, prevent mental health problems and illness, and reduce the severity and impact of mental illness.

This workplan accepts that achieving the full range of services required will require dedicated attention and funding from a variety of sources including other streams within health and collaborations with government agencies. The role of specialist mental health services in helping to reduce the prevalence of mental illness is outlined in the *Blueprint for Mental Health Services in New Zealand* (MHC 1998). It is suggested that secondary prevention activities be developed as an outreach part of specialist services and be focused on those children and young people outside the 3 percent who have a high risk of developing mental illness.

In addition, planning that aims to improve mental health status for those under 20 years must allow for innovation in approaches to problem prevention and provide the flexibility to work with children/nga tamariki and young people/rangatahi who do not fall within the 3 percent. For example, the HFA is acutely aware of the consistent call from Maori for resources to design and lead their own mental health programmes. This must be taken into account in planning services which improve Maori mental health and reduce unacceptable disparities in mental health status.

While specialist assessment and treatment services for the 3 percent of the child/tamaiti and youth/rangatahi population with the most serious mental health disorders is the focus of this workplan, it is also important to continue building on those targeted prevention activities already being piloted. The crucial aspect of prevention and health promotion work is the engagement and collaboration with other sectors, notably public health and primary health.

Links are required with national prevention work such as:

- the programmes which are a part of Strengthening Families
- national youth suicide prevention strategy
- the national campaign to reduce stigma and discrimination associated with mental illness
- the national drug policy.

In addition, good linkages are necessary to help weave together the disparate strands and approaches to health and wellbeing. Specialist services, which are the focus of this plan, therefore need to continue to develop and maintain links with the following:

- the children/nga tamariki and young people/rangatahi that use services
- the families/whanau who use the services
- other agencies such as Child, Youth and Family, Specialist Education Services (SES) and Justice
- primary mental health providers such as one-stop shops, family counselling centres, GPs, marae clinics, school counsellors and other health services like sexual health clinics
- iwi organisations and other community-based services and activities
- community-based health promotion projects such as Healthy Cities, Health Promoting Schools and Mental Health Matters.

## 1.5 Getting it right for young people/rangatahi

The young people/rangatahi consulted in the development of this workplan expressed strong ideas about mental illness and the services they need. The following themes were drawn from discussions with service users in Taranaki, Christchurch and Auckland (and are expanded in Appendix A):

- The wider environment has an impact on the development of problems and their level of severity
- The stigma of mental illness is one of the biggest obstacles in getting help
- Self referral and youth-friendly services like the one-stop shops make services most easy to access
- The style of delivery is important and needs to reflect the necessary youth focus and be youth-friendly
- Young people want to participate more in all aspects of mental health services eg, projects, planning, recruitment, training and quality monitoring.

These points have direct relevance for service providers but also need to be considered in planning future services. This workplan recommends expanding those services that have been successful in achieving youth/rangatahi involvement in service provision and monitoring. Youth coordinator positions which aim to develop youth advisory groups and special youth projects for mental health are required nationally, with ongoing expansions in the areas covered by the Hamilton Office of the HFA.

## 1.6 Specialist mental health services

Specialist mental health services for children/nga tamariki and youth/rangatahi (CAMHS) are aimed at the provision of skilled assessment and treatment for the 3 percent of the population with the most severe mental health problems. Consultation and liaison services are also provided to ensure that the most appropriate supports and treatments are in place for each service user.

The group in receipt of these services includes children/nga tamariki and young people/rangatahi with serious mental health disorders including alcohol and drug abuse and dependence. Other children/nga tamariki and young people/rangatahi seen by services are those with psychological disorders involving severe emotional and behavioural disturbance. Families and whanau also receive assistance from these services, as do other people who are seeking information about recognition of problems and what to do about them.

Currently, the contracted age range for child/tamaiti and youth/rangatahi mental health services covers the group from birth to 20th birthday. Adult services are now expected to work with the group aged 18 and over so that a two-year overlap exists between child/tamaiti and youth/rangatahi and adult mental health services. Service providers are therefore expected to collaborate in getting the right mix of services appropriate for the developmental age of the child or the young person, their mental health needs and their level of family support.

In some areas adult services have established services for the young adult group to meet their distinct needs and provide evidence-based early intervention with young people/rangatahi experiencing a first episode of psychosis.

Further development of specialist services should be based on appropriate models of child/tamaiti and youth/rangatahi mental health. CAMHS, while organisationally linked to

hospitals, should be community-based on the understanding that children/nga tamariki and young people/rangatahi will do better in their own environments. There should be a core range of mental health services available, provided by skilled multidisciplinary teams operating in conjunction with Maori, Pacific workers, with family members, and in liaison with communities and other agencies.

Inpatient care is required when very specialised treatment is needed for a child or young person. Decisions to send people into inpatient services are not made lightly because of the obvious disruption this has to the young person's natural environment and support systems. The enhancement of community-based services to provide a wide spectrum of community care and so prevent inpatient admission is one area of development in this workplan.

Ideally specialist services throughout the country should be based around the needs of the individual, be child/tamaiti and family/whanau centred and be well integrated with all other services for this population. Various models exist of this type of system (Lourie and Katz-Leavy 1991, Stroul 1996, Illback et al 1997). The systems approach to care shows the child/tamaiti and family surrounded by a range of services all collaborating to meet the identified needs.

Specific ways of addressing Maori and Pacific issues are addressed later in this document. Over time and as Maori participation in services increases, we can envisage the emergence of a uniquely New Zealand model of mental health service delivery which weaves together the strands of Maori, Pacific and clinical best practice.

## 2 A Process for Prioritising Future Services

There are numerous problem areas relevant to the development of child/tamaiti and youth/rangatahi mental health services, and these have been identified in previous work by the Ministry of Health and the Mental Health Commission. The workplan aims to address these issues by focusing on priority areas for further funding.

Planning future services relies on some system of prioritisation given that the demand for growth typically outweighs the available funding. To guide this process of decision-making, the following short- to medium-term objectives were formed:

- 1 To have a vision for child/tamaiti and youth/rangatahi mental health which encompasses mental wellbeing and acknowledges that a full spectrum of health promotion and problem prevention activities need to sit alongside treatment and recovery work. This vision symbolised in the whakatauaki Kia Tu Kia Puawai (stand tall with confidence) and is detailed for Maori in the document of the same name.
- 2 To improve services including consultation and liaison for the 3 percent of children/nga tamariki and youth/rangatahi with serious mental illness and their families/whanau, and to ensure that there is future growth of services in line with the benchmarks determined by Government.
- 3 To ensure that disparities in the range of services available in each region are addressed to improve national consistency and equity of access to services.
- 4 To prioritise the establishment and expansion of appropriate services for tamariki and rangatahi Maori and whanau. This is linked in with existing plans to invest in workforce development for Maori and to ensure Maori approaches to mental health are adopted.
- 5 To establish an improved range of appropriate services for Pacific children and young people along with a workforce able to provide specialist and support services for Pacific communities.
- 6 To increase, strengthen and better coordinate the child/tamaiti and youth/rangatahi mental health workforce including human resource management issues and training.
- 7 To promote integrated, safe and high quality services for children/nga tamariki and young people/rangatahi through inter-agency, cross-sector and DHB collaboration.

In this process it has been important to identify and prioritise the various sub-populations requiring specialist services. Any additional funding for child/tamaiti and youth/rangatahi mental health services will therefore be directed in the first instance to those groups where there is high priority. In each case investments will be made in workforce development to secure the necessary skill base before services are provided.

There are significant investments to be made in developing a skilled and diverse workforce and to the attendant issues of recruitment and retention.

The groups prioritised for future service development are:

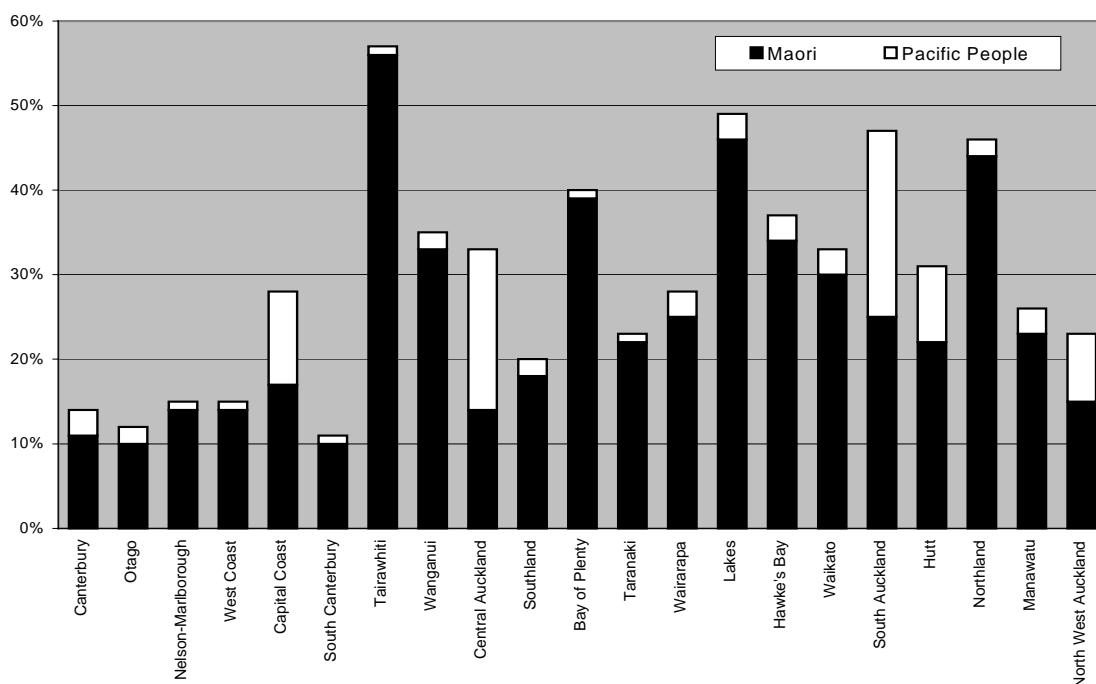
- |                 |  |
|-----------------|--|
| Priority one:   | Nga tamariki and rangatahi Maori with mental health problems, and their whanau   |
| Priority two:   | Pacific children and youth with mental health problems, and their extended families                                    |
| Priority three: | Children/nga tamariki and young people/rangatahi with severe problems and multiple need and families/whanau/caregivers |
| Priority four:  | Other areas of high need (rural, alcohol and drug dependency, suicide prevention, destigmatisation work).              |

These priorities are in line with stated government priorities and are aimed at minimising gaps and disparities.

The prioritisation process in this workplan starts with a focus on tamariki and rangatahi Maori. The percentage of Maori under 20 years in each DHB area is shown in the following chart. The highest density of nga tamariki and rangatahi Maori include Tairāwhiti (56 percent), Rotorua (46 percent), Northland (44 percent), Bay of Plenty (39 percent), Wanganui (33 percent) and Waikato (30 percent). In addition, South Auckland, Waitemata (North and West Auckland) and Hawke’s Bay all have over 13,000 young Maori living in the region.

The second priority for improving disparities is aimed at Pacific people. Service development for Pacific children and youth would clearly need to be in those DHB areas which have the highest density of Pacific people – South Auckland (22 percent), Auckland Central (19 percent), Capital Coast (11 percent), Hutt (9 percent) and North West Auckland (8 percent). In addition, Waikato, Canterbury, Midcentral, Hawke’s Bay and Otago all have over 1000 Pacific youth under the age of 20 living in the region.

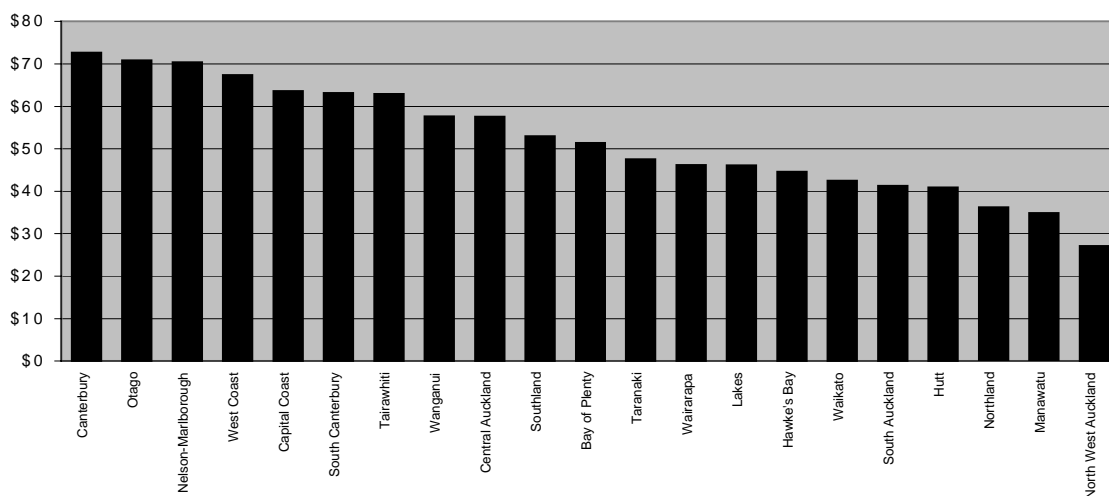
**Figure 1:** Percentage of Maori and Pacific people per DHB region



The third priority for service growth and expansion aligns with the focus on the most severely unwell. In this case, it is emphasising the need for service development for children/nga tamariki and youth/rangatahi who have severe problems and high needs. Within this group are those with involvement with more than one agency in addition to CAMHS eg, Child, Youth and Family, Police Youth Aid, Specialist Education Services.

The needs of these children/nga tamariki and youth/rangatahi and their families/whanau require the intensive specialist services provided by CAMHS. Mental health services to help this client group will be developed in consultation with the other agencies involved with them and in line with intersectoral agreements currently being developed under Strengthening Families.

**Figure 2:** Current child and youth mental health service spend per child and young person by DHB



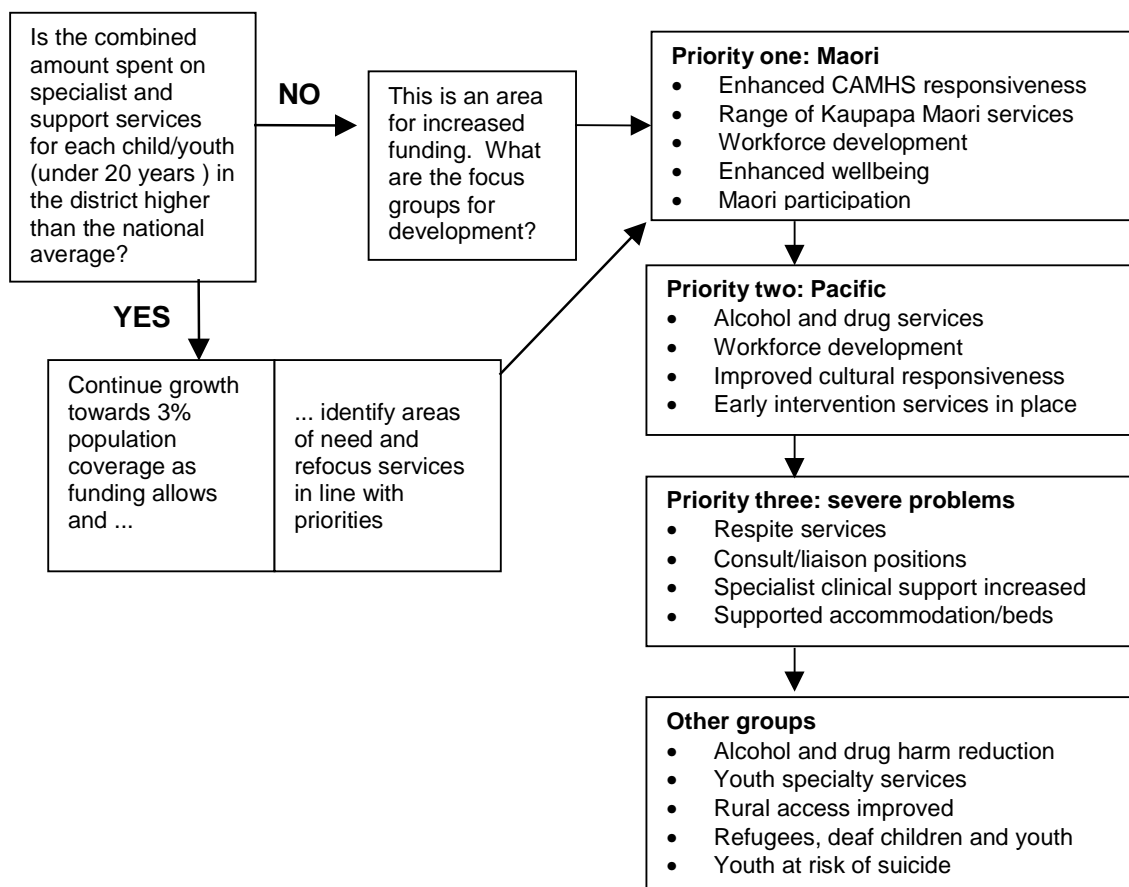
This graph represents the 1999/2000 HFA spend on child/youth-specific mental health services per head of child/youth population within each DHB region. It should be noted that this does not reflect benchmark service levels, and that the difference in regional spending levels may also reflect different regional prices being paid to some providers.

Average spend per child/youth under 20 years (approximately \$52.00 for the 1999/2000 year) has been taken as the starting point to decision-making. The figures include NGO as well as Hospital and Health Service (HHS) funding aimed specifically at children/nga tamariki and young people/rangatahi. Regional service costs have been averaged out over the number of people under 20 years in the region. While it is acknowledged that this is a very rough way of estimating disparities between districts, it gives an indication of where changes are most urgently required.

Of particular concern are those districts where the per child spend is under the average and where Maori make up a high proportion of the population. This workplan puts forward a process of prioritisation aimed to remedy the current discrepancies in funding so that there is greater consistency in funding and more appropriate mental health and alcohol and drug services for tamariki and rangatahi Maori.

The flow chart below outlines the process of prioritisation developed to guide the future service development. It has helped determine the priority actions set out in this document. The actions defined under each priority in the flow chart are indicative only. The aim of the chart is to encourage planners to think in terms of their areas of high need and focus on the reduction of disparities. It is clearly a dynamic model since the position of the DHBs in terms of per child funding will change as new funding is more effectively targeted.

**Figure 3:** Flow chart for decision-making about children and youth prioritisation of funding



The approach to developing new services indicated here will achieve greater consistency of service delivery across the country. Inconsistencies in the way that services are delivered should also be reduced through the national HFA service specifications under which all HHS providers are now operating.

The following sections of the document detail the way in which the workplan objectives and its focus on priority groups will be implemented. This work makes operational the Government's Strategic Framework (MoH 1998) by specifying the steps, sequences and timeframes for developing services. It outlines the practical steps forward as financial and workforce resources become available.

The activities currently undertaken by the HFA will be transferred to the Ministry of Health during 2000. Once the DHBs are established and functional, responsibility for some aspects of the workplan may be transferred to them.

## 3 Service Gaps and Priority Actions for Groups

### 3.1 Introduction

The following sections of this document outline the priority actions for the populations under 20 years with mental health disorders:

- tamariki and rangatahi Maori and their whanau
- Pacific children, young people and their extended families
- children/nga tamariki and youth/rangatahi with severe problems and high need, including those with complex needs and multi agency involvement
- children/nga tamariki and youth/rangatahi with alcohol and drug dependencies.

For each of these groups, there is a short description of the main service gaps and areas to be focused on, followed by a table which identifies priority actions in ranked order. In the section on tamariki and rangatahi Maori the actions are not in priority order since consultation indicated that the needs of Maori in all of the stated areas should be progressed simultaneously. For each proposed service, there are supporting actions which will need to be undertaken to facilitate service development. These are set out in the final column of each table.

While most of the actions which have been identified are specifically aimed at providing more and better services to the 3 percent of the population who are most unwell, there are some included which do not, strictly speaking, fall into this category. The most notable of these is youth/rangatahi one stop shops. These have been included in the tables in response to needs strongly expressed by youth/rangatahi and to highlight the gap in service provision for young people with mild/moderate mental illness. Decisions about best funding streams for these and other mental health services outside the 3 percent will occur between the relevant health groups of the HFA and with other agencies.

Clearly, none of the actions can be progressed without sufficient, appropriately trained people to provide the services which will be contracted. The workforce development which underpins all of the actions in this document is outlined in a separate section. Considerable thought has been given to the way in which the child and youth workforce can be enhanced with three objectives stated – increasing the workforce, strengthening the existing workforce and improving the co-ordination of the delivery of child and youth training.

Section 5 presents the same material as the current section, but analyses it from the perspective of the existing four HFA regions rather than the client groups. This allows readers to see at a glance the developments that are proposed in each of the four regions. The developments outlined in this paper including detailed fulltime equivalent (FTE) requirements per DHB area will be fleshed out in the locality plans which are currently being prepared by the HFA.

## 3.2 Nga tamariki, rangatahi Maori and whanau

The Crown is obligated under the Treaty of Waitangi to ensure that Maori enjoy the same health status as their Treaty partners. Because of this and the recent concentration of effort through Government policy to close the gaps between Maori and non-Maori across all indicators, the workplan gives primary consideration to improving services for tamariki and rangatahi Maori.

Mental illness is a major health problem facing the tangata whenua of Aotearoa, and for this reason the Mental Health Group has explicitly prioritised the mental health and wellbeing of Maori in previous funding plans. Tamariki and rangatahi Maori have higher risks than the general population for all mental health disorders (Horwood and Fergusson 1998) with the most frequently mentioned problems being the widespread abuse of alcohol and drugs, the rise in serious behavioural disorders, and risk taking including self injury and suicide.

In HFA discussions with Maori there has been continued reference to the need for:

- early intervention, health promotion and problem prevention work
- a focus on the range of social, economic and political factors determining mental health status and outcome
- the right of Maori to lead solutions to their own problems.

Maori have discussed the importance of establishing a strong identity, having connectedness and participation in one's culture and being able to fulfil one's role in society as necessary individual attributes in achieving and preserving mental wellbeing. This creates an imperative to undertake mental health promotion and prevention activities alongside treatment, and to advance these using processes which are uniquely Maori.

Traditional concepts of health and healing are the core component of interventions for Maori, specifically Whare Tapa Wha. This model depicts the determinants of health through the four cornerstones of te taha wairua (spiritual aspects), te taha tinana (physical aspects), te taha whanau (family and community aspects) and te taha hinengaro (mental and emotional aspects). In addition, Durie (1995) identifies five principles for purchasing culturally appropriate services:

- **Choice** – the need for a range of Maori and mainstream services so that options are available
- **Relevance** – services that are culturally meaningful and able to address actual needs
- **Integration** – the need for connections within the health sector and between sectors in line with an holistic approach to Maori health
- **Quality** – high standards of care and evidence-based treatment linked with good outcomes
- **Cost-effectiveness** – value for money and consideration of economies of scale.

These dimensions need to be reflected in the range of Kaupapa Maori and mainstream services provided for nga tamariki and rangatahi.

The HFA is advancing a Maori mental health strategy which comprises four parallel strands of activity.

### **3.2.1 Expanded specialist services for Maori**

Most mental health services for Maori are provided via HHS services, while respite, supported accommodation and some Kaupapa Maori services are more typically provided within a more limited non-government sector. This workplan recognises two strands of development for Maori: enhanced mainstream service development and expanded Kaupapa Maori clinical and support services.

Implementing strongly Maori-orientated services within mainstream requires designated positions for Maori, training and mentoring opportunities, education for non-Maori workers in cultural practices including cultural safety, and expanded consultation and liaison roles to create linkages with other services and agencies.

In addition Kaupapa Maori services are required together with Kaupapa service specifications. These services for mental health and/or alcohol and drug problems exist in Auckland, Hamilton, Palmerston North, Wellington, Taranaki and Christchurch. More are required across the country as the workforce becomes available. There is an urgent need for Kaupapa Maori options that can provide more intensive support, treatment and long-term interventions for the group of tamariki and rangatahi Maori with existing serious disorders.

Alongside specialist care is the significant role in respite and substitute care undertaken by whanau, especially grandparents. Respite care by non-relatives is difficult to secure, highlighting the need for Kaupapa Maori supported accommodation and a greater recognition of the role that older people take in managing the ongoing care and recovery of tamariki and rangatahi Maori with severe mental health disorders.

In planning future services, it is necessary to achieve a balance between developing mainstream to be responsive to Maori and resourcing a substantive development of Kaupapa Maori services. Kaupapa Maori services will require time for seeding, for development and consolidation, so that in future they can match those of mainstream CAMHS.

Several streams of work have been raised in the discussion around the future development of specialist services for Maori. These include the development of a cultural assessment tool, establishing national benchmarks for Maori, Kaumatua involvement in service delivery and finally more detailed analysis of Kaupapa Maori service specifications and cost of providing Kaupapa Maori services.

### **3.2.2 Developing the Maori workforce**

A number of specific workforce development initiatives for Maori are underway. Te Rau Puawai is an undergraduate and graduate training programme in mental health for Maori at Massey University. Te Ngaru learning systems and Miria te Hinengaro are initiatives to train Maori practitioners. In a series of wananga (educational processes) these develop and support a Maori model of practice for Maori. Maori enrolled in any CTA-funded course are eligible for up to \$3000 per year in an individualised support and access package.

A review of HHS workforce development policies and procedures specifically targeted activities related to Maori staff. In addition the HFA has supported hui for Maori mental health workers to explore common issues and help strengthen national networks.

### 3.2.3 Enhancing wellness

In the document *In our Hands, Kia Piki te Ora o Te Taitamariki* (Ministry of Youth and others 1998), a proactive approach to preventing youth suicide among rangatahi Maori is outlined. This work dovetails into the work of specialist mental health services many of whom report seeing high numbers of youth who self harm or are at risk of suicide. One of the highest indicators of suicide is having had a previous attempt. Specialist services are therefore encouraged to provide strong consultation/liaison services to emergency departments to facilitate access to specialist mental health services following attempted suicide.

The HFA has developed pilot sites for Maori mental health promotion as part of the Maori mental strategy *Kia Tu Kia Puawai*. These trial uniquely Maori responses to mental health promotion, problem prevention and early intervention. Other iwi initiatives exist such as *Whanau Toko I Te Ora*, a programme of the Maori Women's Welfare League, which is designed to support whanau in caring for their babies and young people, thereby enhancing well-being.

A broader health promotion and problem prevention agenda will be established for Maori to expand this work. This will more fully explore the links needed with other health streams and sectors, and will detail the various funding sources to support the breath of services required.

### 3.2.4 Enhancing Maori participation

The future development of services for tamariki and rangatahi is highly dependent on the participation of Maori in all aspects of service delivery. This ensures access to Kaumatua, Tohunga and iwi to provide Maori with appropriate cultural interventions to back up more mainstream treatment. Maori need to be fully involved in service monitoring with some programmes already well established. A cultural assessment tool is being developed to assist those working with tamariki and rangatahi Maori.

These four strands of development are represented in the following table but are not prioritised. Proposed new services for the years 2000 to 2003 are shown under each stream of activity along with supporting actions that will be required. Actions to enhance the Maori workforce are not shown in this table but are included in a separate section.

**Table 3:** Priority actions: nga tamariki, rangatahi and whanau

Actions in the Maori mental health plan	Proposed service	Proposed districts	Supporting actions required*
Expanded specialist services for Maori	<p>Enhanced mainstream responsiveness: skilled, responsive and well staffed CAMHS services able to provide assessment and treatment for Maori</p> <p>Establish and expand Kaupapa Maori specialist mental health services with full range of clinical services</p> <p>Expansion of Kaupapa Maori alcohol and drug services including early intervention, secondary prevention, consultation and liaison, and advocacy</p> <p>Establish range of support services for Maori eg, community support workers, assistance for respite carers and in-home support options</p> <p>Consultation and liaison services established, focused on tamariki and rangatahi youth involved with Child, Youth and Family and Justice services</p>	<p>South Auckland Northland Midcentral Hawke's Bay Waikato Wanganui Wairarapa Lakes Bay of Plenty Taranaki Tairāwhiti</p>	<p>Provision of culturally safe services appropriate to Maori wherever mental health services are provided</p> <p>Range of NGO services in place appropriate for tamariki, rangatahi and whanau</p> <p>Flexible respite funding designated for Maori</p> <p>Research/evaluation agenda established</p> <p>Enhanced national networking of Maori involved in mental health services for tamariki and rangatahi</p> <p>Links established with Maori groups to enable better support of those tamariki and rangatahi receiving help from specialist services</p> <p>Closer links established with Child, Youth and Family, Youth Justice and Education with a focus on Maori</p>
Developing the workforce	<p>This is covered in the separate workforce section</p>	<p>Nationally</p>	
Enhanced wellbeing	<p>Mental health promotion and problem prevention agenda established for Maori</p> <p>Services designed for improved Maori maternal mental health including alcohol and drug prevention</p> <p>Suicide prevention approaches for Maori enhanced</p>	<p>Selected areas</p>	<p>Research and evaluation projects continued re effective and appropriate prevention activities for Maori</p> <p>Expanded scope of Kia Tu Kia Puawai initiative</p>
Maori participation	<p>Maori participation and monitoring frameworks expanded</p>	<p>Nationally</p>	<p>Framework and best practice guidelines for monitoring services completed</p> <p>Work progressed on cultural assessment tool</p> <p>Positions for Maori youth coordinators in place in areas of high Maori density</p> <p>Development of the roles of Kaumatua and Tohunga in mental health services</p>

\* All proposed actions to develop the workforce are included in a separate section.

### **3.3 Pacific children, young people and their extended families**

It is difficult to measure the extent of mental illness among Pacific people in New Zealand, since the only reliable data which is available is based on inpatient admissions. This information shows that admissions for schizophrenia for both Pacific males and females are more common than for the general population. However, other disorders including alcohol and drug disorders, are reportedly less common (Bathgate and Polutu-Endemann 1997).

A gap in services has been identified for the group of New Zealand-born youth who have high rates of alcohol abuse and criminal activity but who are unlikely to contact the agencies or services that could help. Getting the right approach and style of service delivery is therefore critical in planning future services.

Pacific people have described a model of Pacific health (Crawley et al 1997) based around four pillars of wellbeing supporting Pacific culture depicted as the roof. This structure is set in a wider context of environment and time and as such is not unlike Te Whare Tapa Wha. While each Pacific nation may share something in common with Crawley's model, it is important to note that each will also have unique concepts of mental health and wellness.

The HFA holds contracts with Pacific providers for treatment services for adults with severe mental health or alcohol and drug problems. These may include service provision for children and youth but are not youth specific. Other contracts fund groups and churches to provide health promotion and problem prevention services (in the Auckland region), however none of these focus on the prevention or early identification of mental health problems per se.

Early identification of mental health problems in children and youth is most likely to occur in primary care settings and in Child, Youth and Family and Justice services where Pacific children and youth are over represented. Training in the identification of mental health and alcohol and drug problems would assist those people working with Pacific youth to identify problems and intervene early, or refer on to specialist services for more severe problems. The one-stop shop model of mainstream primary care has been recommended for Pacific youth, given that these services are easy to access and are deliberately youth friendly. These need to provide access to specialist health services for those who have severe mental illness.

There is an urgent need for specialist mental health services to become more appropriate for Pacific people, especially in areas with a high Pacific population. Achieving this will require increased investments in workforce development so that more Pacific people are skilled to take up a range of clinical and support positions. The appropriateness of developing Pacific only services similar to the Kaupapa Maori service model needs to be considered in consultation with local communities, and taking into account issues of choice, quality and cost-effectiveness.

Given the strong preference by Pacific families to maintain their principal caregiver role, there is a need for a range of culturally appropriate treatment options including home-based support options with flexible budgets.

**Table 4:** Priority actions: Pacific children, youth and families

	Proposed service	Proposed districts	Supporting actions required*
1	Mainstream mental health and alcohol and drug services enhanced to provide more effectively for Pacific children, youth and fanau	South, Central Auckland Waitemata Wellington Hutt Valley	Consultation and liaison services enhanced for Pacific children and youth within primary care settings including schools
2	Consultation and liaison services established, focused on Pacific children and youth involved with CYFS and Justice services	South, Central and West Auckland Wellington Hutt Valley	Links established with Pacific community groups to enable better support of Pacific children and young people  Closer links established with CYFS, Youth Justice and Education with a focus on Pacific children and young people
3	Pacific community support work and other NGO services established	South, Central and West Auckland Wellington Hutt Valley	Flexible funding for Pacific respite care  Pacific peoples involved in a range of support activities including in home respite and family support  Consult/liaison positions within CAMHS funded to link with these NGO Pacific services
4	Establish primary mental health services for Pacific youth	Wellington	Intersectoral team established to investigate One Stop Shop facility to serve Pacific youth in greater Wellington area
5	National activities supported for Pacific workers eg, working parties, fono and special projects (including prevention and community development projects)	Nationally	Establish national funding pool with suitable Pacific administration identified  Research agenda established with priorities identified

\* All proposed actions to develop the workforce are included in a separate section.

### 3.4 Children/nga tamariki and youth/rangatahi with severe problems and high need

Children/nga tamariki and young people/rangatahi with high needs are those with severe mental health problems and significant impairment of functioning. Within this group are those with co-morbid disorders (including alcohol and drug dependence) and needs that may cut across health, welfare, justice and education sectors. This group because of their serious mental illness and/or drug and alcohol problems have an increased risk of self harm and suicide.

Since these children/nga tamariki and youth/rangatahi are often clients of a number of Government agencies, an intersectoral approach to their care is being developed. This is happening under the Strengthening Families umbrella. In 1999, \$2.5 million was received by the HFA from Vote Health to provide mental health services to those children/nga tamariki and youth/rangatahi involved with Child, Youth and Family services who also have severe mental health problems. Nga tamariki and rangatahi Maori are over represented in this population with higher levels of psychiatric morbidity and co-morbidity than non-Maori. There is a high level of conduct disorder and alcohol and substance disorder in this group, with a strong relationship between these two problem areas. Pacific youth are also over-represented in the Justice system both for serious offences or for problems involving alcohol abuse and dependence.

A model of service delivery appropriate for this group has been finalised with the aim of having new services in place by July 2000. Existing CAMHS will be expanded to cater more effectively for those who are both Child, Youth and Family clients and have severe mental health problems. Specific services planned are:

- intensive clinical support services to children/nga tamariki and youth/rangatahi and their whanau and caregivers
- increased respite care
- wrap-around services.

At the same time, a wider intersectoral model is being developed which will recommend systems of care for children/nga tamariki and youth/rangatahi with severe mental health problems, disabilities and/or behavioural difficulties who are involved with a number of agencies. Possibilities of joint agency funding are being considered as part of this process. Decisions for the future direction are expected by the end of June 2000. Any future planning by Health will need to take this intersectoral work into account.

Children/nga tamariki and youth/rangatahi with high needs will benefit from the service developments outlined in other parts of this document. However, there are additional gaps for this group which include:

- the development of appropriate and sufficient forensic services
- respite and intensive community-based recovery programmes
- enhanced alcohol and drug services including detoxification and methadone services
- establishing secure inpatient services
- increased and enhanced day treatment services
- improved access to services for children/nga tamariki and youth/rangatahi with complex needs from low socio-economic urban areas
- increased support for children/nga tamariki and youth/rangatahi with high needs in rural areas eg, by the improved use of telepsychiatry.

Linkages and strong relationships across providers are critical to improving services for this population. Similarly the workforce needs training and support to work in various settings eg, schools, in the home, within medical services and with iwi.

### **3.4.1 Young people, rangatahi with first psychosis**

Youth/rangatahi with early psychosis need to be assessed and treated by people who have specific skills in this area. A number of such services have already been set up, spanning a wide age range using skills and resources from both CAMHS and adult services. Specialist practitioners also assist with training and provide outreach services to outlying areas. An increase in the use of telepsychiatry would enhance these services as would an increased capacity to match youth with people of the same ethnic/cultural group.

Young people/rangatahi need direct and ongoing assistance with recovery from illness. While some of this is available through CAMHS, non-clinical support can complement and strengthen the clinical services provided. Community support workers undertake this non-clinical role within adult mental health services but there is no equivalent service available for younger people. Non clinical community support (including youth workers) for young people/rangatahi and their families will be trialed to ensure assertive follow-up to treatment for young people/rangatahi trying to maintain their links with school and social networks. Ideally the range of services available to those people under 20 experiencing first psychosis should match those available to adults.

### 3.4.2 Family and whanau

CAMHS and Kaupapa Maori services have always considered the needs of the children/nga tamariki and youth/rangatahi in the context of their families/whanau. For people with severe illness who are compulsorily treated, this commitment to family has been strengthened recently by the amendment to the Mental Health Act, which requires that families are consulted as part of the assessment and treatment process.

Families and whanau who are caring for children/nga tamariki and young people/rangatahi with serious disorders contributed to the development of this workplan. Their comments are included in Appendix B. In summary families need information, training and support. They especially need information about mental health problems and the treatment options that might be available to their children/nga tamariki and to them as a family.

Families require prompt responses from specialist services when crises arise and want to see quick response teams boosted so that early signs of relapse are well managed. They also require in-home supports as well as counselling, family therapy, training in managing behaviour and drug therapy use, and in-home respite so that they can attend to the needs of other children/nga tamariki.

The National Mental Health Standards have clear requirements for family and carer participation. The HFA has set targets to improve the responsiveness of mental health services to service users on the understanding that service quality is substantially improved where there is good consumer involvement in treatment options, programme planning and service monitoring. Initiatives to improve participation have evolved including youth/rangatahi coordinator positions, designated consumer representatives and advisory bodies attached to CAMHS. These will be enhanced in the current workplan and will be most relevant for people who have intensive or long-term links with CAMHS.

**Table 5:** Priority actions: children and youth with severe problems and high need

	<b>Proposed service</b>	<b>Proposed districts</b>	<b>Supporting actions required*</b>
1	<p>Wraparound services including intensive and mobile clinical services (clinical FTEs, 24 hour 7 day a week)</p> <p>These may be provided in collaboration with other key agencies such as Child, Youth and Family and Specialist Education Services.</p>	Major centres	<p>Funding to extend CAMHS beyond the current working hours</p> <p>Additional positions established for rural and low socioeconomic areas</p> <p>Assertive outreach enhanced by telepsychiatry and consult/liaison positions</p> <p>Assertive follow-up of high needs children across various treatment and support systems</p> <p>Flexible funding for home-based support in line with agreements under Strengthening Families</p> <p>Non clinical support services established including youth workers/coordinators</p> <p>Skilled community support services to provide in-home care including behavioural management and family support</p> <p>Intersectoral joint funding mechanism established for group with highest need</p> <p>Intersectoral linkages with various agencies involved with high needs children and youth</p>
2	Supported accommodation involving short and long term placements for children and youth	All areas	<p>Provision of therapeutic foster care and ongoing clinical backup for such services where this is the treatment recommended by best practice</p> <p>Therapeutic programmes funded for those in residential mental health care</p> <p>Best practice promoted for secure care and management of difficult behaviours</p>
3	Suicide prevention services (assessment and management of suicide) and related evaluation work expanded	All areas	<p>Pilot models of intensive support/follow-up for young people who have attempted suicide (including evaluation)</p> <p>Mental health consultation-liaison positions established eg. for suicide attempt in Emergency Departments, for assistance in suicide risk assessment with GP and other primary care workers including iwi organisations</p>
4	Youth forensic services developed for young people focusing on consult/liaison positions, court liaison and community services. Prompt diagnosis and referral of conduct disorder and comorbid mental illness	Selected areas	<p>National information sharing forum arranged to discuss the future provision of forensic mental health services for children/nga tamariki and youth/rangatahi</p> <p>Specific youth forensic consultation and liaison services set up</p> <p>Investigate joint agency approach with shared funding arrangements</p>
5	Respite care services	All areas	Funding a range of respite options for both crisis and planned respite situations, including home-based or residential support services in line with Strengthening Families agreements

	Proposed service	Proposed districts	Supporting actions required*
6	Focus on the management of specific disorders and comorbidities	Selected areas of need	<p>National best practice guidelines developed for the identification of co-morbid problems in young people with ADHD, ODD and Conduct Disorder</p> <p>National best practice guidelines developed for Pervasive Developmental Disorders</p> <p>Protocols with disability services for support services for young people with Autism</p> <p>Expanded range of services for those with first episode psychosis including intensive packages for family support</p> <p>Consult/liasion positions established for linking with A+D, Paediatrics, schools, adult services, physical/sensory disability and intellectual disability services</p> <p>Services expanded for severe emotional disorders (anxiety, mood disorder, attachment disorders)</p> <p>Implementation of youth suicide strategy with additional services for those self harming and with high risk of suicide</p>
7	Services for those youth, who are involved with CYFS, Justice, alcohol and drug services	Areas of high Maori and Pacific population	<p>Culturally appropriate consult/liasion positions established for this population</p> <p>Kaupapa Maori youth services established</p> <p>Maori and Pacific clinicians available to provide crisis and acute services</p> <p>Intersectoral funding mechanism investigated for those in contact with multiple agencies</p>
8	Therapeutic day and activity programmes for those with complex and/or co-morbid mental health problems including alcohol and drug abuse	All areas	<p>Increased day programmes and therapeutic activities</p> <p>Development of strong links with Education to ensure that day programmes have appropriate schooling input</p> <p>Kaupapa Maori programmes</p>
9	Participation/representation mechanisms established for young services users and families	Auckland Northland	<p>Funding for dedicated youth coordinator positions, youth networks, and special projects</p> <p>Advocacy services established for high needs young service users and families</p> <p>National mental illness anti-discrimination and stigma campaign work developed by and for under 20 populations</p>
10	Specialist programmes designed for special populations: Deaf children and youth, refugees, older adolescents, children of parents with serious illness including A+D, and teenage mothers	Selected areas as appropriate	<p>Needs assessment work completed for refugees and older adolescents</p> <p>Funding for cultural support workers</p> <p>Specific early intervention programmes established with evaluation systems in place</p>

\* All proposed actions to develop the workforce are included in a separate section.

### 3.5 Children/nga tamariki and young people/rangatahi with alcohol and drug dependencies

Substance abuse/dependence has been identified as the most common disorder experienced by young people/rangatahi (young males in particular) between the ages of 16 and 18 years of age (Horwood and Fergusson 1998). This high prevalence is reflected in the mental health access targets of 3.9 percent for 10–14 year olds and 5.5 percent for 15–19 year olds (MoH 1998).

A gap in services devoted to solely drug and alcohol problems in child/nga tamariki and youth/rangatahi was identified in the National Drug Policy Workplan, Treatment Services Gap Definition (May 1999). This is despite recent funding increases in 1999/00 of a further \$2.2 million additional to Mason funding allocated to child and youth/rangatahi alcohol and drug treatment services. In addition, the Mental Health Commission states that the approach to youth alcohol and drug problems varies considerably and is often not clearly defined (MHC 1999b).

Service specifications aim to create a nationally consistent approach to the provision of alcohol and drug services for children/nga tamariki and young people/rangatahi. There is an assumption that CAMHS will work holistically to treat co-morbid alcohol and drug and mental health problems. However, in some cases separate child and youth alcohol and drug services are funded to provide specialist services for this client group. Regardless of the service delivery, all providers working with children/nga tamariki and young people/rangatahi with alcohol and drug abuse problems are expected to work together to provide the best package of care. In order to achieve this, well-trained specialised drug and alcohol staff are required as part of CAMHS teams.

Attention has been given to Kaupapa Maori services which provide a mix of alcohol and drug early intervention, prevention and treatment services. Given the relationship between alcohol and drug problems and crime and mental health problems, it is important that all relevant agencies (Justice, Welfare, and Education) coordinate the services required for early identification and treatment of alcohol and drug problems.

Specific early intervention services have been identified for rangatahi Maori, Pacific youth and other high-risk groups. Early intervention and treatment for alcohol and drug abuse and dependence will be expanded through CAMHS, working closely with alcohol and drug providers and Kaupapa Maori services. CAMHS will also need to provide specialist consultation and training in the identification and management of alcohol and drug abuse and dependence.

Upskilling the community and primary health workforce to intervene earlier in drug and alcohol related problems is being undertaken by the Goodfellow Unit in Auckland. This programme (Tobacco Alcohol and Drug) has shown success in reaching those primary and community health workers involved with Maori and Pacific children/nga tamariki and young people/rangatahi. The programme builds on the series of primary care guidelines produced by the National Health Committee on the management and treatment of depression, anxiety, alcohol and cannabis problems, and on the detection and management of young people at risk of suicide.

Priority actions for children/nga tamariki and youth/rangatahi with alcohol and drug dependence for 2000 to 2003 will be in line with the directions set out in the following table.

**Table 6:** Priority actions: children/nga tamariki and youth/rangatahi with drug and alcohol dependencies

	Proposed service	Proposed districts	Supporting actions required*
1	Kaupapa Maori early intervention and community treatment services expanded for tamariki and rangatahi with alcohol and drug abuse problems	South Auckland Northland Midcentral Hawke's Bay Waikato Wanganui Wairarapa Lakes Bay of Plenty Taranaki Tairāwhiti	Early intervention services established for rangatahi Maori Designated clinical positions for Maori staff increased Links established with Maori health clinics to provide clinical back-up and support, as part of CAMHS consultation/liason services
2	Early intervention and treatment services designed with and for Pacific communities	South and Central Auckland Waitemata Wellington Hutt Valley	Additional positions for services for Pacific youth Providers undertaking mentoring roles for Pacific workers Specialist support provided to Pacific workers through the consultation and liaison function of CAMHS
3	Service expansions for: <ul style="list-style-type: none"> <li>• early intervention</li> <li>• consultation and liaison</li> <li>• specialist interventions</li> <li>• where there are dual diagnoses</li> </ul>	All areas	Designated specialist positions within CAMHS to work with alcohol and drug abuse and dependence Services for youth established within existing Alcohol and Drug Services Drug and alcohol problem prevention positions established as part of Youth One Stop Shops Specific consultation/liason positions for linking with primary care agencies, schools, iwi, community organisations and agencies Scoping exercise on the estimated need for alcohol and drug detoxification services and methadone services for youth nationally Clear protocols for diagnosis and treatment of childhood dependence and abuse established between all relevant services and agencies Assessment and clinical skills expanded to outlying areas using for example mobile teams and video conferencing Youth participation efforts expanded through co-ordinator and youth consumer positions
4	Designated places for opioid addicts in methadone treatment programmes	Areas with highest waiting lists	Increased places on methadone treatment programmes with a focus on those under the age of 20 years
5	Detox facilities available for youth transferring to secure services/prison	Major centres	Protocols developed with Youth Justice and Corrections to manage youth/rangatahi requiring detoxification
6	Scoping exercise completed regarding options to improve intersectoral responses to substance abuse	National work	National project fund available for projects and community development and evaluation work eg, peer education programmes for youth in schools

\* All proposed actions to develop the workforce are included in a separate section.

## 4 Plans to Develop the Workforce

Service developments in child/tamaiti and youth/rangatahi mental health are constrained by limitations in the workforce. According to the *Blueprint*, the child/tamaiti and youth/rangatahi sector was the area most dramatically deficient in terms of services and workforce. There have been significant increases in both in recent years but the deficit remains large, at least half of the guideline level. The Mental Health Commission has identified the need for a comprehensive workforce development plan for specialist child/tamaiti and youth/rangatahi mental health services.

The National Workforce Development Co-ordinating Committee's 1999 report (*WDCC Report*) states: "There are enormous demands on key service personnel, who not only provide services but also supervise students in training and teach courses designed to upskill the workforce. A consequence of this is a shortage of skilled people to provide the volume of training required for the workforce and services to expand."

The *WDCC Report* describes obstacles to workforce development in child and youth mental health that include:

- lack of national co-ordination and leadership
- limited capacity of the child and youth sector to provide training opportunities
- shortage of experienced child and youth mental health clinicians across all professional groups
- critical shortage of child and adolescent psychiatrists
- critical shortage of Maori workforce
- shortage of Pacific people workforce
- limited opportunities for training and development of support worker roles
- lack of national co-ordination for overseas recruitment.

In addition, the education sector has challenges in meeting the needs of the service sector, such as long planning timeframes, recruitment of faculty and clinical supervisors and the one year funding cycle and contracts.

Current HFA-funded workforce development initiatives relevant to child/tamaiti and youth/rangatahi mental health include CTA purchase of:

- Post-entry clinical training for the specialist, multi-disciplinary programme from Auckland School of Medicine, the University of Otago in Christchurch and Wanganui, and UNITEC. Otago Polytechnic, in conjunction with the University of Otago in Dunedin, is offering the course in 2000 for the first time.
- Child and Adolescent psychiatry training from Auckland School of Medicine and the University of Otago (Christchurch) (two trainees in 1999, five trainees in 2000).
- Child and Youth Mental Health stream in the Auckland Healthcare New Graduate Nursing programme (four trainees in 2000).
- Maori trainees in any CTA-funded programme are eligible for a Support and Access package.

Child and youth mental health staff are also eligible to apply for training through Te Rau Puawai at Massey University, through other CTA-funded courses, the alcohol and drug workforce training programmes, and for the scholarships funded by the HFA Maori Health group.

The Mental Health Commission sponsored a hui for Maori CAMHS workers which identified gaps and areas for service development. A cultural assessment tool was discussed at that time with work continuing on guidelines for cultural assessment processes. People working in the sector have developed networks, demonstrating an eagerness to participate in future service developments. The capacity of these networks and groups to lead future services developments could be significantly enhanced through dedicated resources for working parties, conferencing and special project work.

There are ongoing workforce development initiatives in non-specialist mental health services, through the Strengthening Families projects, the New Zealand Youth Suicide Prevention Strategy, and Special Education 2000. According to the *WDCC Report*, all have the potential to enhance the understanding and capability of the community to recognise and respond effectively to the mental health needs of young people.

The HFA completed a Mental Health Workforce Development Action Plan in December 1999, and is presently refining this into a five-year implementation plan, pending advice on the available budget for new workforce initiatives. While eleven goals and associated objectives have been developed, the four highest priorities relate to Maori, children and youth, Pacific people and generic workforce development.

Priority actions are those which help to train and retain workers within New Zealand so that we have a specialist workforce that understands New Zealand's unique needs. However, as recommended by the *WDCC Report*, recruitment and orientation/training of overseas clinicians will continue to be required over the next 3-5 years. Therefore the recommended initiatives include these complementary approaches. The table below identifies the proposals specific to children and youth. However, there are other possible mental health workforce developments which would benefit this sector:

- training in working with children for people outside the specialist child and youth services
- possible workforce development initiatives that result from the Kia Tu Kia Puawai pilots
- facilitation of providers collaborating to address common workforce problems
- wider availability of training related to alcohol and drug problem identification and management
- support for international recruitment and orientation and cultural training for overseas recruits
- maintain and expand the existing drug and alcohol workforce initiatives
- and further developments of the primary and community mental health sectors.

Workforce development initiatives must acknowledge the complexity of the current workforce problems and the complexity of their solutions. Funding for workforce initiatives must be through direct contracts or tagged funding, in order to ensure that the money is spent as intended.

The recommendations below are made on a national basis, as the needs cross geographic boundaries. However, at the implementation stage, initiatives should be targeted to those geographic areas where the needs are greatest. It is expected that HHS-based services, as well as developing NGO services, will benefit from the proposed workforce initiatives.

**Table 7:** Priority actions: strengthen and develop the child and youth mental health workforce

Initiative Description
<p><b>Objective 1 – Increase the child and youth mental health workforce</b></p> <p>Encourage new entrants to the child and youth workforce through positive profiling of the sector</p> <p>Develop training programmes to bridge non-health professionals into child and youth mental health</p> <p>Increase the number of child and adolescent psychiatrists entering and completing training</p> <p>Support international recruitment of child and adolescent psychiatrists</p> <p>Purchase child and youth PECT “streams” in the New Graduate MH Nursing, Advanced MH Nursing, and Maori MH multidisciplinary programmes</p> <p>Fund selected Child and Youth internships for pre- and post-entry psychologists</p> <p>Prioritise selection of Te Rau Puawai applicants who intend to work in child and youth mental health</p> <p>Develop Level 4 Unit Standard/s in child and youth mental health</p> <p>Purchase additional multidisciplinary post entry clinical training (PECT) in child and youth mental health</p>
<p><b>Objective 2 – Strengthen the child and youth mental health workforce</b></p> <p>Invite proposals from service providers for innovative workforce development initiatives in child and youth mental health</p> <p>Support preceptorships for new child and youth mental health staff who do not have a child and youth qualification</p> <p>Fund further development of the Maori network of CAF service workers</p> <p>Review all provider workforce development plans to ensure that they include positive child and youth workforce initiatives</p> <p>Prioritise staff of child and youth services, and Maori and Pacific people, to enrol in any new generic training opportunities</p> <p>Fund advocacy role at national level for service users (children, youth, and families/whanau)</p> <p>Coordinate a project to identify and address the training needs of those delivering care in the proposed therapeutic home-based programmes</p>
<p><b>Objective 3 – Better co-ordinate delivery of child and youth mental health training</b></p> <p>Support establishment of Child and Youth Mental Health Training Centres</p> <p>Work with the education sector to encourage them to offer more Ministry of Education-funded courses, for health, education and social services staff who work with children and youth</p> <p>Review/audit the current PECT multidisciplinary child and youth mental health programmes</p> <p>Review and revise all CTA training specifications to enhance their relevance to working with children and youth</p> <p>Work with the Ministry of Education and relevant professional bodies to encourage them to increase the child and youth mental health content of tertiary courses</p> <p>Publish an up to date national child and youth mental health training directory</p>

## 5 Future Service Priorities by Region

### 5.1 Region covered by the HFA Auckland office

A review by the Northern Region Child and Youth Mental Health Reference Group of services in the Northern region (2000) shows that \$9.8 million of Mason money (additional money made available by Government after 1996) has been allocated to child and youth service expansion since 1997. This funding has been targeted at expanding community-based services, which has increased FTE positions to approximately 40 percent of benchmarks and brought inpatient services even closer to benchmarks. A further \$4 million has been allocated for the year 2000/01 for further expansion in child and youth services.

The gap between existing child/tamaiti and youth/rangatahi services levels and benchmark targets remains a particular area of concern especially in the context of a growing youth/rangatahi population and the additional demands related to an ethnically diverse population. Services for Maori are a priority with some Kaupapa services available alongside mainstream services; however, any further growth in these areas will need to address workforce issues, notably recruitment and training of Maori staff.

Most services are in the greater Auckland area providing assessment and therapeutic interventions, on an outpatient basis with inpatient care available for those with high need. The child/tamaiti, adolescent and family team in central Auckland provides assessment, an early intervention service for first episode psychosis, and a regional consultation and liaison service for those children/nga tamariki and youth/rangatahi in Child, Youth and Family care, with outreach to Northland. There is also a regional forensic liaison service available for young people who are involved with the criminal justice system.

An inpatient unit exists for the Northern region and is expanding to 25 beds, three of which are available to the Hamilton area. This service caters for young people/rangatahi with serious mental illness and typically works with the older adolescent age group. The demand on services by the older child/tamaiti has limited access by younger children/nga tamariki.

An early intervention service and family therapy service is available in some districts with a focus on those youth/rangatahi experiencing a first episode of psychotic illness.

Non-government services exist within the region providing community support, respite and rehabilitation although the extent of these respite services is limited. A four bed residential service is available specifically for those young people/rangatahi who have serious disorders and require a therapeutic programme provided outside their home. Problems have been identified with respite and rehabilitation services for those children/nga tamariki and youth/rangatahi with severe mental health needs in combination with behavioural problems.

Outpatient and residential services are provided for the region for youth/rangatahi with serious alcohol and drug abuse problems. Other groups with special needs are children/nga tamariki and youth/rangatahi with both mental health and alcohol and drug abuse problems, those needing accommodation, and those who have both a mental health disorder and are involved with the criminal justice system.

The review of child/tamaiti and youth/rangatahi services in the Auckland area raised a number of concerns many of which also occur in other areas in the country ie, services not meeting benchmarks, staff shortages, need for greater cultural emphasis within services, inconsistency in service delivery and lack of consistency in data gathering and monitoring systems. Auckland faces a shortage of options for children/nga tamariki and youth/rangatahi who are acutely unwell although some of this has been resolved through the recent funding of additional inpatient beds.

The review highlighted a pressing need for extended community-based services for children/nga tamariki, youth/rangatahi and their families so that interventions could occur early and comprehensively to reduce the impact of problems. It is considered critical that young people/rangatahi who require inpatient services are discharged as soon as possible, with management and follow-up provided through outpatient and community services.

Service gaps were especially noted for children/nga tamariki, and for those youth/rangatahi with pervasive developmental disorders. In addition, children/nga tamariki and young people/rangatahi with affective disorders and those with severe and complex psychological needs require models of care appropriate for them. The work currently being conducted on the group of children/nga tamariki and young people/rangatahi involved with Child, Youth and Family will help to establish a model for working with those groups who require assistance from multiple services.

Priority actions for children/nga tamariki and youth/rangatahi in the Auckland region for the period 2000 to 2003 will be in line with the directions set out in the following table.

**Table 8:** Priority services and supporting funding actions: Auckland

	<b>Proposed service</b>	<b>Proposed districts</b>	<b>Supporting actions required*</b>
1	Establishment and expansion of Kaupapa Maori mental health and alcohol and drug services	South and Central Auckland Northland	Additional clinical and support positions for Maori Consultation/liaison positions established to link with local iwi providers, alcohol and drug services and CAMHS Maori NGO services established for respite and supported accommodation
2	Mainstream enhancement of services for nga tamariki, rangatahi and whanau	All areas	Addition clinical and support positions for Maori Consult/liaison positions to link with iwi providers and support services and agencies eg, SES, Child, Youth and Family, and Youth Justice Mainstream workers providing appropriate and safe services to Maori and Pacific service users
3	NGO community support services established including CSW, respite and supported accommodation	All areas	NGO providers established for CSW, respite and supported accommodation Flexible respite budget established for children and youth

	Proposed service	Proposed districts	Supporting actions required*
4	Pacific community support services established	Waitemata South Auckland	Support work services established appropriate to children and youth and families with flexible funding Feasibility study re an inter-agency approach to comprehensive mental health care provision for young Pacific peoples Consult/liaison positions established for links between primary services, CAMHS, alcohol and drug services and the Pacific community Dedicated Pacific Islands consultation and liaison positions within mainstream to establish links with Pacific workers and key agencies including Child, Youth and Family
5	Enhanced alcohol and drug treatment services	Regional	Additional alcohol and drug treatment positions Additional positions for Pacific youth including early intervention and youth coordination Alcohol and drug and early intervention mental health services tailored to special populations with unique needs eg, people who are deaf, children, those involved with the Justice system, those at risk of suicide
6	Services established for children and youth with severe problems and complex needs	All areas	Consult/liaison positions established to expand linkages to adult services, A+D services, paediatric services, other agency work (Child, Youth and Family), iwi, schools and disability services Level 3 and 4 accommodation established with therapeutic programmes attached Secure inpatient beds for youth involved with the Justice system Additional positions for intensive mobile clinical services
7	Expansion of CAMHS	All areas	Information and support services for families/whanau, also enable networking, advocacy and participation in services Dedicated youth/rangatahi coordinators with designated Maori and Pacific positions Videoconferencing links established in larger centres Outreach, satellite services and mobile teams established for outlying areas Increase in consultation and liaison positions Training modules on specialised areas established Assessment of need undertaken for refugees, Pacific youth, children of parents with serious mental health problems, best options for supported living and need for methadone and detoxification services for youth Therapeutic day and activity programmes including living skills Suicide prevention work with at risk groups

\* All proposed actions to develop the workforce are included in a separate section.

## 5.2 Region covered by the HFA Hamilton office

Mason money assigned to the region has already been allocated with the result that 22 additional FTEs were established in the last 12 months. This expands Child, Youth and Family liaison work and clinical staff available within specialist services. Inpatient beds for the region have recently been secured at Starship Hospital with additional work being undertaken on expanding residential support within the Waikato area.

Community-based teams providing assessment and treatment services are available within the region with additional specialist services in place for dual diagnosis and liaison work with Child, Youth and Family and SES. Dedicated community drug and alcohol assessment and treatment services have been established for young people, three of which are early intervention initiatives and two residential treatment services.

Youth coordinators are attached to the HHS in region to assist communities access the specialist services available for rangatahi. Other staff increases include child psychiatrist and clinical staff positions although workforce shortages continue to be a significant problem across the region.

Kaupapa Maori services have been targeted with a Kaupapa Maori clinical service established in the last 12 months including a child psychiatrist position. This rangatahi service involves 15 people working on the delivery of clinical and early intervention services focused on the 3 percent of rangatahi with serious mental health disorders.

Special emphasis is given to young people/rangatahi with alcohol and drug problems as a result of the consultation supporting the development of the regional plan. Dual diagnosis and early intervention services are closely linked with this as regional priority areas.

The region is attempting to progress intersectoral work in schools, Child, Youth and Family, SES and with disability support services. Children and young people with mild/moderate mental illness may not reach the access threshold for CAMHS but still require interventions and family assistance and good links are necessary with a range of health and welfare services to ensure that they receive help.

The concern around the criteria of the 3 percent with the highest need will be resolved in the Hamilton region through linkages with other relevant agencies. A one year youth coordination pilot with primary providers has been established with intersector work occurring across schools, Child, Youth and Family, SES and disability services to explore options for improving services to those children/nga tamariki and youth/rangatahi on the boundary.

Another boundary of significance is that between the high needs group and those with less severe but highly prevalent problems eg, alcohol and drug abuse. The plan is to work with those children/nga tamariki and youth/rangatahi on the border of the 3 percent on a pilot basis eg, Parentline has been funded to work with children up to age 12 years with problems not sufficiently severe to reach CAMHS criteria.

In working beyond the 3 percent group, the region is aware of the need to investigate the values and meanings that impact on youth/rangatahi problems eg, the causes of youth/rangatahi and other destructive behaviour common among youth/rangatahi in the area. The most at risk young women have been identified as those with depression and sexual abuse histories, while for young men early contributors to later disorders includes conduct disorder and alcohol and drug abuse.

The Hamilton region has historically been involved in community development initiatives as one strategy to strengthen the ability of existing social networks and structures to respond to mental health problems. This approach also goes some way to resolving workforce shortages because local people working in the primary health care areas and with Iwi can be upskilled to work effectively where problems are first identified. The communities covered by the Hamilton office have good capacity to respond to local child/tamaiti, youth and rangatahi problems which suggests that community initiatives should be supported.

Priority actions for children/nga tamariki and youth/rangatahi for the period 2000 to 2003 will be in line with the directions set out in the following table.

**Table 9:** Priority services and supporting funding actions: Hamilton

	Proposed service	Proposed districts	Supporting actions required*
1	Expansion of Kaupapa Maori services	All areas	New clinical and support positions established NGO services developed for tamariki, rangatahi and whanau (respite and community support services)
2	Services for children and youth with severe disorders and multiple problems	All areas	Consultation and liaison services with Child, Youth and Family, SES and other agencies In home support and increased respite budget Therapeutic day and activity programmes Mobile clinical team established for rural outreach
3	Expansion of alcohol and drug early intervention services	All areas	Additional positions for child and youth, alcohol and drug early intervention and harm minimisation Consultation, liaison and training aimed at primary health and community workers especially in the area of drug and alcohol early identification Early intervention services for Maori with links to iwi and Maori health clinics
4	Expansion of CAMHS	All areas	Additional clinical positions Expanded coordinator positions to include family/whanau participation in service planning, monitoring, special projects and advocacy work Consultation, liaison and training aimed at primary health and community workers Therapeutic day and activity programmes
5	Establishment of range of NGO services	All areas	Respite care services established with flexible budgets Support work services established including in home support
6	Early intervention and prevention activities for identified high risk groups	All areas	Expanded community development projects supported eg, those driven by iwi and by youth Targeted prevention interventions for groups with high risk of serious disorders Research and evaluation frameworks developed

\* All proposed actions to develop the workforce are included in a separate section.

### 5.3 Region covered by the HFA Wellington office

The Wellington office is at least to 50 percent of benchmark levels with the recent allocation of an additional \$1.2 million allocated to child/tamaiti and youth/rangatahi mental health. As well as providing specialist assessment and treatment services, the child/tamaiti and youth mental health teams undertake some early intervention services with at risk groups as well as consult/liason services to agencies working with children/nga tamariki and youth/rangatahi with mild to moderate problems.

There are dedicated positions within the hospital child and youth services for tamariki, rangatahi Maori and whanau as well as four services for Maori provided by Iwi and non-government organisations. Kaupapa Maori CAMHS are in place and will continue to develop the range of specialist services available. Additional funding has been tagged for rangatahi alcohol and drug services and for services provided by Maori in this specialised area.

Workforce shortages have prevented the expansion of CAMHS especially in areas of clinical expertise with the most significant gap in Mid Central area with several vacancies existing for specialist clinical staff.

Because of the high numbers of Pacific families living around Porirua and Lower Hutt, there is a need to develop services in these areas. These will need to extend to parents given that child/tamaiti and youth/rangatahi problems are compounded by factors associated with low socioeconomic status. Designated specialist services to meet their unique needs are required for Pacific youth, with strong linkages to the primary health services they access. In addition early intervention services managed intersectorally with Child, Youth and Family would have good effect with high needs Pacific families.

The region has one specialist residential mental health service providing five beds for young people/rangatahi in the Hutt Valley area. In addition, there is a specific early intervention service for young people/rangatahi (15–25 years) who experience a first episode of psychosis.

There continues to be debate about the need for a child/tamaiti and youth/rangatahi designated inpatient unit within Wellington given the recognition that using adult beds for this population is not satisfactory. The Wellington office aims to have crisis respite options in each district along with a flexible budget to enable respite services to be tailored to the individual. Regional inpatient services are also required for the region and requires some scoping of bed numbers and options for delivery.

CAMHS liaison is occurring with Child, Youth and Family residences with additional service involvement required for rangatahi Maori. Related to this is the need for support to families and also other specialist services such as SES. Increases in support and training within families has been undertaken with information provided on the clinical and therapeutic management of child/tamaiti and youth/rangatahi problems.

Links with related agencies and intersectoral initiatives will continue in this region to ensure that high needs children/nga tamariki and youth/rangatahi receive the help they require from the appropriate mix of agencies. The Wraparound Service for 13 to 18 year olds, and Family Start (for 0 upwards) are two strength-based models of intervention. Increased mental health involvement in these initiatives would ensure that service developments aimed at children/nga tamariki and youth/rangatahi mental health are well coordinated.

**Table 10:** Priority services and supporting funding actions: Wellington

	Proposed service	Proposed districts	Supporting actions required*
1	Range of acute care options established	All areas	Scoping exercise completed for regional inpatient beds Flexible funding for acute care packages and in-home clinical support Clinical cover expanded to rural/outlying areas including mobile teams. Investigate telepsychiatry
2	Specialist services expanded	All areas	Clinical positions expanded with increased dedicated positions for Maori Kaupapa Maori development towards full range of clinical skills working with severe problems Liaison services with CYFS, SES and Justice with specific attention given to Maori and Pacific Services to increase youth and family participation in planning and monitoring Day activity programmes and peer support services in place Treatment-based day programmes expanded Increase consult/liaison positions to link with primary mental health providers, community and iwi Increased services to provide outreach to rural areas Providers undertaking mentoring roles for new Maori and Pacific staff
3	Range of support services provided by NGO sector including respite options with flexible budgets	All areas	Kaupapa Maori services established NGO providers active in mentoring roles for new Maori and Pacific staff Support work services established for respite Expanded budget for respite tailored to individual and family/whanau need Culturally appropriate respite options available
4	Services for Pacific peoples	Hutt Wellington	Additional A+D positions for work with Pacific youth Clinical positions expanded with increased dedicated positions for Pacific Scoping completed for one stop shop, primary health care services for Pacific youth Providers undertaking mentoring roles for Pacific staff new to mental health Early intervention services for mental health problems and alcohol and drug abuse in Pacific communities In home support services in place for Pacific families
5	Alcohol and drug services enhanced	All areas	Additional clinical positions for child and youth with A+D problems Consult/liaison positions for high risk groups eg, youth involved with CYFS and Justice Dedicated early intervention positions for work with rangatahi

\* All proposed actions to develop the workforce are included in a separate section.

## 5.4 Region covered by the HFA Christchurch and Dunedin offices

While each locality has its own core service provision, the main centres of Christchurch and Dunedin have the most comprehensive range of specialist mental health services. They provide outreach to complement the services available to neighbouring localities as well as outlying rural areas.

Retaining a skilled workforce is an issue in the south with recruitment, retention and training a constant problem in some areas. Workforce shortages, especially of clinicians with specialist skills, present considerable difficulties in parts of the South Island. Healthlink South provides support to a number of other HHSs in this regard. It is therefore expected that the larger CAMHS will continue to assist with specialist cover across the region and help with recruitment and training.

In spite of workforce shortages, the HFA mental health group in Christchurch has made considerable gains in child and youth mental health services with an overall higher per child/youth spend in comparison with other districts in Aotearoa/New Zealand. For example, there have been recent increases in funding for youth/rangatahi alcohol and drug services across the South Island. Day programmes are being established in Christchurch, Dunedin, Kaikoura, Blenheim, West Coast, Southland and South Canterbury with associated hostel facilities in selected areas. Five beds are available in Hanmer for youth with alcohol and/or drug dependencies as well as three beds in Auckland.

Children/nga tamariki with serious mental health problems requiring inpatient care have access to a regional inpatient unit of eight beds in Christchurch. For the older age group (up to 20 years) there are six inpatient beds available in Christchurch and two in Dunedin. An additional two beds for youth/nga rangatahi are to be funded in Christchurch in 2000/01.

Increases in community-based acute care is recommended for all areas in the South Island since it increases the range of service options for the group of children/nga tamariki and youth/rangatahi with high needs and ensures they receive specialist help within minimum disruption. Similarly increased respite services are indicated to ensure families/whanau have the support required to keep their children within their regular home and social environments.

Specialty youth outpatient services for the 13-18 age group are available with outreach and consultation/liaison services provided to the West Coast, South Canterbury and rural Otago. In addition, an early psychosis service is based in Christchurch for young adults (up to 30 years of age) which specifically aims to avoid or minimise hospital admission and secondary disability. The Otago specialty youth outpatient service is currently funded to provide a day programme for a number of young people. It also has an early intervention service (from 18 years) that targets young adults experiencing their first psychotic episodes.

Other areas of need which have been raised include expansions in specialist services for Maori, focused work (school liaison and respite) with the children/nga tamariki of parents with a mental health problem and the early identification of alcohol and drug problems.

Future service development in the South Island will aim at building the core of specialist services with consistency across the region and with improved outreach to rural areas. The continued development of strong linkages is pivotal to this development, especially between specialist mental health services and other services within region for children/nga tamariki and youth/rangatahi. Consultation and liaison services will therefore be enhanced particularly with Child, Youth and Family, disability support services and primary care services including schools, iwi and community-based organisations. Liaison positions have proved successful in increasing linkages between services and need to be expanded in rural areas (West Coast and Invercargill in particular).

Needs assessment services have also been prioritised for future development to ensure that prompt diagnosis and referral are guaranteed for those with severe problems.

Those with more mild to moderate problems are seen within primary mental health services in Christchurch and Dunedin, both of which are based on the wrap-around model of care. Southland has been identified as an area that would benefit from a similar primary service given its lack of designated CAMHS and geographic isolation. It is anticipated that additional primary services will lead to improved detection of serious mental health problems and ultimately reduce adverse events such as youth suicide.

This workplan therefore recognises the need to develop targeted services outside CAMHS in the short term. Interagency work needs to continue with the aim of securing more appropriate funding streams for work outside the specialist area.

Priority actions for children/nga tamariki and youth/rangatahi for the period 2000 to 2003 will be in line with the directions set out in the following table.

**Table 11:** Priority services and supporting funding actions: Christchurch and Dunedin

	Proposed service	Proposed districts	Supporting actions required*
1	Range of community support work options and NGO services established	All areas	Support positions established with advocacy and regional youth coordination role Designated youth consumer advisor positions established Kaupapa Maori support positions established Respite services with range of options including in home support Family and service user participation networks enhanced
2	Specialist clinical positions enhanced	Southland Nelson-Marlborough West Coast Otago	Expand clinical base Positions established for mobile team to assist with clinical care to outlying areas Telepsychiatry links established for rural areas Consult/liason positions increased for high needs children and youth for linkages with SES, CYFS and forensic services Consult/liason positions increased with primary care providers, schools, community and iwi-based organisations Day and activity programmes established
3	Increased range of options for acute care including in home support	All areas	Service cover to rural areas expanded to ensure children and youth can be maintained in the home with intensive clinical and support work Flexible care packages tailored to child and family need
4	Early intervention, prevention and special projects established for groups with high risk	Selected areas of high risk	Projects funded for prevention work in areas: A+D, Deaf community, eating disorders, suicide prevention, children of parents with problems and Maori Funding for special projects which are responsive to local needs and or which are aligned to the community development model outlined in Kia Tu Kia Puawai
5	Primary care services with focus on early intervention	Southland with cover to outlying areas	Primary mental health services developed in the community for those at risk of serious problems, with access provided to outlying areas including training primary care workers Positions for primary mental health support for family/whanau established with advocacy and networking role

\* All proposed actions to develop the workforce are included in a separate section.

## 6 Funding Required and Timeframes

Since the Mason report in 1996, new services have been funded across the four HFA regions with the additional money made available by Government. Baseline money has also been directed to increase child/tamaiti and youth/rangatahi services: for example, additional beds, child/tamaiti and youth/rangatahi specific alcohol and drug funding and Youth Specialty Services.

In spite of additional funds, child and youth services across the country remain well below the benchmarks indicated in the *Blueprint* (MHC 1998). The Government has now stated its commitment to implementing the *Blueprint*. This workplan outlines the first stage of that implementation for the child and youth services.

In order to calculate the resources required to bridge the gaps in service (when measured against the *Blueprint*), the additional services required were spread in a linear fashion over a 10-year period ie, up to the year 2010. Then additional resources required for the first three years were calculated, based on existing service costs, and with adjustments for price path increases.

This work is included in more detail in Appendix C and shows the level to which services could realistically be developed by the year 2002/03. While it is acknowledged that a linear model may not be accurate, this gives an indication of the progress that can be made with regular funding input.

The table below shows the increasing levels of achievement against benchmarks as the service developments outlined in this plan are implemented.

**Table 12:** Percentage of benchmarks met

Resource Type	99/00 (Base Year)	00/01	01/02	02/03
Beds or care packages	38.0%	44.5%	51.0%	57.3%
Community FTEs	48.7%	54.1%	59.5%	64.8%
Day programmes	20.5%	28.9%	37.2%	45.3%

These figures are a guide only and will be refined further (with more detailed DHB breakdowns) for inclusion in the forthcoming HFA locality plans.

The following table indicates the estimated cost of additional resources required over the next three years to achieve the service improvements outlined. Workforce is an integral part of this development. The cost of workforce development is not included in *Blueprint* funding estimates. It has therefore been indicated in addition to the actual components of service delivery. The 2000/01 technical prices from the HFA national purchase framework (where applicable) have been used to determine these figures.

**Table 13:** New resources required 2000/01 to 2002/03

Resource Type	00/01 \$M	01/02 \$M	02/03 \$M	Total \$M
Beds or care packages	2.738	5.489	8.255	<b>16.482</b>
FTEs	5.211	10.449	15.712	<b>31.372</b>
Day programmes	1.139	2.284	3.434	<b>6.857</b>
<b>Subtotal</b>	<b>9.088</b>	<b>18.222</b>	<b>27.401</b>	<b>54.711</b>
Workforce development	0.385	1.195	1.495	<b>3.075</b>
<b>Total</b>	<b>\$9.473</b>	<b>\$19.417</b>	<b>\$28.896</b>	<b>\$57.786</b>

The table above shows that funding would need to increase at a rate of approximately \$10 million each year to be able to implement the service developments outlined in this report. A more detailed breakdown of annual costs is included below.

**Table 14:** Annual cost of future service developments

Financial Year	Population Forecast	Resource Type	Blueprint Benchmark Volumes	Previous Year Resources	New Resources	Total Resources	% of Benchmark	Resource Gap	Value of Gap (\$M)	New Resources (\$M)
1999/00 (base year)	3,873,500	Beds or care packages	201.4			76.5	38.0%	124.9	24.601	
		Community FTEs	1107.8			540.0	48.7%	567.8	45.663	
		Day programmes	155.0			31.7	20.5%	123.3	10.481	
									<b>80.745</b>	
2000/01	3,907,200	Beds or care packages	203.1	76.5	13.9	90.4	44.5%	112.7	22.198	2.738
		Community FTEs	1117.4	540.0	64.8	604.8	54.1%	512.6	41.224	5.211
		Day programmes	156.3	31.7	13.4	45.1	28.9%	111.2	9.452	1.139
									<b>72.874</b>	<b>9.088</b>
2001/02	3,936,422	Beds or care packages	204.6	90.4	13.9	104.3	51.0%	100.3	19.854	2.752
		Community FTEs	1125.9	604.8	64.8	669.6	59.5%	456.3	36.880	5.237
		Day programmes	157.4	45.1	13.4	58.5	37.2%	98.9	8.449	1.145
									<b>65.183</b>	<b>9.134</b>
2002/03	3,965,234	Beds or care packages	206.2	104.3	13.9	118.2	57.3%	88.0	17.507	2.765
		Community FTEs	1134.1	669.6	64.8	734.4	64.8%	399.7	32.466	5.264
		Day programmes	158.6	58.5	13.4	71.9	45.3%	86.7	7.443	1.150
									<b>57.416</b>	<b>9.179</b>

By the end of the 2002/03 financial year, achievement towards child and youth service benchmarks will have increased at the following rates:

Beds or care packages:	increase from	76.5	to	118.2	(54%)
Community FTEs:	increase from	540.0	to	734.4	(36%)
Day programmes:	increase from	31.7	to	71.9	(127%)

Most of the actions identified will be provided by specialist services working with the 3 percent of the population who are most unwell. However, other actions are included which more appropriately fit into the primary mental health and public health areas. Funding is included for a limited number of these activities. It is clear that ongoing intersectoral and interagency discussions are required to determine the best funding streams for the range of services required to improve the mental health status of children/nga tamariki and youth/rangatahi in this country.

The figures presented in this document reflect the need for services against benchmarks and also the current spend per child/youth within each DHB area. It must be remembered that these figures do not reflect the number of children/nga tamariki and young people/rangatahi who are actually accessing specialist mental health services.

Service planning would obviously be substantially improved with good quality data about the use of specialist services and the outcomes arising from assessment and therapeutic interventions. Service usage figures are not available but will be in future through the Mental Health Information National Collection which is currently being implemented.

Data on quality and service outcomes is similarly problematic, requiring good systems of evaluation at the provider level, quality improvement systems, regular service monitoring involving consumer and Maori participation, and outcome research conducted on a national basis. These streams of work will need to progress alongside the service improvements listed.

This workplan does not address all areas of unmet need. It does however show the first important steps to address the deficits, knowing that these steps are good foundations for future progress. The plan will be particularly useful for the DHBs as a guide to priorities for new and improved mental health services for children/nga tamariki and youth/rangatahi.

## 7 Glossary

ADHD	Attention Deficit Hyperactivity Disorder
A+D	Alcohol and Drugs
<i>Blueprint</i>	MHC 1998 (see references)
CAF	Child and Family Services
CAMHS	Child and Adolescent Mental Health Services
Child, Youth and Family	Department of Child, Youth and Family Services
Conduct Disorder	Pattern of behaviour which violates the rights of others and society's rules
Consult Liaison	Positions within mental health services that coordinate care and provide advice and support for other sectors
CSW	Community Support Workers
CTA	Clinical Training Agency
DHB	District Health Board
FTEs	Full-Time Equivalent staffing
HFA	Health Funding Authority
HHS	Hospital and Health Service
Kia Tu Kia Puawai	The whakataurangi and vision statement for the mental health group of the HFA. Meaning: 'stand tall with confidence'. Also the name of the HFA pilot project for Maori mental health promotion and problem prevention
MH	Mental Health
NGO	Non-government Organisation
ODD	Oppositional Defiant Disorder
PECT	Post-Entry Clinical Training, the CTA-funded education programmes which have a significant clinical component, last at least six months, lead to a recognised qualification, and are available to people who hold a health professional registration
Preceptorships	A formal programme of supervision for employees new to a particular service area, for example for the first six months on the job
SES	Specialist Education Services
Te Rau Puawai	An undergraduate and graduate education programme at Massey University, which supports Maori studying in a programme related to mental health
<i>WDCC Report</i>	See National Mental Health Workforce Development Coordinating Committee 1999

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## **Appendix A: Summary of themes from meeting with young service users**

### **1 Identifying the factors that cause problems or make them worse**

- Young people/rangatahi accept the biological determinants which contribute to mental illness. Recognise that you can be born with a predisposition to a mental illness.
- Problems are seen as transitory, being caused in the main by trauma or stress. Those who thought that their illness would be ongoing, described it as something which could be managed and integrated into their lives.
- They also express real concern for the immediate environment which is perceived to dictate the level of severity of the illness. For example, family pressure, race relations and social influences like television present images which young people cannot live up to.
- The things they saw as having the most negative impact on mental health were poor parenting “being dragged up”, an overemphasis on academic and sporting achievement, having “the right image”, violence, being rejected for being gay, being exposed to taunting and hassling from peers and boys putting pressure on girls.
- There was a strong desire to see the wider social environment change to be more accepting of difference.
- Variety of opinions regarding whether young people should be treated more like adults ie, having definite roles and responsibilities from a young age, versus letting kids simply be kids without lots of structure.
- Large number of comments which demonstrate that young people have ideas and opinions about broad sociopolitical issues. For example discussions were recorded about race relations, the high rate of teenage pregnancy, the structure of the school system and the place of young people in society.

### **2 Actions which help to identify problems in the early stage**

- More counsellors are needed in high school so that problems are picked up before they escalate.
- A preferred option for improving access to services was the one-stop shop model where young people can self refer to a range of youth-oriented health services.
- There is a recognition that more research might lead to eradicating mental illness or at least working out what treatments work well for young people. There is a perception that science and medical conditions get lots of research attention but mental health doesn't ‘you could be 100 percent healthy but not happy’.

### **3 Improving and expanding specialist services for youth**

- All services need to demonstrate an explicit youth/rangatahi focus, be youth/rangatahi friendly and undertake youth advocacy work.
- Young people/rangatahi need time to build trust with therapists. They say the best relationships are those where the adults listen to youth/rangatahi concerns, take time to engage, use humour and activities and show a real understanding of the perspective of young people/rangatahi.

- The qualifications of staff are not seen as important yet frequent mention was made of the need for professionalism, particularly being trusted not to betray confidences.
- There is clear interest in improving youth/rangatahi participation in specialist services, for example in staff recruitment, youth/rangatahi advisory groups, youth/rangatahi inspection teams for quality monitoring, youth/rangatahi led training programmes, special projects, and designated youth/rangatahi space within the treatment setting.
- Young people/rangatahi want to bring their day to day concerns into counselling within specialist services and to have opportunities to share with other young people/rangatahi in therapeutic settings which also incorporate fun and activities.
- Important that young people get to talk to a counsellor/therapist from their own culture.
- There was acknowledgement that there is a high turn over of specialist staff. This makes relationship building and trust hard. Young people said that staff needed better pay and also get more positive compliments for the work they do. These things would achieve a more stable staff with good continuity of care.
- More accommodation is needed for youth but it must be close to buses and be close enough to hospital for outpatient and group work.

#### **4 Reducing the stigma of mental illness**

- Disclosure of a mental health problem often gets a bad reaction from parents and friends. In spite of the stigma, young people/rangatahi with serious illness take active roles in helping families and friends deal with their illness. They provide information and guidance, an approach which increases self-confidence and a sense of control. One young woman said she was the first in her family to get specialist mental health help for a debilitating illness that had affected several family members.
- The stigma associated with mental illness makes getting help hard. Language can be most problematic with the terms “mental health” and “consumer” having numerous derogatory associations. Youth/rangatahi using specialist mental health services thought that the services would be most easy to access if they were simply called child and youth health services.
- Other young people said that mental health was an okay term and that we should retain this but do more work to have it better understood and accepted. These young people said that by being too liberal or politically correct about language you ended up obscuring what they were about ... better to be upfront.
- Maori are particularly shy about getting help from specialist services. Parents will approach services if the young ones take them along and explain what is happening and why.

## Appendix B: Themes from family and whanau – service developments that assist the caregivers

### 1 Actions which help to identify, and act on, problems in the early stage

- Variety of people need to be involved to identify problems eg, occupational therapist at the child and family centre first picked up the serious mental health problem. These people need training. GP training to pick up problems needs attention. Homeopaths are really good for young ones because they spend the time talking things over. Their approach is holistic.
- Agencies, WINZ and others need training in how to identify problems. Skill NZ have programmes for youth at risk.
- We need a programme for youth falling through gaps – they absolutely rely on community organisations – they need a drop-in-centre.
- Local directory of counsellors is good – saw this advertised in paper. I bought the book and finally got the disorder identified. Some use of private counsellors is necessary.
- School can help deal with problems but need Maori counsellors to talk to parents. Maori are shy to come into the white person's system. My daughter took the lead and I followed.
- Important that people can self refer to specialist services.
- Everyone talks at school about the child and adolescent service because the mental health service is under general child and youth services. This keeps a high profile of services in the community. You know you can ring up anytime for professional help – and therefore early help when problems arise.
- Need more peer support systems to get to problems early.
- Need counsellors in primary school to pick up on suicide risk eg, why is homework not done, what are the underlying causes? Maybe have CAMHS train workers in schools. Child advocates at school.
- Need help at primary school for ADHD and better understanding of what causes poor concentration and bad behaviour. Early help would have prevented further problems.

### 2 Addressing the factors that cause problems or make them worse

- Mental health problems must be caused by biological factors but other things also create problems.
- Peer pressure hard on young people and creates low self esteem. Low self esteem leads to depression then to talk of suicide. Problems don't just go away once you've had help eg, your children may be more at risk of suicide as they get older.
- Children experience high expectations. Sport is over-stressed at school. Parents reward achievements with presents for their kids. So no focus on mental wellbeing. We don't know about it or learn about it at school.
- Intellectual ability has become everything – it's over-stressed at school with the higher ability class getting all the privileges. The other kids say they're stupid.
- Politics have big repercussions on young Maori. The elders and parents get caught up in managing iwi affairs and they need to include the young ones. Rangatahi need to know their background, and to know what the current iwi discussions are about.

- Television programmes at night contribute to problems eg, seeing the perfect woman. They learn that it's not okay to be who you are. They don't get any acknowledgement for being just fine the way they are.
- Adoption, loss, grief, rejection can lead to crisis in teenage years.

### **3 Improving support services for families**

- Parent support needed. It can be very lonely. You get so low on resources. Meeting other Mums with same problems is great. Mums are the bottom line. Your child is dependent on your mental health. Mums are home more and take more of the emotional load. This puts pressure on family and marriage because you're so tuned into the situation. You keep everyone happy and there are other kids to care for. It really helps hearing that your worst moments are seen as normal in the context of a support group.
- Parent involvement in specialist services is great for us. Questionnaires are no good. You need to talk to other parents at different stages of recovery ... gives you some hope or some idea of what to expect.
- A day programme to send children to would help. Mums take unpaid leave from work when necessary but need extra community-based support and holiday programmes.
- Need more services just to help parents. There's no other way for us to get information and support. You need things like training, information, advocacy, links with agencies.
- Respite essential, especially the same nurse to come into the home. We need continuity so that our children build up trust and eventually let the family become part of the therapy.
- Need proper residential respite outside the home for young people. They need somewhere to go when they are getting unwell.

### **4 Improving specialist services**

- Crisis teams needed to respond to parent calls. Parents know when things are falling apart and need prompt help. Prevention is better than waiting for a crisis. The compulsory treatment order only works when there's a real crisis so no point waiting until then.
- Families need therapy too, especially after the discharge when we have to cope. We need training on dealing with our daughter's problem but also help for the whole family.
- Acute units need to be homely and comforting for young people. They can be a frightening place for an adolescent girl. Staff are great, warm and empathetic but the unit is bleak. Kids should be kept out of adult units. In adult wards everyone gets mixed up ... so the very violent are in with lesser disorders.
- Staff in acute wards need help ie finances, and more staff. They are good but they don't cope. I visited acute ward over two-year period and saw staff continually overloaded.
- There needs to be counselling and rehabilitation while young people are in the acute unit and all through specialist services. Should help save money on readmissions. No good just having medication without help for the underlying causes.
- More effort is need to address drug use. There needs to be more involvement of the CADS team. Dual Diagnosis is very problematic.
- The young person gets counselling but the family also needs feedback and the opportunity to input into sessions.

- Staff need time for training eg, cognitive behaviour therapy (CBT) seems to work well and every team member should at least know about therapies and where to go for these. Training for parents in these therapies would really help also.
- More money for integrated care ie, the Falloon model. People go into home and work with youth like a CSW but more skilled. They actually do therapy in the home with everyone.
- Families mostly need integrated care. That's the services working together or even being located in one place. Need one centre with all services together to stop the fragmentation.
- Need one person managing the treatment options and discharge. Children and young people with serious disorders are in contact with several agencies including school and need one person to coordinate their care and provide support for the family as care giver, many of whom have numerous and severe problems themselves. Integration is key.
- Discharge planning essential. We had a buddy with us in hospital at the family meeting. This advocacy was essential eg, we were able to ask for help like family therapy ... because it seemed a basic requirement under the circumstances.

## 5 Reducing the stigma of mental illness

- There is a huge fear of mental illness. We don't tell our parents that our child is unwell due to stigma – “something mental”. Worried about “stigma” of mental illness. Thought my daughter would get a heavy label so I nearly didn't come to get help.
- I felt embarrassed – didn't want people to know. People look at you and think “what sort of family have you got?”. My fault – failed as mothers. Need to share how you feel as failure, the high hopes you have for your children. Loss and grief important issues to deal with.
- School blamed me and said our daughter was bad. The daughter's self esteem was very low by then. Daughter doesn't have mental health problems – she's considered wayward.
- Picking up Ritalin makes you identifiable as 'mental', so school needs to deal with this in a sensitive manner and discreet ie pick it up before lunch break.
- Children get teased mercilessly about becoming mentally unwell and or bad.
- Early intervention would help young people because their friends simply fall away ... don't visit any more.

## Appendix C: Planning on a linear basis to meet benchmark levels by 2010

