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## Let's get real: Workshops to develop core competencies

People from the mental health, addiction and education sectors will have the chance to contribute to the development of competencies required to work in the sector, in a series of workshops planned for November and December.

The Ministry of Health-led project aims to develop a competencies framework for people working in services that treat, care and support people with mental illness and addiction issues.

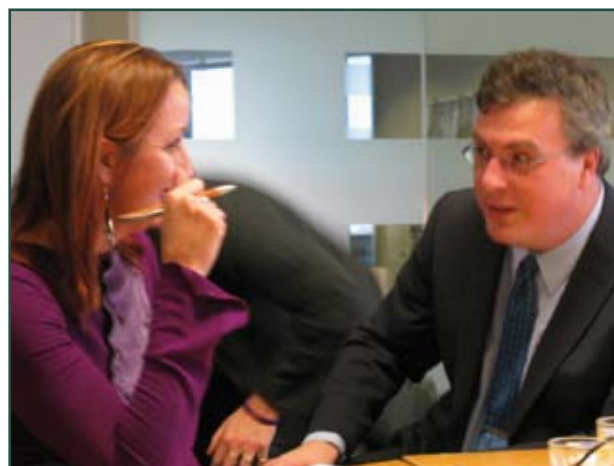
Competency means the skills, knowledge and attitudes needed for excellent performance.

The project's advisory group, which comprises people from the mental health, addiction and education sectors, along with a service users group, have developed a first draft set of core competencies in preparation for the workshops.

Open invitations have gone out to the sector under the new name developed with the input of the advisory group: 'Let's get real: Real skills for people working in mental health and addictions'.

'Let's get real' aims to create a shared language for people working in mental health and addiction.

The main purposes of the framework are to influence education and training; improve recruitment, retention, professional development and performance management processes; and support occupations not regulated by the Health Practitioners Competence Assurance Act 2003. Ultimately it's about improving services for service users. The workshops were advertised in late October, so check the details on our website, through your regional workforce development co-ordinator or through your local networks. Robyn Shearer, Workforce Development Manager says that 'if you can't attend the workshops, you will still have an alternative opportunity to contribute, by giving us feedback directly'.



*Above: Robyn Shearer and Oliver Poppelwell and below: Siwsan Naughton and Alana Ruakere-Mack at the first Core Competency Advisory Group meeting.*



'We see the workshops as an opportunity to test how the draft 'Let's get real' skills, knowledge and attitudes apply to delivery of services – so we are hoping for a wide range of people who would access or deliver services, or who are involved in education, to attend the workshops.' Once the workshops are completed and final feedback received, 'Let's get real' will be piloted.

For more details, visit  
<http://www.moh.govt.nz/mentalhealth>



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# EDITORIAL

## Dr Janice Wilson



### Continuing the drive for information-led service development

The recent launch of Te Rau Hinengaro, the New Zealand Mental Health Survey, highlights the enormous value of having a strong information base from which to develop policy and services. This will probably be seen as the most important data source on common mental disorders in our population for many years to come. Ongoing research and inquiry based on this information will continue for some time to help answer all kinds of questions, as will further information gathering on specific areas not able to be included in this survey.

Equally important is gathering standardised information about what actually happens to service users within our systems. Do we make a difference and do we provide value? Are we doing the right thing? On what has money been spent? What is working and what is not working? What have we achieved? And how does all this compare across the country?

A lot is happening so we can better answer these questions at an individual level, at team and service level, at District Health Board level and across and between DHBs.

- PRIMHED (Project for the Integration of Mental Health Data). We now have a new national project manager to help lead the development of revising and integrating mental health information. This brings together a revision of MHINC with the MH-SMART initiative, and provides a start to aligning outcome measurement with input and output data by 2008.
- Within PRIMHED is the MHIRS development to achieve an information reporting system for NGOs.
- Standard Outcome Measures. We are still rolling out MH-SMART. This is not going to go away and, despite some people's reservations, Health of the Nation Outcome Scales (NoNOS) is still the best general clinical standard measure internationally. Other additional standard measures can and will be used in time, and when we are ready.
- Continued focus on the application of evidence base or best information into practice and trying to find simple and useful ways to achieve this.

All of this is going to take time and focus. Although some of this work is about system development, most of it is about culture and attitude change. Wherever we are in the mental health sector or system, we all need to be asking ourselves every day:

- Are we making a difference and do we provide value?
- Are we doing the right thing?
- What is working and what is not working?
- What have we achieved?
- On what has the money been spent?
- How do we compare across New Zealand and with other countries?

Only by asking and actively using the information we receive, do we create an environment of continuous improvement.



# Disability allowance changes

**People with psychiatric, physical, sensory or intellectual disabilities living in community residential services and receiving a Residential Support Subsidy can now apply to Work and Income New Zealand for a Disability Allowance.**

This is a significant change because, since 1995, people living in a community residential service were generally not seen as eligible for a Disability Allowance by Work and Income, based on the interpretation of the Social Security Act 1964. After two successful appeals by clients with physical disabilities to the Social Security Appeal Authority in 2005, the Government reconsidered this interpretation and announced in the 2006 Budget that it would invest an additional \$60 million over five years in Disability Allowance payments.

As a result, people receiving a Residential Support Subsidy can apply for a Disability Allowance on the same basis as other people living in the community. Access to a Disability Allowance will help with residents' ongoing disability-related costs, such as medical and dental fees, and pharmaceutical and certain other costs that may not be covered in their service providers' contracts with the Ministry of Health or a District Health Board.

Work and Income New Zealand's Residential Subsidy Unit has recently sent letters to residential clients, key stakeholders and all residential support providers, to advise them of this change, which is expected to benefit a significant number of people with mental illness.

## 'Renovation' of adult mental health service specifications

**Consultation on a 'renovation' of adult mental health service specifications has been completed, with a final version expected later this year.**

The renovation updates the structure and content of the existing adult mental health service specifications so that they mirror the tiered structure of other specifications on the Nationwide Service Framework.

'This is quite different from a review or rewrite. Rather, the aim has been to recast existing service specifications so that they are consistent with the National Service Framework structure,' Joan Mirkin of the Ministry of Health says.

A wide range of DHB funders and planners were involved in the consultation process and it is intended that the renovation will form a base for development of other service specifications such as Child and Youth, Forensic, Older People, and Addictions.

In addition to finalising the renovation, the Ministry is preparing to talk with DHBs about a work plan for reviews of the Service Cover Schedule and the NSF, as envisaged in *Te Kōkiri – The Mental Health and Addiction Action Plan 2006–2015*.

# Hawke's Bay DHB gets results with KPP

**It's only by knowing who the people are – and their real needs – that you can make a positive difference.**

That's according to Kim Henneker, clinical leader community services within Hawke's Bay DHB's Mental Health and Addiction Services, whose team adopted the 'Knowing the People Planning' (KPP) approach to mental health care in 2004.



Kim Henneker

'Although we've only been using KPP since early 2005 we're already seeing some positive results. KPP's practical, common sense approach is really working for us,' says Kim.

The approach is based on key values and features, such as identifying real needs like housing, work, social support, access to primary health care, and the person being identified on re-entry to the services to ensure ease of access.

KPP is the brainchild of David King of the University of Auckland and Barry Welsh of the Ministry of Health. Although it is supported by the Ministry of Health, participation by DHBs is entirely voluntary. Currently, 10 DHBs have joined the project, and others are expressing interest.

KPP began in 1999 in the South Island, when panels, including service users, families and staff, agreed on a series of features that would make mental health services work well for them.

'KPP is designed for the population of consumers whose needs are long term. Its principles include identifying your population, knowing who the people are and what the real needs are, finding out how well those needs are met now, creating solutions for gaps identified and measuring the outcomes,' says Kim.

'For Hawke's Bay DHB, this has meant a move away from never quite coming up with a clear

solution, having lots of talk and no action, and not having a clear grasp of trends and numbers. With KPP we are now getting some clear, tangible outcomes related to the real local needs.

'KPP is simple and easy to use, and its process makes sense – knowing who your people are and what their needs are, then steadily working to make a difference. If it's just improving housing for one small group, then that's an achievement,' she says.

The key features that underpin the KPP-Hawke's Bay DHB's approach to care:

- contact 'come what may'
- recovery plan in place
- access to services
- recognition on re-entry
- primary health care relationship
- real outcomes that make a difference
- work
- housing
- social inclusion
- relationships
- support.

Some improvements since the DHB adopted KPP:

- increased social supports and wider range of work/activity options
- an increase in the number of recovery plans completed and up to date
- less use of first generation (typical) depot medication – 68 percent of people have only one CATT contact or admission to the Mental Health InPatient Unit
- an increase in independent accommodation – from 64 percent in May 2004 to 74 percent in October 2005
- better relationships with friendly landlords, resulting in improved accommodation packages.

# Mental health team role in criminal justice work

**The Ministry's Mental Health Directorate will play a key role in cross-sector plans to address emerging challenges facing the criminal justice sector.**

In August 2006, the Government announced plans to take an intersectoral approach to reduce reoffending and crime rates, and stem rapidly growing prison numbers. The suite of initiatives, called 'Effective Interventions in the Criminal Justice System', will involve the justice, social development and employment, corrections, housing, police, education and health sectors.

'The Prime Minister has expressed a strong expectation that agencies will investigate ways to address the growing concern around the escalating prison muster, the impact of alcohol and drug abuse on crime and imprisonment rates, and the status of prisoner health,' says John Hobbs, who has been seconded into the Directorate from the Sector Policy Directorate to lead the project.

John says that the Ministry of Health will be involved in a number of ways, including reporting on the availability of alcohol and drug treatment programmes for offenders in the community,

reviewing the interface between the mental health/addiction treatment and the criminal justice systems, and contributing to a report on expanding judicial supervision of alcohol and drug treatment for offenders. The Ministry of Justice and Department of Corrections will also be heavily involved in this work.

The work has just begun, and will involve collection of relevant data to describe existing arrangements, a literature review of domestic and international evidence of best practice, discussions with people with relevant expertise, a discussion document outlining the issues confronting the sector and options for improvement. All of this work is to be completed by August 2007. We hope to release a discussion document by mid-May 2007.

'We'll also be looking to work closely with DHBs, as they will play a significant role in providing information and developing options for improving the interaction between mental health and addiction services and the criminal justice systems,' John says.

The mental health sector's involvement will be led by the Ministry's Mental Health Directorate.

## Happiness: Accept, Belong, Connect

'Happiness: Accept, Belong, Connect' was the theme for this year's Mental Health Awareness Week, from 9 to 15 October.

This year we saw community groups, providers and other agencies from across the country organising a variety of events and activities to mark the week.

Take a look at the Mental Health Foundation's website [www.mentalhealth.org.nz](http://www.mentalhealth.org.nz) for more details on the event, as well as a toolkit and other resources.



Laughter yoga workshops conducted by Mohinder Anand – Founder Auckland Laughter Club – were organised by Otago Mental Health Support Trust in Otago and Dunedin.

# New GM looks forward to making a difference

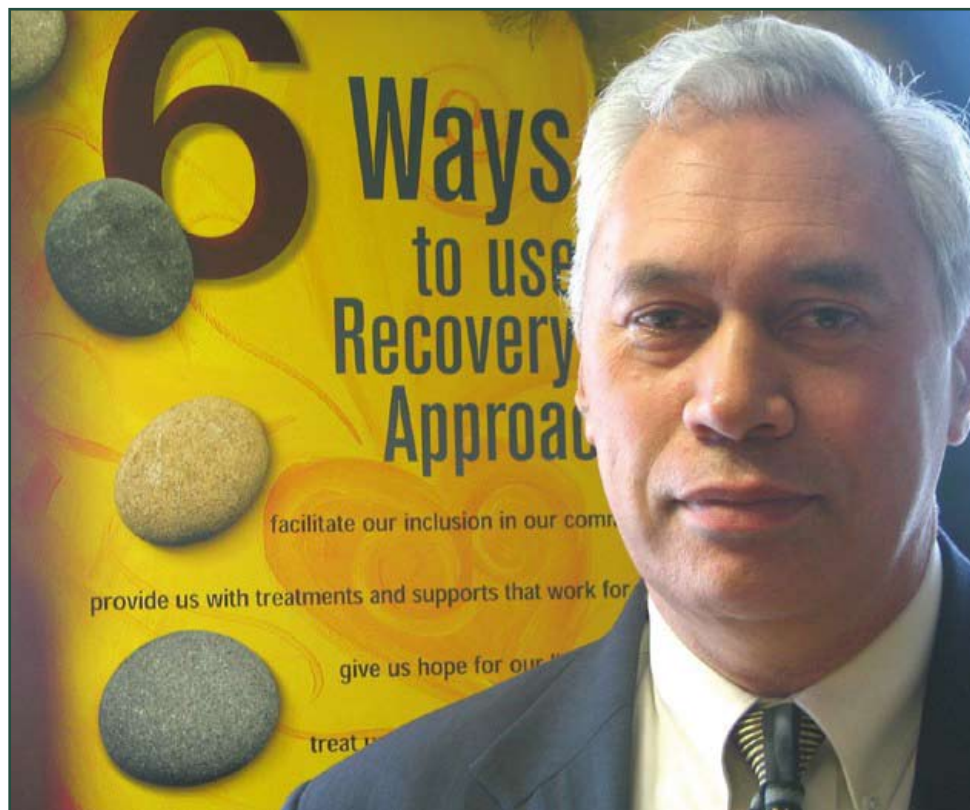
The Mental Health Commission's Selwyn Katene is looking forward to 'making a difference' in his new role as General Manager.

Selwyn was appointed to the role in early October, and with nearly 30 years' experience in the health sector (including senior management roles with the Ministry of Health and several pharmaceutical firms, as well as Ministerial advisory roles) he's no stranger to health.

'Having said that, I'm relatively new to mental health, but in terms of the public health sector, many of the issues around quality of work, collaboration and relationship building are very similar.'

Selwyn's most recent position in the public service was as adviser to Associate Health Minister Hon Damien O'Connor, and also to Hon Annette King, in her capacity as Minister of State Services and Minister of Health. From 1992 to 1995 he was a manager at the Public Health Commission, and prior to that Selwyn worked in the pharmaceutical industry.

'I think one of the key things is looking at ways of working with the health sector to provide high-quality work that leads to improved mental health and a better understanding of mental illness – the recent de-stigmatisation campaign



New Mental Health Commission General Manager Selwyn Katene.

has been extremely effective in helping break down some of those barriers,' he says.

'One of my key roles will be to try and make a difference. The Mental Health Commission is one player in a wide network of organisations, and I'd like to have a strong focus on ensuring the Commission continues to support and work closely and collaboratively with all the other agencies, particularly the Ministry.'

Selwyn has a PhD in Māori Studies from Massey University, and MA and MPM degrees from Victoria University. He also studied health leadership at Cambridge University.

Selwyn and his wife of 31 years, Rahui, have five children and three grandchildren.

# Huge success for primary mental health sector workshops

Primary and specialist mental health providers had the chance to 'meet and greet' at a series of workshops held around the country in September.

'Hundreds of representatives from across the sector took part in these highly successful workshops. I'd say this was the first time that we had specialist mental health, NGO and primary health care providers together in this kind of environment,' says Kristan Johnston of the Ministry of Health.



Kristan Johnston

The Ministry of Health and DHB-led workshops, held in Auckland, Rotorua, Wellington and Christchurch, presented an overview of primary mental health development at a strategic and regional level, and gave participants the chance to share ideas and learning around primary mental health development at a regional level.

'The workshops have been sparked by focus on primary health care of the new mental health and addiction action plan 'Te Kōkiri'. The purpose was to try and broaden regional networking across the health and social service sector levels by introducing different people and really getting some talking happening,' Kristan says.

The key themes were around building the capacity of primary health care, building linkages and working together, strengthening the roles of PHOs and promoting mental health and wellbeing.

'I came away with the impression that the workshops were hugely successful, with participants talking about how fantastic the focus on primary health care was. Certainly, everyone

seemed to be pleased to see the emphasis on a joined-up approach to addressing mental health issues within primary health care.

'There was a real sense of the fact that primary care's time has come, and that so much can be done at this level to address less severe cases of mental illness,' Kristan adds.

Participants included PHO managers, primary health care practitioners, mental health and addiction NGOs, consumer-led advocacy and support services, health and social service NGOs, DHB specialist mental health and addiction services, DHB funders and planners, mental health workforce agencies and shared service agencies.

The regional primary mental health DHB contacts are:

Northern Region – Bram Kukler  
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# Te Rau Hinengaro – New Zealand Mental Health Survey

A survey looking at the mental health of New Zealanders provides valuable information for those planning and delivering mental health services.

Te Rau Hinengaro – The New Zealand Mental Health Survey involved interviews with close to 13,000 people in 2004, including nearly 2,600 Māori and more than 2,000 Pacific peoples.

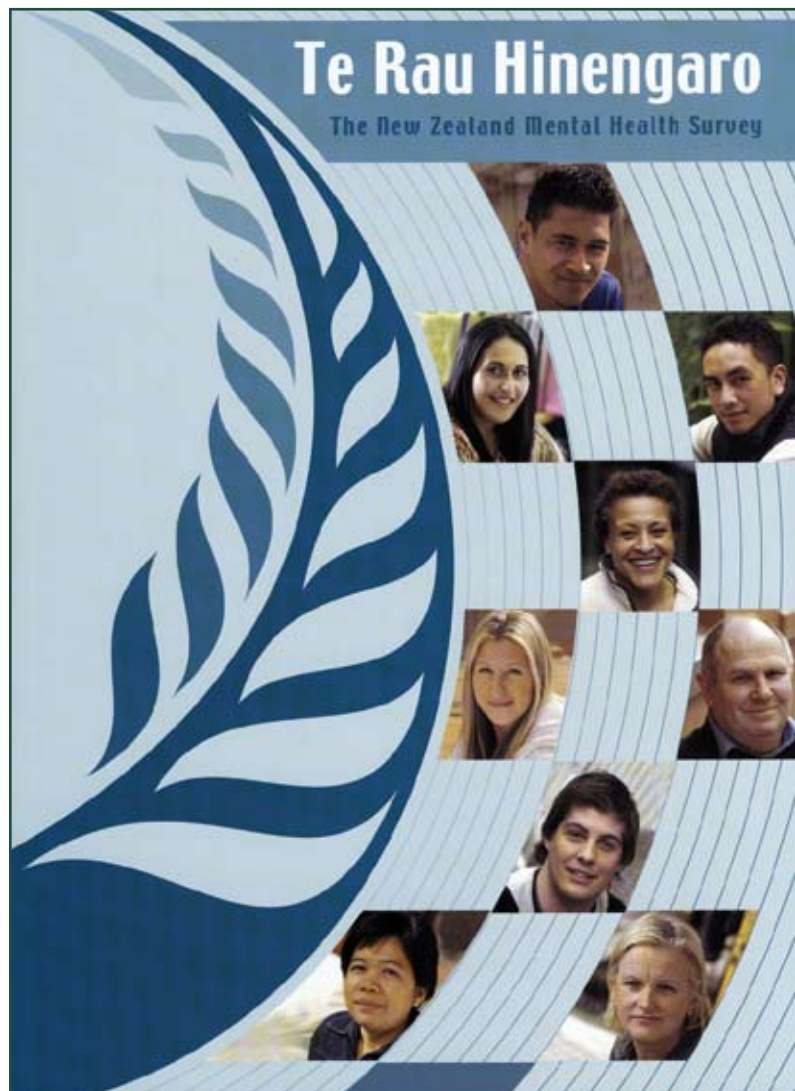
It is the first survey in New Zealand to provide estimates of the prevalence of mental disorders among the adult population of different ethnic groups, and provides important and not previously available information about the prevalence of mental disorders and their patterns of onset and impact for adults in New Zealand.

Te Rau Hinengaro covers depression, anxiety disorders, alcohol and drug abuse and dependence, bipolar disorder (manic depression) and eating disorders. It does not cover psychotic disorders such as schizophrenia and delusional disorders. This is because the methodology used in this survey was not suitable for such low prevalence (uncommon) disorders.

Te Rau Hinengaro confirms the Like Minds, Like Mine message that one in five (20.7 percent) of those people surveyed have experienced a mental disorder in the past 12 months. The survey also estimates that the lifetime risk (up to 75 years of age) of experiencing any common mental disorder, such as depression, anxiety or an alcohol or drug disorder, is 46.4 percent, namely nearly half of the population.

Some key findings from the survey:

- New Zealand has high prevalences of anxiety, mood and substance abuse disorders, which are exceeded only by the United States for



anxiety (14.7 percent compared with 18.2 percent), by the United States (9.6 percent), Ukraine (9.1 percent) and France (8.5 percent) compared with New Zealand's 7.7 percent for mood, and only by the Ukraine and United States for substance abuse disorders out of 15 countries who have conducted similar surveys as at 2004.

- Anxiety disorders were the most common group of disorders in the past 12 months (15 percent), followed by mood disorders (8 percent), then substance abuse (3.5 percent). Eating disorders were rare (0.5 percent).

- All disorders were most common in 16 to 24-year-olds and declined with age. This is particularly true for substance disorders. Anxiety and depression were more common in women, and substance abuse more common in men (double the rate of women).
- New Zealand lifetime prevalence rates for anxiety, mood and substance abuse disorders are higher than for European countries and similar to the United States – where similar surveys have been carried out.
- Some experience of mental disorder is common (20 percent in the past year) and it is also common to have experience of more than one (37 percent). The most common combination of disorders is anxiety and mood disorders. Having more than one mental disorder is linked with suicidal behaviour (such as suicide attempts) and increased mental health service use.

- People with mental disorder are more likely to be physically unwell and the reverse is also true.
- There is significant unmet need for people with mental disorders. Of all the 12-month cases of mental disorder only 39 percent had visited health services in the past 12 months.
- Most people with a mental disorder saw the problem as fixing itself – the most commonly endorsed reason for delaying seeking, stopping treatment or not seeking help were attitudinal: ‘I thought the problem would get better by itself’.

You can find more detailed information about the survey and its findings at [www.moh.govt.nz/mentalhealth](http://www.moh.govt.nz/mentalhealth)



Members of the research team present at the launch. From back left: Magnus McGee, Jesse Kokaua, Dr Christopher Gale, Dr Rees Tapsell, Prof Mark Oakley Browne. From front left: Prof Elisabeth Wells, Dr Joanne Baxter, Dr Kate Scott.

# Te Kōkiri – ‘a quiet revolution’

Anne Helm believes Te Kōkiri reflects a ‘quiet revolution’ in the mental health sector.

*Te Kōkiri – The Mental Health and Addiction Action Plan 2006–2015*, was launched by at the Michael Fowler Centre in Wellington in early August.

Te Kōkiri’s purpose is to directly implement *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan*. In particular, it aims to address the 10 leading challenges outlined in Te Tāhuhu.

Anne Helm, a member of the plan’s advisory group, spoke at the launch, describing the plan as ‘a quiet revolution’.

‘The themes of leadership and recovery, and the language used throughout the document, are significant.



Anne Helm

‘Te Kōkiri provides a mandate for leadership, indicating that people will lead their own recovery with full citizen rights and responsibilities.

‘The language of collaborative partnership and the rhetoric of recovery are in this document. To move beyond rhetoric, we need to build a culture of wellness itself within the services of our sector, and we need to recover and move on from the historic practice of containment, control and patronising concern.’

Anne believes the sector is entering an era where it works with, not for, mental health service users, tangata whaiora – and she says the mandate for peer recovery workers reflected in the plan will greatly support this.

However, she adds that no amount of planning will work without good attitudes and effective relationships.

‘At the end of the day, success depends on how well we respond to distress, whether it’s in a

## Work progresses on KPIs

The development of a Key Performance Indicator Framework for New Zealand aims to provide a quality improvement tool for mental health services.

The project, funded by the Ministry of Health, is designed to provide opportunities for DHBs and NGOs to benchmark their services and enhance collaboration across the sector.

Although the framework is based on the nine ‘domains’ that already form the basis of the Australian framework (which include effectiveness, appropriateness, efficiency,

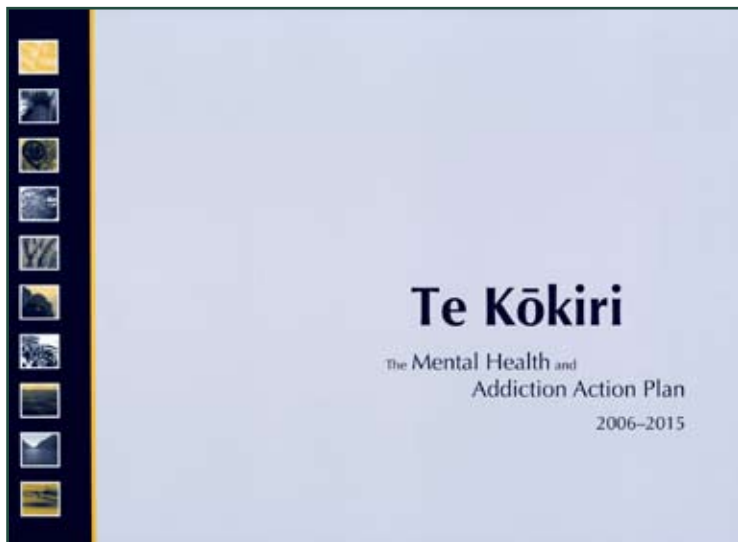
accessibility, continuity, responsiveness, capability, safety and sustainability), a key difference is that the work in New Zealand is being led by providers.

‘We intend that the framework reflects the salient issues for the New Zealand mental health sector and is aligned to Te Tāhuhu and related mental health service initiatives,’ Project Officer Emma Maddren says.

‘Essentially, the project is all about enhancing the use of information to better inform quality improvement efforts and to provide opportunities to share those efforts.’

psychiatric emergency, acute inpatient setting, or in the community; in education, places of work, sport, leisure, the arts and in worship; and to the friends and families who care for people in times of this distress.

‘Results are born of quality relationships and no plan can prescribe actions for that,’ Anne says.



*Te Tāhuhu – Improving Mental Health* described the outcomes government wants to achieve in mental health and addiction services. It has set 10 leading challenges that must be met in order to achieve these desired outcomes. These are:

- promotion and prevention
- building mental health services
- responsiveness
- workforce and recovery culture
- Māori mental health
- primary health care
- addiction
- funding mechanisms for recovery
- transparency and trust
- working together.

The project’s design group comprises DHB, NGO, family, consumer, Māori and Pacific expert representatives. Next steps include finalising and agreeing the sub-domains and indicators for New Zealand. The proposed framework and recommendations for implementation are expected to be submitted late February 2007.

For more information contact Emma Maddren on [emma.maddren@xtra.co.nz](mailto:emma.maddren@xtra.co.nz)

## Ministry of Health publications

Unless otherwise specified, you can obtain copies of all Ministry of Health publications from:

Ministry of Health, C/o Wickliffe Limited,  
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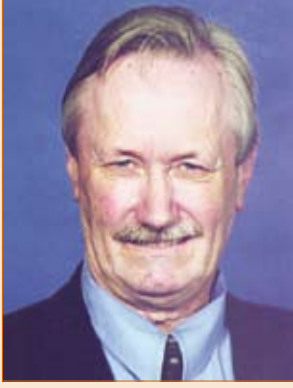
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# Chaplow's Column

David Chaplow

Director of Mental Health

## Contact, Connection, Personality and the 'Talking Therapies'

Consistent feedback tells us that those persons who access mental health services need the opportunity to tell their story. Usually that doesn't happen unless there is a 'safe' environment, time to do so, and a firm rapport with a service provider who evinces warm and understanding empathy and whose stated intentions and body language-alignment are consistent with someone who is listening.

'Talking' with a person not only offers the opportunity to make contact; it allows the chance for the service provider to meet the 'person' rather than just their illness and symptoms. Understanding the development of personhood as expressed through personality is fundamental to understanding mental health with all of its variation.

One of the relatively neglected aspects of mental health service provision over the past decade-and-a-half has been the lack of understanding and lack of emphasis of the importance of the developing person, and the use of 'personality disorder' as both a diagnosis of exclusion and as a pejorative epithet to be applied to anyone who causes service-providers or services, discomfort.

'Talking' is important in respect of support, education and 'reconstruction' of the recovering service user. All are reflected in a variety of 'talking therapies', each applied in appropriate circumstances after assessment and formulation (or understanding and summation of the presenting person's problems).

In 1967, Truax and Carkhuff wrote that the important issues in the range of psychotherapies were in fact 'genuineness, non-possessive warmth and accurate empathy', attributes of the therapist, rather than any attributes or methodologies of the particular psychotherapy. Today, there is a firm

evidence base for the effectiveness and efficacy of the cognitively based therapies and evidence for the psychoanalytically orientated therapies when a person is so overwhelmed by distress that they can't progress in any other manner.

It is important to understand where the Government and Ministry stand in terms of their commitment to recognising the importance of personality disorder (as adjunctive to mental health problems) and the 'talking therapies', and in having a workforce trained and capable of doing something about them. Te Tāhuhu (The Second Mental Health and Addiction Plan 2005) promises to, 'broaden the range of services that are available to people most severely affected by mental illness and addiction' with a focus on broader psycho-social approaches (pp 9–10). Te Kōkiri (The Mental Health and Addiction Action Plan – pp 18 and 20) states that the National Service Framework will be revised to, 'ensure that all service users can have their needs met well' (eg, groups such as people diagnosed with personality disorder, people with experience of trauma, people diagnosed with eating disorders ...). It also promises to 'expand the range of effective and integrated services to include, 'psychological therapies' etc'.

These are serious statements and will require a serious commitment, alignment and resolve of both the Ministry and the sector to bring about improvement.

### References

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