MINISTRY OF HEALTH
MANATŪ HAUORA

Mental Health Directorate
Newsletter

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Te Tāhuhu is Launched

The Minister of Health, Hon Annette King, launched *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan* on 28 June 2005.

The launch was held at the Harbourview Lounge at the Wellington Convention Centre and was attended by approximately 100 people.

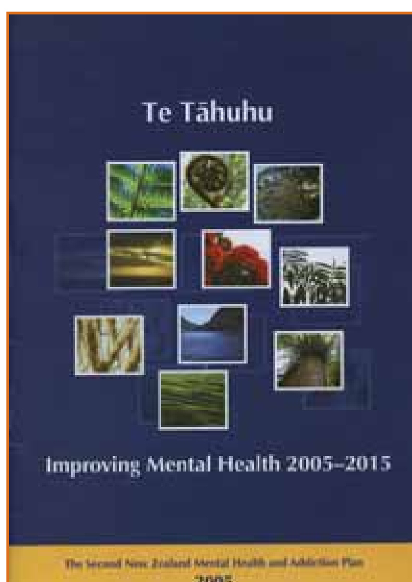
Individuals from across the mental health sector were in attendance. DHB chairs and chief executives and other senior management staff, providers, clinicians, sector representatives from NGOs, chief executives of other government departments, primary health care, PHOs, professional groups, DHB consumer advisors, service users and family members.

Karl Pulotu-Endemann was the MC for the occasion, and Tu Williams kaumatua. Both Karl and Tu had assisted the Ministry with the public consultation on the draft plan in 2004.

Te Tāhuhu – Improving Mental Health was made possible through a great deal of co-operation across the mental health sector and through extensive public consultation.

Pictured above, from left: Janice Wilson, Deputy Director-General Mental Health, Ministry of Health; Hon Annette King, Minister of Health; Anne Hunt, a consumer, at the launch.

Pictured below: *Te Tāhuhu – Improving Mental Health 2005–2015: The second New Zealand mental health and addiction plan.*



The Plan marks a new era in mental health, providing a new sense of direction, a new strategic vision and a mandate for leadership, to continue to build on past successes and achievements. It is built around a set of outcome statements that describe what government wants to achieve for mental health in New Zealand, both what is expected from people in the mental health sector and what people can expect from publicly funded mental health and addiction services.

Te Tāhuhu – Improving Mental Health also identifies 10 leading challenges that need to be addressed in order to achieve the outcomes.

The next step is an action plan jointly developed by DHBs and the Ministry of Health with input from key sector stakeholders. This is due to be reported to Cabinet by the end of March 2006.

An external advisory group will be appointed by Dr Karen Poutasi, Director-General of Health, to develop the action plan. This advisory group will be chaired by Memo Musa, Chief Executive of Whanganui District Health Board, and Dr Janice Wilson, Deputy Director-General Mental Health, will be Deputy Chair.

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EDITORIAL

Dr Janice Wilson

'If you don't measure it, it doesn't count; and if it doesn't count, you don't care.'

This was the mantra of the international conference I attended a week ago on mental health epidemiology, economics and evaluation. As we move into the next 10 years of mental health reform with the launch of Te Tāhuhu, the second New Zealand Mental Health and Addiction Plan, it is timely to be thinking about measurement. There is no doubt that over the past 10 years there has been tremendous changes in mental health care delivery, and even in the way people think about mental health, but we are still not sure how to measure changes in peoples' lives in a way that counts.

Most of health and medicine have been focused on 'outcomes' for a while. For example, a surgeon is really interested in 'fixing the problem' and in mortality rates from his or her surgery. Public health physicians are really interested in the results of immunisation, ie, the decrease or elimination of infectious disease.

For years in mental health we have been more interested in inputs: bricks and mortar or workforce or beds, and in processes: drug treatments, psychotherapies, rehabilitation. A study undertaken in the UK has shown that psychiatrists believed that as long as the patient or consumer was satisfied with them as a physician, then they had achieved success. It is not that inputs and processes are not important. They are! However, a focus on outcomes for consumers or service users will improve the thinking and practice about inputs and processes.

For the past five or so years, New Zealand has been working on measuring outcomes in mental health, what to measure, from whose perspective and how to count such measures. This is hard, and by and large unchartered territory. What we know about this is as good as any other country, and we are working alongside Australia, the US and the UK in this endeavour.

Te Tāhuhu brings an outcomes focus to the policy framework for the next 10 years. Outcomes for all New Zealanders, for people with experience of mental illness and addiction, and for family and friends, will underpin all the actions taken in implementation. As in the rest of health, these will also form the basis upon which the performance of the system is measured, along with other measures of inputs, processes, and outputs.

Wherever we work in the mental health sector our first thought must be: 'What outcomes are we trying to achieve, whose outcomes, how do we measure these and how do these relate to what we know about inputs, processes and outputs?'

Addressing Gambling Harm

Steady progress continues to be made in addressing problem gambling for individuals and their family/whānau, says senior contracts manager Vicki Berkahn.

'The Strategic Plan for Addressing and Minimising Gambling Harm is very clear in its approach to addressing gambling harm,' says Vicki. 'It provides clear rationale and principles for funding a range of intervention services for individuals and significant others who need assistance for their gambling problems.'

Responsibility for problem gambling services transferred to the Ministry of Health on 1 July 2004. Previously, services were funded by the Problem Gambling Committee – a trust comprising problem gambling service providers and gambling industry representatives. The Committee was funded by a voluntary levy on gambling profits.

The Ministry now funds problem gambling services across the continuum of harm and across the population. The project is managed jointly by the Public Health and Mental Health Directorates. 'The harm from gambling, including problem gambling, is complex,' Vicki says. 'Rather than a single approach, a variety of different interventions and approaches, including for different populations, are required.'

As directed by the strategic plan, the first phase of extending the availability of intervention services has been undertaken with service providers invited to submit expressions of interest. The Ministry has since contracted new and/or expanded services in seven geographical areas where there are service coverage gaps as identified in the problem gambling needs assessment.

As the problem gambling intervention services sector builds and diversifies, we will continue to build our knowledge base around effective interventions, including culturally relevant services, says Vicki.

The strategic plan is available on the Ministry of Health's problem gambling webpage www.moh.govt.nz/problemgambling

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, PO Box 932, Dunedin

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Northern Region
Two Years On

Derek Wright

Regional Director, Northern DHB Support Agency Ltd

In December 2002 the Mental Health Commission (MHC) completed their report on the Auckland region's mental health services. This report was critical of the region, citing a lack of regional planning, lack of regional consistency and poor service integration. Whilst you can argue with the detail in the report, it was clear that issues did exist.

So what has happened since the review?

Although the MHC report focused on Auckland, the planning since the review has also included Northland.

In October 2003 Network North Coalition (NNC) was established. NNC brings together all the key players in the region, and includes NGOs, provider GMs clinical directors, mental health funder and planners, representatives from the four DHB local stakeholder groups, family, consumers, Māori, Pacific, primary health care, older persons services, child and youth services, alcohol and other drugs services and the PSA.

This group meets every month, and although there are about 36 people on the group, it functions well.

NNC's role is to:

- advise on planning and funding of mental health services
- undertake projects to develop services across the region
- communicate with key stakeholder groups
- advocate on behalf of mental health services.

NNC has recently completed a five year strategic directions document for the region and this has lead to the development of a number of key projects.

The MHC review identified the areas listed.

Before the review there was:

- lack of co-ordination
- gaps in service provision
- poor information sharing/communication
- lack of leadership
- lack of shared vision
- fragmentation.

Since the review much has changed. There is now:

- a shared vision for mental health services
- a shared 'regional' strategic direction
- better communication
- improved service co-ordination
- reduced duplication
- better information to enhance decision-making
- identified priorities for service improvement.

This region was also proactive in working with the Ministry to give mental health a three-year funding stream.

The northern region has worked hard to ensure there is regional collaboration and consistency and there are a number of key developments in place.

- A shared information system across the three Auckland DHBs.
- Implementing the mental health line across the Northern Region.
- This region has recently undertaken the Camberwell Needs Assessment.
- There is regional workforce planning.
- Development of a regional housing project.

Like all mental health services there is still much to be achieved, but this region now has a clear sense of direction and structures that allows it to move forward.

INTRODUCING
new team member

Arthur Selwyn has been seconded from the Māori education sector as an analyst in the Mental Health Directorate, Ministry of Health. These are his impressions of the Mental Health Directorate.

Ngati Tuwharetoa, Ngati Toa, Ngati Kahungunu, Ngapuhi.

I was born and raised in Te Awamutu. Moved to Porirua in 1992. Married to Lynn in 1994. Best move of my life. Ever. Father of two girls and a boy.

I have a background in education, teaching basic computer skills to 14–18 year olds (CYF and police/truancy referrals) for the past eight years.

So how did I get here? Wrote some policies, or rather made a couple of changes for old job. Liked looking for the relevant info and finding new uses for the word 'subsequent'. Secondment offered. Secondment gratefully accepted. Time for a change.

My expectations: Obtain new knowledge. Use it for the benefit of all against evil tyrants. Save the world. Or maybe I just wanted to get out of the rut I'd made myself comfortable in.

I'm coming in from outside of the bureaucratic bubble (by invitation) and having a bit of look. What's really shocking is that when anybody asks me how it's going at the Ministry, like a green Kermit I tell them I really like it. And I mean it too.

Current impressions: With my vast 2 months' experience as an analyst for the Māori Mental Health Team: Less is better, and yet, don't take any short cuts. Emotion is for poetry and parliament. Regardless of creed or inclination, people run a mile at the slightest mention of cost. I am no longer me. I am the Ministry.

I enjoy the fact that here at the Ministry, you leave work at work – unheard of in previous life. Also, learning background info to whatever I'm doing. Seeing how the machine runs. Do the work, send it where it needs to go, clear your head for the next one. Recognising the wry inner smile when it (an issue from previous work) jumps back for you to follow up on. And finally, the people I'm working with. Friendly, helpful, clever, professional.

I do not enjoy the prospect of probably never playing golf again. Just got down to single figures too. (Saturday is family day, people…).

All-time favourite question: Can I have a Zinger Works Burger upsized to a large, please?

National Framework for Eating Disorder Services Consultation Paper

The Ministry of Health will be releasing a consultation paper on a National Framework for Eating Disorder Services.

This consultation document presents current service availability and discusses related issues in order to start developing a National Framework for Eating Disorder Services.

Primary health care practitioners, secondary mental health and general medical services, and non-governmental organisations provide a significant amount of treatment, education, support and care for people with eating disorders. They are supported by specialist services in Auckland, Wellington and Christchurch.

This paper outlines how services might be delivered at local, regional and national levels. Several options are available to improve access nationwide and include the development of new services and/or the expansion of existing services.

Ongoing consultation with advisory groups and involvement with service providers and District Health Boards will be needed to progress service development. Once a national plan is established this framework could serve as the basis for service specifications.

Copies of the consultation document will be available from www.moh.govt.nz in October.

Workforce Development

The next Ministry of Health national mental health and addictions workforce development plan is due for release in December this year.

Robyn Shearer and Susan Potter from the Mental Health Directorate are meeting with sector groups to discuss the plan and get feedback on content. The plan retains the systems approach to mental health and addictions workforce development which was seen in the 2002 Mental Health (Alcohol and Other Drugs) Workforce Development Framework.

One of the strategic areas focuses on organisational development – looking at how mental health and addictions services providers can better manage services to serve the people who need them. There are some key themes in the plan that service providers can develop within their organisations – leadership and implementing service improvement methodology.

Service improvement models can assist organisations to work through how to improve their services by using methods of quality improvement – via process mapping and PLAN–DO–STUDY–ACT cycles. This work is being demonstrated through two of our national workforce initiatives. One is through the Mental Health Workforce Development Programme's National Resource Group and the other through a project that is being lead by the New Zealand Guidelines Group on assessment of those at risk of suicide – who may present through Emergency Departments.

Both initiatives are looking to assist services with process mapping that gets services, service users, clinicians, referrers, family/whānau/significant others around the table to discuss where problems accessing good service can occur. The journey of a service user (using a typical referral) is then put onto a process map and 'blocks' in the system are identified, from there, the PLAN–DO–STUDY–ACT cycle is put into action – usually starting with some quick wins. The project teams work together on this and give feedback to the original identifiers of issues on how things are progressing.

Feedback so far has been excellent with the latest workshops for the National Resource Group happening with funders and planners in the

News Snippets

Problem Gambling Intervention Services in New Zealand: 2004 National Statistics

This report presents national statistics for problem gambling intervention services for the 2004 calendar year. This is the eighth national statistics report and the first to be published by the Ministry of Health since assuming responsibility for funding and co-ordinating problem gambling services on 1 July 2004.

The purpose of the national statistics is to provide objective and reliable data about people seeking assistance for their own or someone else's problem gambling through specialist problem gambling treatment services, says problem gambling project leader Debbie Edwards. 'The annual report of national statistics has proven to be a unique and useful data set in the sector, which continues to advance the collective knowledge base of gambling harm, including problem gambling.'

This sentiment is echoed by the manager of gaming policy for the Department of Internal affairs, John Markland. 'What we see in [the national statistics reports] is information about the sharp end of gambling-related harm that has been systematically gathered and reported in a similar format over a long period.'

John says the reports are envied by many other jurisdictions around the world. 'The established and emerging trends set out in the reports are one invaluable source of evidence that the Department of Internal Affairs has drawn on in the past, and will continue to draw on in the future, when developing its policy advice on gambling issues.'

The report will be available from October on the Ministry of Health's problem gambling webpage www.moh.govt.nz/problemgambling

southern region. There have also been pilot projects with Pacific and Maternal Mental Health services in Auckland, Child and Youth services in Wellington, Adult acute inpatient services in Waikato and more recently Canterbury DHB.

The original training for the model was provided by the National Institute for Mental Health in England (NIMHE) – and in the New Zealand way – we have developed the model to suit our unique environment by adding workshops designed for service users and caregivers/family/whānau – so the best opportunities come from the process mapping exercise. Now NIHME is interested in our developments and are keen to share what we have learned.

Not only is this work a great opportunity for services to work with service users and referrers on how to make improvements, but also for each group to learn some of the issues faced when accessing services and the real pressure some services are under.

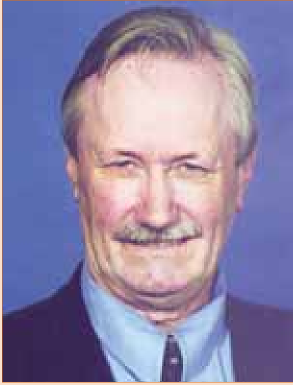
Government agencies take shared approach to seeking input from sector

The Department of Internal Affairs (DIA) and the Ministry of Health are the government agencies assigned responsibility for achieving the objectives of the Gambling Act 2003.

The Ministry and DIA have both a statutory obligation to consult on specific components of their responsibilities. 'Furthermore,' says problem gambling project leader Debbie Edwards, 'both agencies have identified collaboration with the health, community, research and industry sectors as critical to the effectiveness of initiatives to prevent and minimise gambling harm.'

It is proposed that the group meet three times a year, with the first meeting scheduled for October 2005.

DIA has a key role in addressing problem gambling through the regulation and enforcement of the supply of gambling opportunities, and the practice of gambling operators. It administers the Act and takes a lead role in developing harm minimisation regulations.



Chaplow's Column

David Chaplow

Director of Mental Health

'Te Tāhuhu' refers to the 'ridgepole' of the Māori meeting house. In the metaphor of the house-as-ancestor it becomes the 'backbone, serving the purpose of, providing a framework for the rest of the body.'

Te Tāhuhu is an apt metaphor for the Second National Mental Health and Addiction Plan title, as it sets out a philosophic framework for the mental health services for the next 10-years. In order to achieve the vision, the body of work will need to be reflected in a plan that provides step-wise progress to the realisation of the vision. The plan will be the responsibility of both the DHBs and the Ministry of Health and will require wide sector consultation and input.

Mental health is ever changing. What seems right and sensible today may appear misguided or impractical by 2015. This is why it is important to get it right. For example, in the 1990s one of the visions for the future encompassed a greater emphasis on community-based care. This was reflected in *Looking Forward* and *Moving Forward* and by the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act). Hindsight has suggested that the vision was slightly ahead of its time in that the 'community' wasn't, by and large, equipped to initially compulsorily assess and treat the majority of those committed under the Act. It has taken time to build community capacity for mental health services.

Addiction service philosophy and service provision have also changed over the decades. The philosophy expressed in the Alcoholism and Other Addictions Act 1966 is dated and needs revision urgently. The quality of assessment and treatment programmes currently being offered in our addiction services is also under scrutiny and the measurement of outcome is important.

The next decade will raise similar debates about how to achieve and maintain mental health and what mental health and addiction services should look like. Human-rights issues balancing those of the community and those of the individual and issues around the extent of mandated (or coerced) care (under the provisions of the Act, and the importance of the voice of the service-user and carer around choice, consultation, and participation will again figure prominently. In the spectrum of mental health, the balance between service provision both at the 'illness' end and at the 'wellness' end will need careful thought in terms of models of service provision and the clinical pathways between.

The plan will be delivered to Cabinet by March 2006. This means a lot of work between now and then. The past 10 years has seen mental health provision in New Zealand progress measurably. The next 10 years will be just as important and to ensure that progress continues, the plan must reflect accurately our direction and measurable steps to achieve it. Your continued input will be valued.