

Tauawhitia te Wero launched

A new national mental health and addiction workforce development plan was launched at the Wellington Convention Centre by Health Minister Hon Peter Hodgson on 19 December.

Tauawhitia te Wero – Embracing the Challenge is about having the right people in the right place at the right time to treat, care for and support people who use mental health and addiction services.

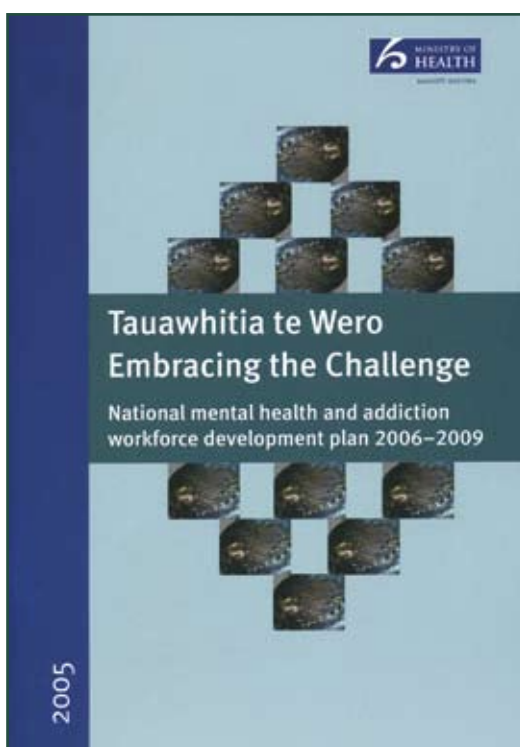
Its vision for the future is to have a diverse workforce that is responsive to the needs of service users, their families/whānau and significant others; and confident that they make a positive and unique contribution to the journey of recovery.

The launch was attended by a wide range of representatives from the Ministry of Health, District Health Boards, NGOs and other leaders in the field.

To coincide with the launch, the plan was also published on the Ministry's website.

Robyn Shearer, Project Manager Workforce in the Mental Health Directorate, says the plan has already attracted a great deal of positive feedback. 'Lots of people working in the sector had views on how the plan should look, and what should go into it. The launch was a nice way to celebrate all their input.'

Tauawhitia te Wero strengthens organisation development, and will help services address ways to develop the culture and systems they need to recruit and retain staff.



One of its highlights is a national training plan that aims to improve the co-ordination of training and will review undergraduate education. It may also include arrangements to address accreditation of in-service training programmes, increase access to training by workers in District Health Boards and NGOs, and train the workforce in information use to support evidence-based best practice.

The size of the workforce is difficult to measure, so two of the plan's key initiatives are stocktakes of the mental health and addiction workforce in NGOs and in District Health Boards.

The plan also lays the groundwork for innovative workforce design projects. The existing mental health and addiction workforce is expected to have to change to meet future demands for services created by an ageing population. Workforce design projects could include expanding the scopes of practice for non-psychiatrists such as nurse practitioners, strengthening the role of family/whānau advisors, and reducing the administrative burden on clinicians and support workers.

Tauawhitia te Wero sets out actions to be taken up to 2009, and will serve as a foundation for the next 10-year plan.



Contents

Tauawhitia te Wero launched	1
Introducing new team members	3
Primary health network meetings a success.....	4
Conference fosters Trans-Tasman links	4
New service co-ordinators fill the gaps.....	5
Draft action plan nears completion	5
Framework looks at the child and adolescent mental health workforce	6
First Te Rau Puawai recipient graduates.....	7
Next round of Māori mental health scholarships	8
Like Minds, Like Mine picks up ad award.....	9
Feasibility report paves way for national depression initiative	9
Health assessments help young people who have offended.....	10
New reports on suicide trends.....	10
The effects of CAOS.....	11
Skipworth Says.....	12

EDITORIAL

Dr Janice Wilson



Accolades often come our way internationally for the successes in the reforms of mental health services. Yet we know a great deal is still to be achieved. Despite much effort over the past 10 years, an area that we have failed to have much impact on thus far is the range of services that respond to acute and emergency needs of people with mental illness and their families. Why is this?

Emergency services in health are notoriously stressful, yet health professionals are often attracted by the immediacy and action of responding to health crises. Numerous TV programmes attest to this, and contribute to the public's understanding of the functions, the issues and the hospital politics involved in working in the Emergency Department. One of the compelling factors for viewers is the portrayal of the 'duty of care' ethic implicit and strongly imbedded in the professionals employed.

Emergency services are the peak of the pyramid of all health services and, for many, are not infrequently the entrance to other health services. The successful functioning of emergency services depends strongly on the relationships formed with all other health and related social services. That is, A&E can only function when the pathways to the required care are well understood and agreed. Good relationships and agreed responsibilities are essential with all medical and surgical specialties, including the ICU. The system (the whole pyramid) has to work as a whole. It is acknowledged that this is difficult, complex and not only relies on professionalism and competence, but on strong leadership.

But it is different in mental health services I hear you say. This is true. Can we imagine a TV programme devoted to emergency services for people with mental illness? The mental health system is even more complex with multiple providers involved, thus achieving agreed responsibilities is harder. There are also definitional issues about what is a mental health crisis or emergency, although these definitional issues are part of the substrate of general health emergencies. We, in mental health, unfortunately, have more debate about this, with frequently hard-held views and positions. Apart from these two features, however, the general concepts of crisis and emergencies services are much the same.

No one now denies that special skills are required to work in A&E, and thus Emergency Medicine has become a subspecialty in its own right in both Medicine and Nursing. The time is long overdue for us to do this also in mental health services. By doing this, we will address not only the competencies (attitudes, knowledge and skills) required, but by necessity, definitional issues and boundary relationship issues within mental health services, within health services and with other agencies. We will also create an opportunity for leadership including academic and research leadership, which currently in New Zealand is sadly lacking.

And lastly, but by no means the least, we can address the issue of 'the duty of care'.

This is a good challenge to start off a New Year! Happy New Year to you all.

INTRODUCING

new team members

New Manager for Mental Health Policy and Service Development

Joan Mirkin, who has been at the Ministry of Health since 1993, has taken up a new role as **Manager of Mental Health Policy and Service Development** in the Mental Health Directorate.



Joan is new to the mental health sector, having previously been Manager of Crown Entity Funding and Performance. She started her working life as a teacher, and worked in the NGO sector with the New Zealand Childcare Association and in family planning before joining the Ministry.

‘One of the exciting challenges I’m looking forward to in this job is helping to develop and implement the action plan for *Te Tāhuhu – Improving Mental Health*,’ she says, ‘and I am particularly keen to maintain and build on the positive engagement that the Directorate has had with the sector in developing both *Te Tāhuhu* and the action plan.’

Joan’s interests in her spare time include golf, painting and going to the gym.

New Senior Māori Analyst

Ko Aoraki te Mauka
Ko Waitaki te Awa
Ko Arowhenua te Marae
Ko Waitaha, Kāti Māmoe, me Kai Tahu ngā Iwi
Ko Melanie Sargent taku ingoa

Melanie Sargent has joined the Mental Health Directorate as a Senior Māori Analyst.



She previously lectured in the postgraduate public health programme at the Department of Public Health and General Practice in Otago University’s Christchurch School of Medicine, and held a research contract from Canterbury DHB. Melanie, who is working on developing the action plan for *Te Tāhuhu – Improving Mental Health*, moved to the Directorate because she wanted to further her interest in policy and to work at a national level.

‘This is a very supportive team, the work is challenging and interesting, and it’s an exciting time to be here,’ she says.

Outside work, Melanie enjoys tramping around the mountains of her turangawaewae, Te Wai Pounamu.

Primary health network meetings a success

People involved in primary mental health had a chance to meet up and discuss topical issues at two meetings held in the North Island in October.

The primary mental health network meetings, held in Auckland on 18 October and in Wellington on 25 October, were arranged after delegates to the Primary Focus 2 conference expressed a need for more networking forums for primary health people focusing on mental health service delivery, so they could share information, discuss issues and learn from each other.

The meetings also provided an opportunity for the 36 primary mental health projects being funded as demonstration projects to present an overview of their initiative and the issues and challenges they had faced to date. The team contracted to evaluate the demonstration projects also attended.

A wide range of health sector workers attended, included representatives from DHBs, PHOs, secondary services and NGOs. Issues raised included access for Māori, workforce development – particularly the need for more qualified Māori therapists – mental health training for primary care workers, the need for locum support for GPs and nurses in rural areas, and the tools needed to support the demonstration projects.

Senior Analyst, Primary Health Care Delivery, Rosemary Simpson, says people who attended the meetings enjoyed putting names to faces, discovering what other organisations were doing and discussing issues they had in common. ‘When there’s a lot happening, it’s good to know you’re not alone – if you’re the only mental health nurse in a practice, it’s helpful to be able to meet up with mental health nurses from other areas.’

The Ministry would like to hold more of these networking meetings in future.

Conference fosters Trans-Tasman links

Two representatives of the Mental Health Directorate have attended one of the major events on the Australian health conference calendar.

Analyst Kristan Johnston and Project Manager Nemu Lallu flew to Perth in November to attend the annual Divisions of General Practice Network Forum. A new element in this year’s conference was a one-day symposium for Australia’s primary mental health care network.

Australia has a Better Outcomes initiative which provides A\$120 million over four years for mental health in primary care, targeting the mild to moderate end of the spectrum. ‘In New Zealand, we’ve been trying to build specialist services for

mental health at the severe end, so we wanted to look at the work Australia was doing on the milder issues that appear in primary care, such as anxiety and depression,’ says Kristan.

‘The conference was a chance for us to outline our work programme, and to see what’s happening in Australia. We had lots of things in common, as well as some areas where we differed – for example, we’re good at building a wider health team with a nursing-style model, while Australia’s services are still GP-based.’

He hoped to be able to build a relationship with Australia’s primary mental health care network, which might grow to include a shared information base and links between organisations working on similar projects.

New service co-ordinators fill the gaps

One of the 36 primary mental health projects funded by the Ministry of Health until June 2007 is a primary mental health initiative run by Capital PHO to improve services for people with mild to moderate mental illnesses.

Capital PHO has employed a primary mental health co-ordinator and shares a child and youth mental health co-ordinator with two other PHOs. The co-ordinators have people referred from GPs, primary care nurses, and community groups that work alongside PHOs.

Dr Helen Rodenburg, a GP on the Capital PHO Board, says the PHO consulted with community groups before putting together its proposal. It

found that what was most needed was extra help for people with a mild to moderate mental illness, especially Māori, Pacific peoples and those on low incomes.

‘It’s all about filling the gaps. Primary care often hasn’t had the resources it needs – for example, if a person needs treatment for anxiety, or needs to spend a longer time with a doctor,’ says Helen. ‘We’ve put our funding into packages of care, and we have a strong emphasis on problem solving. Often people have complex family needs, so an assessment by a co-ordinator is very useful.’

The co-ordinators are already very busy, with one receiving five referrals on a single day.

Draft action plan nears completion

The draft of the action plan to implement *Te Tāhuhu – Improving Mental Health* is expected to be finalised in early January.

Cabinet will then be asked to approve and release the draft action plan for consultation. The consultation process will take place through established channels – regional mental health networks, consumer networks, NGO networks and DHBs – in March and April 2006.

Te Tāhuhu – Improving Mental Health: The Second New Zealand Mental Health and Addiction Plan builds on the national mental health strategy, draws together government interests in mental health and addiction, and provides a clear statement on government priorities for investment in mental health and addiction for the next decade.

When the Government agreed to *Te Tāhuhu – Improving Mental Health* in June 2005, it directed

that an action plan to implement the document be reported to Cabinet’s social development committee by 31 March 2006. The action plan is being jointly developed by the Ministry of Health and DHBs, working with stakeholder representatives through an advisory group that reports directly to the Director-General of Health.

Whanganui District Health Board Chief Executive Officer Memo Musa chairs the advisory group, with Janice Wilson, Deputy Director-General of the Mental Health Directorate, as deputy chair. The group had its first meeting on 21 August 2005, and has had four further meetings since then.

The advisory group has agreed to use the same framework for the action plan as was used in the Cancer Control Strategy’s action plan. The actions all relate directly to ten leading challenges in *Te Tāhuhu – Improving Mental Health*. The leading challenges were a mix of both high level strategic statements and specific operational statements, and the action plan will be the same.

Framework looks at the child and adolescent mental health workforce

A framework for the development of the child and adolescent mental health workforce over the next decade is expected to be available for consultation early next year.

Auckland University's Werry Centre conducted a national stocktake of child and adolescent mental health services. It found significant gaps between current workforce numbers and the number of staff recommended in the *Blueprint for Mental Health Services in New Zealand*. The gap was wider in child and adolescent services than in adult services.

The Werry Centre has now developed a draft 10-year framework to increase the capacity and capability of the child and adolescent mental health and addiction workforce.

The Strategic Framework for Child and Adolescent Mental Health Workforce Development describes strategies to forge a dynamic relationship between policy agencies, funders, mental health and education providers to increase the capacity and capability of the sector.

Employers and training institutions will be able to use the framework's suggestions to look at the expected level of need and plan accordingly.



The framework looks at models locally and overseas, and takes other issues – such as providing cultural appropriate services – into account.

There has already been extensive consultation on the draft framework, including a symposium for key stakeholders in September and consultation with other workforce development programmes.

The Werry Centre, whose role is to strengthen the child and adolescent mental health workforce, has just moved premises. Its 14 staff are based in the Faculty of Medical and Health Sciences at the University of Auckland in Symonds Street. The centre previously shared space with the rest of its department, but now has its own dedicated space in the Keystone Building, Symonds Street – which will enable it to host events and allow others to use its resources.

First Te Rau Puawai recipient graduates

Nicole Coupe, Kai Tahu, Te Atiawa, has become the first recipient of a Te Rau Puawai bursary to complete her doctoral research.

Te Rau Puawai is a joint initiative from Massey University and the Ministry of Health aimed at increasing the professional Māori mental health workforce. It provides bursaries for students seeking university qualifications in a Māori mental health related discipline.

Nicole, who has been awarded a Doctor of Philosophy degree in Māori Studies by Massey University, researched Māori suicide prevention using a combination of kaupapa Māori methodology and epidemiological research. She found that Māori who tried to commit suicide were more likely to be alienated from their culture, which suggested that future suicide prevention initiatives should incorporate Māori holistic models of wellness.

‘The Te Rau Puawai grant meant I was able to spend six months concentrating on writing up my research without having to worry about finances. It was a big help,’ says Nicole.

Nicole works at the New Zealand Guidelines Group implementing *The Assessment of Management of*



The Mental Health Directorate congratulates Nicole Coupe and Amohia Boulton on their graduation with PhDs

People at Risk of Suicide guideline into emergency departments, mental health services and Māori health services in DHBs.

Also graduating from Massey University with a Doctor of Philosophy degree in Māori Studies was Amohia Boulton, Ngai Te Rangī, Ngāti Ranginui, Ngāti Pukenga. Amohia (whose research was profiled in the last issue of the Newsletter) is a Health Research Council Post Doctoral Fellow based at Te Pumanawa Hauora Research Centre for Māori Health and Development at Massey. She investigated the experiences of Māori mental health providers contracting to provide mental health services for the Crown.

Amohia has been awarded an HRC Strategic Development Grant to further her doctoral work.

Next round of Māori mental health scholarships

An innovative programme to promote Māori mental health will start advertising its next series of scholarships in mid-January.

The Henry Rongomau Bennett Memorial Scholarships – named after the first Māori psychiatrist – aim to develop:

- leadership in Māori mental health
- competence in te ao Māori (Māori culture)
- clinical excellence in mental health.

The first of the Ministry of Health-funded scholarships were given out in 2002 to five Māori registrars in psychiatry training programmes. Since then, the scholarship programme's scope has

been widened to include Māori working in mental health services, Māori mental health nurses, Māori clinical psychologists and fifth-year medical students.

As part of the programme, Hauora.com – the Māori organisation that administers the scholarships – ran a training programme for GPs to help improve their diagnosis of Māori with mental health issues. For Alcohol and Other Drug (AOD) workers, it ran workshops on presentation skills and organised a secondment programme that allowed them to spend time with other AOD providers to learn some new things to take back and use at their own services.

The closing date for applications for the next round of scholarships will be in April 2006.



Melissa Gardi © 2004

Previous recipients from left: Dr Mark Lawrence (recipient), Dr Donna Clarke (recipient), Dr Sylvia van Altvorst (psychiatrist), Dr Rees Tapsell (psychiatrist and member of committee), Prof Mason Durie (chair of committee), Dr Claire Patterson (recipient), Dr Pamela Bennett (psychiatrist, member of committee, who is also Henry Bennett's daughter) and Dr Hinemoa Elder (recipient)

Like Minds, Like Mine picks up ad award

The Like Minds, Like Mine advertising campaign has won an award for its success in changing public attitudes towards people with a mental illness.

The campaign, which has been running for five years and features Kiwis who challenge myths and stereotypes around mental illness, won a silver award for sustained success in advertising at the EFFIE (Effective in Advertising) awards.

Entrants in the sustained success category had to show the ongoing success of their campaigns over three years or more. Like Minds, Like Mine was competing against commercial ads that cost millions of dollars more to make.

Gerard Vaughan, National Project Manager for Like Minds, Like Mine, says he is particularly pleased that the campaign won its award in a category that measured long-term evidence of progress. The judges had described Like Minds, Like Mine as



A still from one of the EFFIE Award winning TV advertisements

the most successful social issue campaign in New Zealand history.

‘This award is the result of the collective efforts of many people around the country who challenge discriminatory attitudes to mental illness every day,’ says Gerard. ‘I think they should all be very proud of the campaign’s success.’

Feasibility report paves way for national depression initiative

A feasibility report will give the Ministry of Health advice on developing a national initiative to address depression.

The report, prepared by Phoenix Research, Janet Peters and Kathryn Nemec, draws together three reports:

- an environmental scan to identify the major issues around depression, including key players and challenges, which included interviews with 83 stakeholders
- a review of overseas depression campaigns and of the research on the effectiveness of different types of strategies

- a nationwide phone survey of 1301 people to provide a baseline understanding of the general public’s knowledge, attitudes and behaviours of depression and awareness of the help available.

The Ministry is currently considering the feasibility report to inform the planning of the national depression initiative. The initiative will focus on recognising the symptoms of depression as early as possible, ensuring people with depression are appropriately supported and treated, and promoting protective factors that support mental health.

Health assessments help young people who have offended

The Health and Education Assessment Initiative is an interagency strategy that aims to provide assessments and effective interventions to children and young people at risk of a constant pattern of offending behaviour, where that behaviour may be directly related to poor health or disengagement with the education system.

The information – gathered in the assessments of eligible children and young people aged from 10 to 16 – enables family members attending Youth Justice’s statutory family group conferences to decide which actions need to be taken to change the young person’s pattern of behaviour.

The health assessments look at all aspects of a young person’s physical, mental and sexual health. Both the child or young person and a member of their family need to consent to take part in the programme. The assessments remain confidential – for example, if a young person has sexual health problems but doesn’t want the nature of the problem revealed, the assessment can exclude details and simply recommend a referral to a sexual health specialist. The only information that is available to the Family Group Conference is that relevant to the offending

unless the young person agrees to share all the information in the assessment.

Two-day training courses have been held for the 120 primary care nurses and GPs who carry out the assessments. Further in-depth training is planned for health assessors on how to engage effectively with young people to provide comprehensive and relevant assessments and recommendations for the Family Group Conference.

Colin Hamlin, Senior Advisor in the Ministry of Health’s Mental Health Policy and Service Development team, says the young people being assessed have often had little primary health care. Some have sight or hearing problems, or need urgent dental care.

The pilot strategy was launched in April 2004 in the Waikato, the Bay of Plenty, Wellington, Nelson, Marlborough and the West Coast of the South Island. It now extends to the north of Hamilton, and will be rolled out to Auckland, Northland and the rest of the South Island by June 2006.

‘The feedback from the people involved in delivering the initiative has been overwhelmingly positive,’ says Colin. ‘They’re very pleased to have extra resources to address the needs of a high-risk group that usually misses out.’

New reports on suicide trends

Six new reports on suicide in New Zealand have been released by Associate Health Minister Hon Jim Anderton.

Five of the reports explore a range of social explanations for New Zealand’s suicide trends to 1999, with topics ranging from the correlation between suicide and socioeconomic fluctuations in New Zealand over 20 years to an analysis of contemporary Māori views of suicide. A sixth report, *The Cost of Suicide*, estimates that the 460 suicides and 5095 attempted suicides in 2002 cost nearly \$1.4 billion, including lost production

in the workforce. Each suicide is estimated to cost \$2,931,250.

The Ministry of Health commissioned the research from the Wellington School of Medicine and Health Sciences to broaden understanding of the causes of suicide and to inform the development of the draft New Zealand Suicide Prevention Strategy. The strategy is being revised and is expected to be ready for release by mid-2006.

The six reports are available from the Ministry’s suicide prevention web pages:
www.moh.govt.nz/suicideprevention

The effects of CAOS

Phillipa Gaines, Manager, Mental Health System Development



I am often asked what happened to the findings from the CAOS project.

The main objective of the Mental Health Classification and Outcomes Study (CAOS) was to develop a first version of a casemix classification system suited to the needs of mental health services in New Zealand. At the conclusion of the study in 2003 the project had achieved this original objective and much more. However, to now operationalise the CAOS classification system nationally requires the right combination of conditions relying principally on the collection of good quality Mental Health Standard Measures of Assessment and Recovery (MH-SMART) data.

Whilst we now have the first version of our very own mental health classification, the most immediate gain from CAOS was experience in outcome measurement. The DHB staff involved in the collection of the consumer outcome measures used in the CAOS study have been well positioned to understand and manage the recent introduction of the HoNOS (Health of the Nation Outcome Scale) into routine clinical use as part of the MH-SMART initiative.

First and foremost MH-SMART data needs to support clinical staff in the delivery of good quality care to consumers. The casemix adjusted analysis

of aggregated outcome data will come as a second stage of development and at that point DHBs and the Ministry will need the final product from CAOS to interpret any reports.

In the meantime the Ministry has prepared a business case for the development of an Integrated Mental Health Information System that combines MHINC and outcome data into one data set. This business case is one of the first priority action areas under the National Mental Health Information Strategy.

The design and development of the mental health information reporting system (MHIRS) for NGOs has been delayed subject to a final decision on the integrated data collection system. This is because the integrated data collection will change the way MHINC data is collected and will determine the design of the MHIRS system.

The Ministry expects to be able to make a more formal announcement about both developments early in the New Year and looks forward to working with the sector to progress the development of our national data collection alongside the other priority areas identified in the National Mental Health Information Strategy.

Ministry of Health publications

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

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Skipworth Says

Jeremy Skipworth

Deputy Director of Mental Health

The Ministry is from Mars and the sector is from Venus.

Before joining the Ministry I worked for a certain local District Health Board, though my new role required that I keep a foot in both camps, by virtue of one day a week working in the sector. Many colleagues from New Zealand, and other countries, have subsequently commented to me on what a good idea this split role is, affording both sectors insights into the other. However, to avoid accusations of this being some undercover operation, and at risk of putting one of my feet in my mouth (or possibly both), I thought some 'free and frank' (as they call it in the Ministry) might be in order ...

A good marriage is facilitated when both parties speak the same language, spend time talking to each other, and understand what each other's role, responsibilities and challenges are. My first observation on joining the Ministry was that I didn't even understand the language they were speaking. It was a little like all the new medical terms when I started Medical School. I asked for a month or two what the various acronyms stood for, pretending I understood the answers, but eventually felt as though I should know, so stopped asking. Two years on I can follow at least half the conversations, and feel pretty good about that.

My second observation was that even in DHBs, there is a level of management who understand the 'bureau-speak', but these people don't usually have clinical contact. The Ministry tends to interact with the 'bureau-speakers', for obvious reasons (otherwise interpreters would be needed, and that is really time-consuming and frustrating).

Thirdly I was impressed when I joined the Ministry by how dedicated and hard working people in the Mental Health Directorate are. The breadth and depth of work is simply staggering.

In the field, where clinical lingo is parlance of preference, the clinicians I work with have little idea about the bureaucracy (except a few who have previously been lucky enough to have my current role). They generally regard the Ministry as this malevolent force, frustrating good clinical practice by imposing burdensome data recording requirements, creating unnecessary red tape which inevitably results in delay or inaction, while also requiring that standards are met, with consequences for poor performance. And the image of the 'Gliding On' bureaucrat with his feet up on a cushy number doesn't help.

Paranoia, distrust, suspicion, even resentment are consequences of cultural differences not understood or embraced. But there are some solutions to make this marriage work better (free counselling tips).

One idea would be to have more jobs like mine, with a foot in both camps. This is a good idea, especially for advisors at all levels. Our recent initiative to have an Advanced Trainee in Administrative Psychiatry at the Ministry is a further example, and now that Greg is partially bilingual, he will be a great asset to the sector in whatever role he tackles next. I also think there should be more interaction between Ministry folk and clinicians. Interpreters may be required, but we fund these services (I think anyway). Field trips – not to talk to managers, but to see what happens in the field – should also be encouraged. Genuine collaboration does occur, such as with the implementation plan for *Te Tāhuhu*, but DHBs need to think carefully about how to effectively include clinicians in the field.

We may be from different planets, but better communication, and a bit of cross-fertilisation, will be of benefit to all.