



Support for family and whānau

As described in the Minister of Health's document, *Te Tāhuhu: Improving Mental Health 2005–2015* the Government recognises the importance of support for family, whānau and friends who support, and who are affected by people with experience of mental illness and addiction.

To that end, the Ministry of Health has a national contract with Schizophrenia Fellowship (SF) New Zealand, which advocates on behalf of family, whānau and friends. SF New Zealand is a not-for-profit organisation with a national office and 21 branches nationwide. As well as being an advocacy service, SF New Zealand provides information, support, education, a range of mental health resources and, in some areas, cultural fieldworkers. While SF New Zealand branches primarily provide support to families, in some regions service users are also included.

There are also support services for family and whānau at regional and local levels, which are funded by District Health Boards (DHBs). As an example, Counties Manukau DHB funds Whāriki: Whaiora and Family/ Whānau Services, which is part of Challenge Trust. Louise Rattray is a family and whānau support worker with that service.

Louise says, 'It is recognised that inclusion of family and whānau in their loved one's treatment and recovery is beneficial, leading to positive outcomes for all involved. However, during times of unwellness, the stress for families can be considerable. At such times, a family/whānau service like Whāriki can address the needs of individual family members by providing practical and positive support through education, information and a listening ear.'



Louise Rattray, Family Support Worker/Trainer, Challenge Trust (left) and Kirstin Vaauli, Family Advisor, Counties Manukau DHB.

Both support agencies, SF New Zealand and Whāriki: Whaiora and Family/Whānau Services, work closely with Counties Manukau DHB Family Advisor, Kirstin Vaauli. Kirstin has a key strategic position, which includes ensuring the mental health services in Counties Manukau work effectively with family and whānau members. 'When it comes to family and whānau support,' says Kirstin, 'the real tragedy is that many people do not know much about what is out there. As family advisor, it is a matter of supporting the development of processes within mental health services to ensure that connecting families to such services becomes a part of standard practice'.

For further information about mental health family and whānau support services contact:

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EDITORIAL

Robyn Shearer



Our newspapers and media have recently been focusing on health stories. In the context of mental health and addictions, however, news stories are not always positive and most do little to engender public confidence that when someone needs assistance they will receive it in a timely and professional manner.

There is no doubt that the ‘business’ of health is a complex one. In mental health and addiction services, the complexity can be heightened by the circumstances that lead someone to require assistance. Some of the ‘tools’ that enable the right assistance to be provided are, among others, thorough assessment and history taking, developing rapport and involvement of family and whānau support.

But perhaps one of the most important things is the ease with which the right services can be navigated. While *Blueprint* funding has enabled an expansion of specialist services for people with mental health and addiction issues, all too often we receive feedback that the system is extremely hard to navigate. This is not only so for the public, but also for health professionals. For instance, have you ever tried to find the local mental health service in the phone book? It is not easy. Ministry mental health staff often field calls from people wanting to know how to get in touch with a mental health service. Directing people to the right person to talk to is difficult enough, but becomes more complex with the need to find the right service within easy reach of a person’s home and family support. These and other navigation difficulties mean that, unless it is a ‘dire emergency’, people are often pushed from pillar to post in seeking assistance.

Access to services remains a priority for the Ministry of Health. With the very successful campaigns, such as the National Depression Initiative and ‘Like Minds, Like Mine’, we want to encourage people to seek help early. Feedback, however, suggests that this can be difficult to do, with some services having waiting lists or with ‘criteria’ limited to the 3 percent. For example, I had feedback from a ‘potential’ service user who was told over the phone that he did not fit into the ‘3 percent’ of the population with mental illness, therefore he was not able to receive entry to the service. This person was experiencing severe symptoms of depression. He was not informed of where he could get help, but was told to ring back if he got worse. He already felt at a very low point in his life.

This prompts the question – how can someone tell whether a person’s mental health issue is serious just from talking to them on the phone or having a brief meeting? If we are to ensure we have respected services, with good assessment and treatment practice, then such a ‘once over lightly’ approach will not work. To gain the



Frozen Funds Charitable Trust launched

On 14 February, the Frozen Funds Charitable Trust was launched in Wellington.

The term 'frozen funds' refers to the interest on patient's welfare benefits paid into psychiatric and psychopaedic hospital trust accounts in the 1970s and 1980s. The interest money was kept by the institutions to fund such things as recreational projects. In 1987, this practice ceased and the interest money was taken from the hospitals for payment to the people who owned it.

As a result, in the early 1990s, over half the accumulated interest had been returned to its rightful owners. However, there remained an unclaimed balance, which initially amounted to \$4.3 million. In view of this, the Government made the decision that the funds should be used to benefit people who used mental health and intellectual disability services. A charitable trust was established for this purpose. Over a number of years, the Public Trust worked with stakeholders in the mental health and intellectual disability



At the launch of the Frozen Funds Charitable Trust (from left) Cheryl Mennie, Tracey Cannon, Grenville Gaskell, Hon Ruth Dyson, John Sutherland, Kerry Whitworth, Mary O'Hagan, Don Mather, Adrienne Olsen.

sectors to develop the Trust Deed. Finally, in 2006, the Trust Deed was signed off by the Government and, in 2007, trustees were appointed. As from 2008, members of the trust board will manage the trust in perpetuity. The income will be distributed in the form of grants that charitable organisations can apply for annually.

This year, the funds available for grants are approximately \$300,000, however, this amount will vary annually

according to market returns. The trust board set a theme for 2008, 'Raising public awareness of the legacy of institutionalisation', and expressions of interest from charitable organisations closed on 31 March.

As a guide for future allocations projects can involve advocacy, education, the creative arts, media research or any other approach that addresses this theme.

For further information about the Frozen Funds Charitable Trust visit: www.frozenfunds.co.nz or email Cheryl.Mennie@publictrust.co.nz



respect of people who need services, we must make sure such services are accessible, available and of high quality – the right people, right time, right place, doing the right thing.

We need people to have confidence in what we do and in the services we deliver. Our work in the implementation of Te Kōkiri is about ensuring improved access to services for people. It is, however, only as good as the individual contact that service users and families have with a mental health and/or addiction service.

Delivery of mental health and addiction services is acknowledged as being complex and challenging,

and for this reason alone, an 'attitude of helping' by all involved is essential. That attitude must be both considered and thoughtful. It requires a level of maturity and leadership which implicitly understands that a kind word and appropriate direction to the right place goes a long way towards someone's mental health.

If we are to inspire people to work in the mental health and addiction sector, it is important that we promote the wonderful rewards and job satisfaction that come from being able to support someone with mental illness or addictions issues. Our workforce are our role models.

Te Tāhuhu update – National co-existing disorders project

Te Tāhuhu: Improving Mental Health 2005–2015 (Minister of Health 2005) sets out 10 leading challenges that people face when working in the area of addictions and mental health.

These are further expanded on in *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015 (Minister of Health 2006)* with a number of tasks. One of these is ‘developing a coherent national approach to co-existing mental health and substance use/abuse disorders’. To achieve this, a project entitled ‘A coherent national approach to co-existing disorders’ has been initiated by the Ministry of Health.

What is the project about?

The term ‘co-existing disorders’, in this instance, refers to people who may experience alcohol and/or other drug issues as well as mental health issues. While some services are already working with co-existing issues, this project will offer specific assistance and guidance in the areas of workforce development, organisational development, infrastructure development and best practice.

Jenny Wolf, the Ministry’s Addictions Project Manager explains, ‘Co-existing disorders are being targeted because, anecdotally, it is estimated that 80 percent of mental health consumers have had a problem with substance use/abuse at some point in their lives. Of this 80 percent, 25–35 percent will have a co-morbid, **active** substance use disorder. From consumer feedback, it is evident that some people have been ‘ping-ponged’ between mental health and AOD [Alcohol and Other Drugs] services, with neither service picking them up. Some consumers have reported a lack of questioning from mental health services about substance use and some have indicated that they would like their concurrent issues to be addressed by the same service.’

Through Te Tāhuhu, the Ministry acknowledges that both mental health and AOD services need to be more dual-diagnosis capable. (See the table below identifying where AOD and mental health services need to become more ‘co-existing disorder capable’.) Additionally, AOD services need to be equipped to screen for problem gambling, and problem gambling services need to be equipped to screen for AOD use/abuse – and this will be formally developed over time.

What are the expectations?

The Ministry’s expectations are that services will look at how they can better respond to co-existing presentations. Accordingly, the following table sets out the four quadrants (low to high severity) of AOD and mental health issues, and the services which are expected to respond in each case.

Note: This is a stated expectation for specialist mental health and specialist AOD services. The primary care area requires further discussion.

The four quadrants	
Less severe mental disorder/ more severe substance disorder AOD services	More severe mental disorder/ more severe substance disorder Co-working and specialist dual diagnosis
Less severe mental disorder/ less severe substance disorder Primary care	More severe mental disorder/ less severe substance disorder Mental health

What will happen next?

In order to ascertain the supports that services will require to address this issue, the Ministry will hold discussions with consumers, funders, service leaders of mental health, AOD and problem gambling services, and will also hold key sector meetings (for example, with Child and Adolescent Mental Health and Addiction Services). One idea relates to the development of a guidance document that will provide information on models of best practice, systems integration and service composition. Additionally, a plan could be developed that would focus on a national approach, taking into account local differences, rather than a prescriptive 'one size fits all' approach. Key areas for discussion will be: service philosophy and service development, systems integration and workforce development.

Key partners

The Mental Health and Addictions Workforce Programmes (Matua Raki, Te Pou, The Werry Centre and Te Rau Matatini), the Mental Health Commission and the National Committee for Addiction Treatment (NCAT) are key partners with the Ministry, and are assisting to generate a plan as well as an infrastructure with which to drive it.

How can I have a say?

Should you wish to discuss any thoughts or comments with us, please contact:
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Know the people

Our Southern Team

Three members of the Ministry's Mental Health Group live in the South Island. They are Bevan Sloan and Heidi Browne from Christchurch, and Jesse Kokaua from Dunedin.

Bevan Sloan is the Acting Manager of the Mental Health Group's Systems Development team. His background is in accounting and previous roles within the group have included finance manager and senior business analyst. In his current role, Bevan is responsible for implementing the Mental Health Information Strategy 2005. This involves developing an integrated national information system to capture data across the mental health sector, including both DHB and non-governmental organisation (NGO) mental health and addiction services. The system is called PRIMHD, the Programme for Integration of Mental Health Data, and Bevan chairs the executive committee for its development. Bevan is also involved with the mental health performance improvement function and with the monitoring and reporting of mental health funding and service growth.



Heidi Browne is an information analyst in the Systems Development team. She has worked in the Mental Health Group for over four years. Heidi provides a variety of centralised data for mental health information requests, to inform policy development, service monitoring and for performance improvement.



Jesse Kokaua, a statistician and research analyst, is the sole Dunedin-based member of the Systems Development team. He has been with the Ministry of Health since 2000 and involved in a large range of projects requiring statistical input. Some of these include *Te Ora Ora: Pacific Mental Health Profile*, the Ministry's mental health Blueprint model and development of DHB service profiles. More recently he has been part of the Pacific research team for *Te Rau Hinengaro: The New Zealand Mental Health Survey* (Ministry of Health 2006). He is currently employed half-time with the mental health group and half-time with Public Health Intelligence where he is seconded to do further analysis of Te Rau Hinengaro.



Meeting the service improvement challenge with participatory action research

At the Ministry of Health's invitation, the following article was contributed by Associate Professor Wayne Miles, Director Waitemata District Health Board Knowledge Centre and Clinical Associate Professor, Auckland University.

Quality and safety has become central to the thinking of many practitioners, planners and funders of health care. From something akin to an optional extra, it is now assuming a day-to-day focus.

Reports, such as the recent one about significant events in New Zealand hospitals, are important in creating this focus. It is interesting to see the emergence of journals devoted to the topic (such as the BMJ group journal *Quality & Safety in Health Care*) and international conferences dedicated totally to the area.

It is topical, then, to review my experiences of the emergence in New Zealand of a culture of improvement in mental health services, especially those that utilise the principles of participatory action research (PAR) to create service change and to look at ways that such endeavours might be sustained and spread.

Through the Mental Health Commission, early in its inception, several projects were conducted that schooled local participants in the basic methodological principles of PAR and allowed local changes to occur. The Ministry of Health sponsored a range of initiatives across the country, based on the methods of service improvement developed by the National Institute of Mental Health in England. The latest endeavour is a collaborative project supported by the Ministry and run out of the offices of the New Zealand Guidelines Group, which aims to improve care for those who present at emergency departments with suicidal ideas or self-harm actions.

The learnings from these projects confirm what is emerging internationally, that is that these service

improvement projects based on PAR principles do impact positively. The key elements in all these endeavours are:

Participation: that is having all the people who are key to the outcome under consideration involved in the service change work. Often, this will mean creating environments where at least the health service user and their family/whānau, the clinicians delivering care and the managers running the services interact. All must have an equal part in the design of the process, the gathering of data and the decisions about what will happen.

Research: that is the careful and systematic gathering of relevant information that will help the group make considered decisions. It is crucial that this is well gathered and analysed in a non-biased way. It does not have to be numbers, often story is more useful, but it must be story that is open and freely gathered not slanted by the inquiry.

Action: the often neglected component of projects. This is not what is done BUT what is informed by the review of the assembled information by the full participant group.

PAR-based service improvement has four key strengths, and all are interrelated; the participation and collaboration, empowerment of all involved (especially those who in traditional systems have little influence), creation of new knowledge and organisational or social change.

What is becoming increasingly apparent from our local work, and that of overseas centres, is how crucial the provision of a small, focused, support capacity is for the design, operation and



Primary mental health care update

Since 2005, the Ministry has funded a number of primary mental health initiatives, with a total of 61 Primary Health Organisations (PHOs) now involved.

The interim evaluation report from the Wellington School of Medicine shows that the mental health of 80 percent of service users has improved. Importantly, the initiatives also have good access rates by Māori. Such findings help to justify the continued development of primary mental health care.

One thing that all the models have in common is that they introduce another level of care that people with mild-to-moderate mental health problems previously did not have as an option. Extended GP consultations, assessments by primary mental health co-ordinators and packages of care (for example, brief talking therapies) all represent an additional service 'step' between traditional primary health care (standard GP consultations) and secondary or specialist care. In other words, all of the models have moved towards a 'stepped care' approach (described below) to primary mental health service provision. There is now evidence for both the clinical and cost-effectiveness of stepped care models.

The Ministry is currently developing policy advice in which a stepped care model of primary mental health service provision is being considered. A stepped care approach is one in which service users' needs are matched with the least intensive, but effective, intervention. In this approach, people with mild-to-moderate mental health problems would be supported in primary health care through lifestyle advice (for example, diet, exercise, alcohol and drug use) and other self-help strategies. People with moderate-to-severe mental health problems would ideally have the option of either drug treatment or some form of talking therapy (along with lifestyle advice and support for self-care).

Further information about the stepped care approach and other activities of the primary mental health team can be found in the Primary Mental Health Update attached to this newsletter, or contact:

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sustaining of this type of work. I would like to see that, in New Zealand, we develop such a national resource that is expert in the use of the tools and that trains others to implement them. It would have two immediate benefits: work done would be most likely to create change and we would not have groups throughout the country re-inventing the wheel. This centre would not have any ownership of the areas of change or what change happens (that is, the content of the projects), it would purely input to the process.

Hudleson et al in *Quality & Safety in Health Care* (February 2008) note: 'quality improvement in healthcare organisations requires structural reorganisation and systems reform, and also the development of an appropriate organisational "culture"'. The New Zealand mental health experience shows that PAR-based change methods can create such shifts.

Contact: Wayne.miles@waitematadhb.govt.nz

Suicide prevention action plan launched

While it is encouraging to know that New Zealand's suicide rate has reduced by about 19 percent since the late 1990s, the Ministry is mindful that there are still too many New Zealanders taking their own lives and there is still much more we need to do.

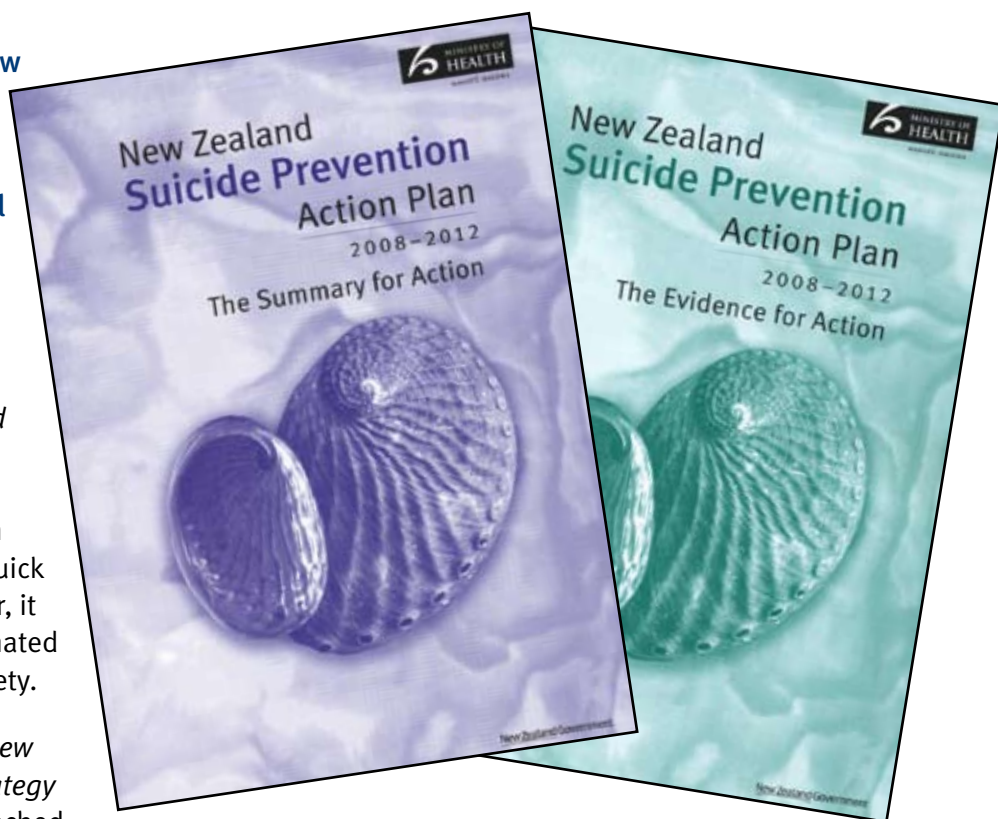
In view of this, *The New Zealand Suicide Prevention Action Plan 2008–2012* (the Action Plan), was released on 17 March, with the message that there is no 'quick fix' in suicide prevention, rather, it requires long-term and co-ordinated action across the whole of society.

The Action Plan builds on the *New Zealand Suicide Prevention Strategy 2006–2016* (the Strategy), launched in 2006, and is made up of two companion documents, designed to be read together. These are *The Summary for Action*, which outlines what the actions are, who will do them and by when, and *The Evidence for Action*, which discusses the evidence and context underlying the actions.

A range of suicide prevention initiatives is well under way across the country, and the Ministry of Health will continue to be the Government agency responsible for their co-ordination.

Examples of current suicide prevention initiatives include:

- raising awareness about depression and encouraging help-seeking
- improving the care and follow-up of people who have made a suicide attempt
- reducing the risk of suicide for at-risk children and young people
- supporting families, friends and communities following a suicide



- professional development for teachers to improve the mental health of the whole school
- improving co-ordination of suicide prevention activities within district health regions
- providing information about suicide and suicide prevention
- Māori community development for suicide prevention
- skills-based training in suicide intervention.

The Action Plan is available on the Ministry of Health website
www.moh.govt.nz/suicideprevention

Hard copies are available from Suicide Prevention Information New Zealand www.spinz.org.nz
Phone: (09) 300 7035

or Wickliffe
Email: moh@wickliffe.co.nz
Phone: (04) 496 2277.

The future for eating disorders services

The Ministry of Health has recently released (April 2008) the document, *Future Directions for Eating Disorders Services in New Zealand (Future Directions)*.

The term 'eating disorder' is commonly used to refer to one or more of a range of disorders with wide degrees of severity and duration, for example anorexia nervosa and bulimia nervosa. The disorders affect a small proportion of the population, and in some cases may require hospitalisation or other intensive treatments.

Primarily, *Future Directions* has been developed as a guide for District Health Boards (DHBs), as they seek to improve the range and effectiveness of services and supports for people with eating disorders. It is also available to the public through the Ministry's website (refer below). The document has a strong emphasis on community-based services and supporting people as close to their homes as is safely possible. It also encourages

DHBs to work together, wherever possible, to better address service user needs.

Future Directions stresses the need for eating disorders services that:

- provide smooth service delivery across primary, secondary and tertiary settings, easy transitions between services, and continuity of care
- provide effective early intervention
- provide a wider range of services and a multi-disciplinary approach to care
- enable service users to actively participate in the planning of their own recovery.

Future Directions for Eating Disorders Services in New Zealand is available at <http://www.moh.govt.nz>

For further information, please contact scott_connew@moh.govt.nz.

The 2008 New Zealand Mental Health Media Grants

Applications for the 2008 New Zealand Mental Health Media Grants, opened on 1 March and will close on 30 May 2008.

The grants, which were launched last year, seek proposals for projects that will help reduce stigma and discrimination by informing the public about mental health issues and experiences.

A grant pool of \$50,000 is available across two categories (journalism and creative) with grants of up to \$12,000 for each project. In 2007, the Media Grants attracted 12 journalism applications

and 30 creative applications, and out of those four recipients were chosen.

The grants are administered by the Mental Health Foundation and are funded as part of the Like Minds, Like Mine programme. They replace the Carter Center Fellowships offered to journalists in New Zealand from 2001 to 2005/6.

For further information about the Media Grants, contact the Mental Health Foundation:

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website: www.mediagrants.org.nz

INTRODUCING

new team members

Roz Sorensen, **Senior Project Manager**

The Mental Health Group is delighted to welcome Roz Sorensen who recently joined us as a senior project manager, based in Auckland. Roz is managing the review of the mental health nationwide services framework (in particular, the service cover document and service specifications) and also the policy work on mental health of older people and dementia.

Roz comes to the Ministry with a wealth of experience in the health sector at a senior level, ranging from charge nurse manager to senior positions in DHB provider arm and funding divisions. Immediately prior to joining the Ministry, she was Senior Project Manager, Regional Mental Health Team at the Northern DHB Support Agency.

In addition to being a registered general and obstetric nurse, Roz also has certificates in cardiothoracic nursing and in Te Ara Reo Māori, a Diploma in Business, a Masters in Health Management and is hoping to have her Doctorate in Nursing finished this year.

Frances Hughes, **Principal Advisor to the Office of the Director of Mental Health**

The Ministry recently welcomed back Frances Hughes, who took up a six-month contract as Principal Advisor in the Office of the Director of Mental Health. Frances has over 25 years' experience in the New Zealand health service and has played a major role in nursing leadership.

Over the last 20 years, Frances has been instrumental in the development of mental health nursing, both professionally, clinically and educationally. Known for her innovative style and strategic approaches to health care, Frances held the first Professor of Nursing position and was the Director of the Centre for Mental Health Policy, Research and Service Development at the University of Auckland.

Frances has also held the position of Commandant-Colonel of the Royal New Zealand Army Nursing core. She was the first nurse to be awarded the Harkness Fellowship in Health Care Policy and this allowed her to study US health policy. In 2005, Frances was made an Officer of the New Zealand Order of Merit for her services to mental health.



Feedback

The Ministry of Health's Mental Health quarterly newsletter highlights aspects of the Ministry's work.

If you would like to provide feedback to the Ministry, or to suggest mental health topics that you would like to see included in the newsletter, you are invited to contact the editor, Maureen O'Hara.

Your contact details

To update your contact details, or to be added to or removed from our mailing list, please also contact Maureen O'Hara.

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Other staff changes

Noleen Stretton, Advisor, Financial Monitoring

The Ministry recently farewelled Noleen Stretton, Advisor, Financial Monitoring. Noleen began with the Ministry two years ago and was originally based in Wellington before moving to the Christchurch office. During her time in the Ministry, Noleen was a key person for the co-ordination of the mental health pricing project. She was also involved in co-ordination of the Mental Health Group's performance functions and contract monitoring. With her family, Noleen has moved to Darwin. She will be missed, especially by the networks she created with DHBs in relation to the mental health pricing work.

Basia Arnold

Basia Arnold left the Ministry in February, after nearly 12 years, to take on the position of Policy Manager, Youth Justice in the Ministry of Justice. She came to the Ministry after 10 years of working as a clinical psychologist, mainly in the child and youth area, and has carried on her interest in children and young people during her stay at the Ministry. For six years, she was the mental health lead on the work associated with the Mental Health Information National Collection (MHINC) and recalls those days with fondness. 'We tried carrots, we tried sticks, and in the end, we learnt patience.'

Basia is probably best known for her leadership of the child and youth mental health sector at the



Ministry. Early on she and her colleague, Maria Cotter, started a process of quarterly meetings of people from the child and youth mental health sector to discuss issues of concern and to share ideas and information. Initially, there was some scepticism about whether these meetings would work, but, 12 years on, they are a key way in which the sector and the Ministry communicate with each other.

Basia has been a strong advocate of intersectoral work, believing that people working in mental health need to be involved with the social and justice sectors. She was involved in the development of the youth offending strategy and the intersectoral strategy for children and young people with high and complex needs, which led to the development of the High and Complex Needs (HCN) unit.

Most recently, Basia was involved in last year's restructure of the Ministry and has been the leader of the Across-Ministry Child and Youth team. This has brought together the disparate parts of the Ministry that have children and young people as a focus. While the interests of these groups are as diverse as oral health, immunisation and sexual health, with regular meetings, strong and supportive relationships are being built as people come together with the common goal of helping our young.

'Forming strong, trusting relationships with individuals in other agencies is the key,' Basia says, and it is something she put a lot of heart into. Her new position with the Ministry of Justice will allow her to continue this approach. We wish her every success.

Ministry of Health publications

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

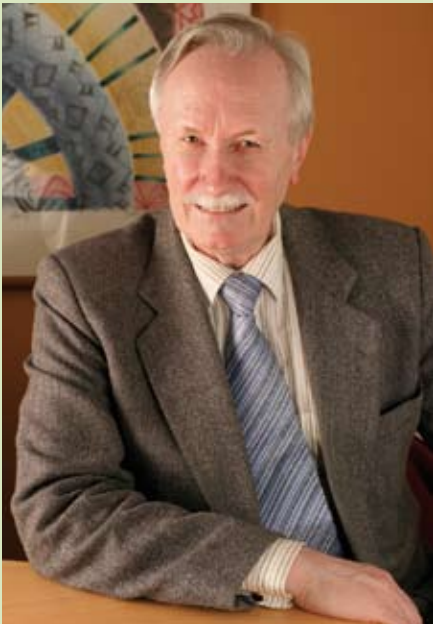
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Phone: (04) 496 2277 (Wellington)

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Email: moh@wickliffe.co.nz

Ministry of Health publications are also available on our website: www.moh.govt.nz



Chaplow's Column

David Chaplow

Director of Mental Health

'Recovery' – application or abdication?

A recent independent inquiry critically considered the concept of the 'Recovery Model', raising the following questions.

- Is 'recovery' expressed as a clinical model (as opposed to a philosophy)?
- How is 'recovery' expressed in service policy?
- In a risk-averse society, how can service-user autonomy be compatible with risk management, relapse prevention and coercion?

The word 'recovery' is now included in service specifications and action plans (for example, *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015* (Ministry of Health 2006). Services now boast that they are 'evidenced-based' and 'recovery-orientated'. Yet it is unclear whether these words are 'slogans' only or have implications for service structure or policy expression. Many confuse 'recovering' (the

process) with 'recovery' (the outcome). Hence the valid criticism (by consumers mainly) that efforts to measure recovery 'outcomes' fall short because of the failure to measure the recovery 'process', these being issues of wellbeing, hope and spiritual connection. It appears that the personal meaning to the individual is what is important in 'recovery'.

The recovery concept in New Zealand connotes enjoying a meaningful life in the midst of illness and encompasses the notions of meaning and purpose, taking responsibility, having a renewed sense of hope and destiny, having meaningful relationships and activities, making decisions about one's own treatment and life, being able to ask for help and being supported in all of the above.

It appears to me that the word 'recovery' means different things to different people and that the challenge for mental health services is to develop definitions, strategies and policies that harness the recovery capacities of service users in the context of addressing the expectations of the community. The promotion of one to the neglect of the other is to become polarised between harmful paternalism and over involvement on the one hand and harmful neglect and irresponsibly poor practice on the other.

Mental illness is an entity that can strike at the body and soul of a person and, depending on age and 'strengths', illnesses can be brief or long-lasting, and can have minor or devastating sequelae. There is an expectation in culture and law that when a person is sufficiently incapacitated by mental disorder, benign and helpful structures are placed around that person (by family, community and services) until capacity and competence are fully restored. It seems to me, therefore, that 'recovery' principles need clear definition and expression in our service policies and structures and to operate within a framework of safety.

References

Davidson L, O'Connell M, Tondora J, et al. 2006. The top ten concerns about recovery encountered in mental health transformation. *Psychiatric Services* 57(5): 640–45.

Meehan T, King R, Beavis P, et al. 2008. Recovery-based practice: do we know what we mean or mean what we know? *Australian and NZ Journal of Psychiatry* 42:177–82.