

Blueprint  
for Mental Health Services  
in New Zealand

How Things Need to Be

Mental  
Health  
COMMISSION

December 1998

Every care has been taken in the preparation of the information contained in this document. The Mental Health Commission cannot accept any legal liability for any errors or omissions.

Requests for further copies and any feedback on this document should be addressed to:

The Mental Health Commission  
P O Box 12 479  
Wellington

Ph: 04 474 8900 Fax: 474 8901  
email: [fryan@mhc.govt.nz](mailto:fryan@mhc.govt.nz)

Published by the Mental Health Commission,  
Wellington, December 1998  
ISBN: 0-478-11357-9

*Cover painting by  
Reimana Hobman, Pablos Art Studios, Wellington  
Cover design by  
Jamie Boynton, Putahi Associates Ltd, Wellington*

# Treaty Implications

As the founding document of New Zealand, Te Tiriti o Waitangi must be acknowledged and its principles incorporated in all aspects of health services provision for all New Zealanders, and in particular for tangata whenua. The Mental Health Commission acknowledges the significance of the Treaty as the original blueprint for interactions between the Crown and tangata whenua.

## Article One

Article One places an obligation on the Crown to consult and collaborate with iwi, hapu and Maori, as tangata whenua, in order to determine their attitudes and expectations with regard to the functions and operation of 'good government'.

With regard to the public funding and provision of mental health services, this requires meaningful consultation with Maori, and Maori involvement in the planning of mental health services.

As agents of the Crown, the Mental Health Commission developed this revised Blueprint after consultation with Maori, specifically with due regard to the impact it may have on Maori communities and organisations.

## Article Two

Article Two guarantees Maori rights of ownership, including non-material assets such as te reo Maori, Maori health and tikanga Maori, and confirms the authority of iwi, hapu and Maori, as tangata whenua, over their own property, assets, and resources. Article Two establishes the principle of 'tino rangatiratanga' – self-determination and jurisdiction for Maori communities and organisations – such that they can manage their own property, assets and resources. This Article directs agents of the Crown to negotiate directly with Maori social constructions such as iwi, hapu and whanau with regard to policy which impacts on them.

This Blueprint acknowledges tino rangatiratanga through specifications for more kaupapa Maori services and directions and guidelines which will provide increased opportunities for Maori to create and implement strategies and services which will improve mental health services and mental health outcomes for Maori.

## Article Three

Article Three guarantees Maori the same rights of citizenship and privileges as British subjects, including the rights of equal access to mental health services and to equal health outcomes, and the right to access mainstream mental health services which meet the needs of Maori.

This Blueprint acknowledges the need for equity of participation, access, and outcomes, and that these goals are far from being achieved at present.

# Mihi

E nga mana, e nga reo, e nga matawaka tenei te mihi nui kia koutou katoa.

Ka mihi ki to tatau kai hanga mo ana manaaki tanga ia tatau.

Kia whakapai hia toona nei ingoa.

Ka mihi ano ki o tatau tini aitua puta noa i Aotearoa.

Haere, haere moe mai i roto i Te Ariki.

Ka apiti hono tatai hono te hunga mate kia ratau.

Ka apiti hono tatai hono tatau te hunga ora kia tatau.

Tena koutou, tena koutou, tena koutou katoa.

## Foreword

In December 1997 we produced the *Blueprint working document* which was widely distributed.

This document builds on the initial Blueprint and includes changes as a result of feedback received from many people and organisations.

It sets out our translation of the levels of services and the changes required to fully implement the Government's National Mental Health Strategy.

This edition has emphasised strongly the need for a recovery approach in the delivery of services. There is an expanded section on meeting the needs of Maori and there are specific sections that address the needs of Pacific people. The needs of families of people with mental illness is also given greater recognition.

This Blueprint has a strong emphasis on the importance of respect for the rights and recognition of equality, in recovery from mental illness.

Good, responsive mental health services are not the only prerequisites to help people with mental illness to recover. Equally important are all the other aspects of a person's life, for example their family and friends, their work, their home. For most people who experience mental illness, interaction with the mental health service takes up only a fraction of their lives. Eliminating discrimination and creating an environment where people with mental illness fully participate is an essential component to recovery.

At this half-way point in the Commission's life we know what is needed to have a good mental health service in this country. There is agreement on what is basically required to move forward even though there may be differences within the sector on how this might best be done.

Now we are entering the implementation phase. New Zealand does have the ability to provide a high quality, well integrated mental health service that assists people to recover and treats them with respect and dignity. What is most needed to implement the Blueprint is a clear commitment to the funding required, an organised and coordinated approach to strengthening the workforce and a service funding plan. The necessary changes will be made if we all have the will to make them happen.

**Barbara Disley**  
Chair

# Executive Summary

This revised Blueprint for mental health services in New Zealand follows on from the *Blueprint Working Document, 1997*. It has been produced by the Mental Health Commission as its description of the mental health service developments required for implementation of the Government's National Mental Health Strategy.

- The focus of this Blueprint is on a recovery approach in service delivery. This approach is consistent with the guiding principles of the Strategy, which state that services must empower consumers, assure their rights, get the best outcomes, increase their control over their mental health and well-being, and enable them to fully participate in society. This focus on recovery reflects the shift of thinking which is happening throughout the sector.
- The recovery approach requires mental health services to work towards righting the discrimination against people with mental illness which occurs within services and in the wider community.
- The Blueprint has considered the needs of people affected by mental illness as the starting point for describing service quality requirements, essential service components, and resource guidelines.
- The Strategy requires mental health services to be delivered to the 3% of the population who at any given time are most severely affected by mental illness. The development of this percentage was done primarily for national and regional planning, and any translation of these figures for requirements at a local level must take into account the local population and its needs.
- The Blueprint gives detailed resource guidelines for achieving the percentage targets outlined in the Strategy. They are a current best estimate and will be revised as more information becomes available.
- Designing a mental health infrastructure or system that accommodates all types of providers is a challenge. Innovative service delivery is extremely important for mental health services in order to meet the needs of the people who use them, in the best possible way. An environment should be fostered in which people working in the mental health sector are encouraged to continually look at new and better ways of delivering services.
- Service users need to be able to move easily from one service to another, whether they be general health or mental health services, or services provided by other sectors.
- The Blueprint gives particular emphasis to meeting the mental health needs of Maori, as mental illness is now the number one health concern for Maori; priority must be given to developing effective services for them. This Blueprint has a new section dedicated to services for Maori.

- Mental health services for Pacific people have also been given special consideration in the Blueprint. The Commission supports increasing ownership and provision of services for Pacific people as the best means of achieving improvements in the quality of life for Pacific consumers.
- There are significant advantages when support for families is provided as part of a continuing care programme. Services are more likely to be effective when they utilise the knowledge and experience of the people closest to the person who is ill.
- Whilst there have been improvements in service delivery in the mental health sector, more needs to be done. This Blueprint for a well functioning sector is the Commission's view of the way forward.

# TABLE OF CONTENTS

<b>1</b>	<b>Introduction .....</b>	<b>1</b>
1.1	Purpose of the Blueprint .....	1
1.2	The recovery approach .....	1
1.3	The Mental Health Commission's role .....	2
1.4	The National Mental Health Strategy .....	3
1.5	Scope and role of this Blueprint .....	3
1.6	Monitoring .....	4
<b>2</b>	<b>Needs and Needs Groups .....</b>	<b>6</b>
2.1	Good outcomes occur when needs are met .....	6
2.2	The cost of mental illness .....	6
2.3	Prevalence of mental illness and health problems .....	7
2.4	Needs groups among those affected by serious mental illness .....	7
2.4.1	Adults .....	8
2.4.2	Families .....	9
2.4.3	Children and young people .....	10
2.4.4	Older people .....	11
2.4.5	Maori .....	11
2.4.6	Pacific people .....	11
2.4.7	People using forensic services .....	11
2.4.8	Other cultural and social groups .....	11
2.5	The general community's needs .....	12
<b>3</b>	<b>How Needs Should Be Met .....</b>	<b>14</b>
3.1	Philosophy and values for mental health services .....	14
3.2	Guiding principles .....	14
3.3	Recovery in action .....	15
3.3.1	What is recovery? .....	15
3.3.2	Mental health services and recovery .....	16
3.4	Discrimination .....	18
3.4.1	Discrimination is a barrier to recovery .....	18
3.4.2	Mental health services and discrimination .....	19
3.5	The National Mental Health Standards .....	21
3.6	Providers' responsibilities for quality improvement .....	21
<b>4</b>	<b>Who Should Meet the Needs .....</b>	<b>22</b>
4.1	Responsibility is shared by everyone and all sectors .....	22
4.2	Public health services' responsibilities .....	23
4.3	Primary health services' responsibilities .....	24
4.4	Mental health services' responsibilities .....	26

<b>5</b>	<b>Essential Service Components .....</b>	<b>27</b>
5.1	Access targets .....	27
5.1.1	Ministry of Health access benchmarks .....	27
5.1.2	Mental Health Commission service .....	28
	components and resource guidelines	
5.1.3	Service needs within age groups .....	29
5.1.4	Local and innovative solutions .....	30
5.1.5	Service components and resource .....	31
	guidelines in this document	
5.2	Services for adults .....	31
5.2.1	Services for people who are acutely unwell or in crisis .....	31
5.2.2	Services for people with severe ongoing or .....	32
	recurring illness, and those with short-term but significant mental health problems	
5.2.3	Services for people with ongoing severe mental .....	37
	health problems and disability support needs	
5.2.4	Alcohol and drug services .....	39
5.2.5	Resource guidelines .....	41
5.3	Services for younger people .....	42
5.3.1	Service components .....	42
5.3.2	Resource guidelines for services for children .....	44
5.3.3	Resource guidelines for services for youth .....	45
5.4	Services for older people .....	45
5.4.1	Service components .....	45
5.4.2	Resource guidelines .....	46
5.5	Forensic services .....	47
5.5.1	Service components .....	47
5.5.2	Resource guidelines .....	49
5.6	Mental illness prevention .....	49
5.6.1	Service components .....	49
5.6.2	Resource guidelines .....	50
5.7	Summary of all resource guidelines for all age groups .....	50
5.8	Services for Maori .....	52
5.9	Services for Pacific people .....	52
5.10	Providing services safely .....	52
5.10.1	The risk of harm .....	52
5.10.2	Managing safe services .....	53
5.10.3	Clinical responsibility for reducing the risk of harm .....	53
5.10.4	Protecting people and sharing personal information .....	54

<b>6</b>	<b>Services for Maori</b> .....	55
6.1	Introduction .....	55
6.2	Key issues .....	56
6.2.1	Increasing concern about poor mental health .....	56
6.2.2	Access .....	57
6.2.3	Culturally effective services .....	57
6.2.4	Funding and contracting constraints .....	58
6.2.5	Workforce development .....	58
6.2.6	Inappropriate performance measures .....	59
6.2.7	Discrimination and recovery .....	59
6.3	Essential service components .....	60
6.3.1	Meeting the needs of Maori .....	60
6.3.2	Mainstream services .....	62
6.3.3	Kaupapa Maori services .....	62
6.3.4	Maori advocacy and support services .....	62
6.3.5	Early intervention .....	62
6.3.6	Public health services .....	63
6.3.7	Services for Maori with mental illness and .....	64
	alcohol and drug problems	
6.3.8	Forensic services .....	64
6.3.9	Children and young people .....	65
6.3.10	Maori workforce .....	65
6.4	Translating principles into action .....	67
<b>7</b>	<b>Services for Pacific People</b> .....	68
7.1	Philosophy .....	68
7.2	Priorities for Pacific people .....	68
7.2.1	Workforce development .....	68
7.2.2	Models of service delivery which work for .....	69
	Pacific people	
7.2.3	Culturally appropriate audit tools .....	69
7.2.4	Research .....	70
7.2.5	Discrimination and recovery .....	70
7.2.6	Service provision .....	71
7.2.7	Evaluation and monitoring .....	72
<b>8</b>	<b>Bringing It All Together</b> .....	73
	<b>Providing a comprehensive continuum of services</b>	
8.1	Pathways for appropriate and timely accessing .....	73
	of services	
8.2	Providing services in rural settings .....	73
8.3	Service planning for local populations .....	74

<b>9</b>	<b>Infrastructure .....</b>	<b>76</b>
9.1	The necessity for co-ordination .....	76
9.2	Co-ordination for the individual .....	76
9.3	Co-ordination between agencies .....	77
9.4	Co-ordination between sectors .....	77
9.5	Mental health workforce .....	78
9.5.1	Mental Health Workforce Development Strategy .....	78
9.5.2	National Certificate in Mental Health (Support Work) .....	79
9.5.3	The role of the funder .....	79
9.5.4	Health providers .....	79
9.5.5	Accelerated workforce development for Maori .....	80
9.5.6	Pacific people's workforce .....	80
9.5.7	The consumer workforce .....	80
9.5.8	The workforce, recovery and discrimination .....	80
9.6	Evaluation and monitoring of service effectiveness .....	81
9.7	Mental health information .....	81
<b>Appendix I</b>	<b>.....</b>	<b>83</b>
	<b>Towards equality respect and rights for people who experience mental illness</b>	
<b>Appendix II</b>	<b>.....</b>	<b>90</b>
	<b>A matrix for translating principles into action for Maori mental health</b>	
<b>Appendix III</b>	<b>.....</b>	<b>96</b>
	<b>Implementation of the National Mental Health Standards</b>	
<b>Appendix IV</b>	<b>.....</b>	<b>99</b>
	<b>A summary of the resource guidelines by age group</b>	
<b>Appendix V</b>	<b>.....</b>	<b>103</b>
	<b>Development of the input resource guidelines</b>	
<b>Appendix VI</b>	<b>.....</b>	<b>110</b>
	<b>Glossary of terms</b>	
<b>Appendix VII</b>	<b>.....</b>	<b>115</b>
	<b>Contributors</b>	

# 1 Introduction

## 1.1 Purpose of the Blueprint

This document is a revision of the *Blueprint for Mental Health Services in New Zealand: Working Document* published in November 1997, and includes feedback from the sector and work completed by the Commission since then.

The Blueprint is a **National Mental Health Service Development Plan**, setting out the Commission's view of the qualitative and quantitative changes needed (what kinds and levels of service there need to be for different groups of people) to realise the objectives of the Government's National Mental Health Strategy. The Commission has developed this final Blueprint so that it can continue to carry out its responsibility for monitoring implementation of the Strategy.

This Blueprint provides a plan for a well functioning mental health system which ensures adequate and appropriate treatment and support for those affected most severely by mental illness. It should be noted that although a range of economic, social, educational, and cultural strategies are required to improve the mental health status of New Zealanders, this Blueprint does not directly address the wider problems in New Zealand society which contribute to poor mental health.

## 1.2 The recovery approach

Recovery is a journey as much as a destination. It is different for everyone. For some people with mental illness, recovery is a road they travel on only once or twice, to a destination that is relatively easy to find. For others, recovery is a maze with an elusive destination, a maze that takes a lifetime to navigate.

Recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment, and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them.

Historically, mental health services have failed to use a recovery approach. Recovery could never take place in an environment where people were isolated from their communities, where power was used to coerce people and deny them choices, and where people with mental illness were expected to never get better.

Some people have experienced recovery without using mental health services. Others have experienced recovery in spite of them. But most will do much

better if services are designed and delivered to facilitate their recovery. Virtually everything the mental health sector does can either assist or impede recovery.

The Blueprint builds on the National Mental Health Strategy by making more explicit the need for services to use a recovery approach, and to tackle discrimination, which is a major barrier to recovery. This emphasis on recovery and discrimination reflects an evolution in thinking which has occurred in the sector since the Government's Strategy was written.

### 1.3 The Mental Health Commission's role

The Commission was established by the Government in 1996. The Commission has the following functions:

- To monitor the implementation of the National Mental Health Strategy
- To reduce discrimination against people with mental illness
- To ensure the mental health workforce is strengthened.

The Commission's vision statement is:

*To ensure that people with mental illness live in an environment which respects their rights, provides fair and equal opportunities, and have access to a fully developed range of mental health services which is provided by the right combination of people responding appropriately to people's needs in order to achieve the best possible outcomes and recovery.*

Achieving this vision will ensure:

- the recovery approach is standard practice in all services
- discrimination is recognised as a barrier to recovery and is given zero tolerance by all services
- best practices are identified and routinely incorporated in all services
- outcomes are measured and service development is driven by best outcomes and recovery
- the Government's service access targets are achieved
- the National Mental Health Standards are achieved in all services
- funding and contracting processes are in place which promote comprehensive and integrated services, and collaborative approaches
- legislation is amended to allow more effective and efficient service delivery
- service users and mental health workers understand health consumers' rights and are partners in all decision making that affects service users
- there are sufficient people in the workforce with the necessary range of skills, knowledge, and attitudes to support the recovery of service users
- structures support service delivery, integration, and improvement
- a comprehensive range of services is available for all needs and population groups.

## 1.4 The National Mental Health Strategy

The National Mental Health Strategy was launched by the Government in June 1994 with the publication of *Looking Forward: Strategic Directions for the Mental Health Services* and developed further in the National Mental Health Plan, *Moving Forward: The National Mental Health Plan for More and Better Services*, (July 1997). The Strategy has two key goals:

1. *To decrease the prevalence of mental illness and mental health problems within the community*
2. *To increase the health status of and reduce the impact of mental disorders on consumers, their families, caregivers, and the general community*

and seven strategic directions:

1. *More mental health services*
2. *More and better services for Maori*
3. *Better mental health services*
4. *Balancing personal rights with protection of the public*
5. *Developing and implementing the national drug policy*
6. *Developing the mental health services infrastructure*
7. *Strengthening promotion and prevention.*

This Blueprint focuses on the mental health service developments required to meet the needs of people affected most severely by mental illness, and mostly addresses the National Mental Health Strategy's second goal; the first goal requires a much wider approach involving other sectors.

According to Health Funding Authority (HFA) estimates, mental health services presently serve about 1.5% of adults, and about 0.7% of children and young people.<sup>1</sup> The Government's Strategy aims to increase mental health services so that they are able to meet the needs of 3% of the population by 2004. This Blueprint focuses on the 'more and better' services needed to achieve these 3% access objectives.

## 1.5 Scope and role of this Blueprint

Some people would want this document to be very detailed and highly prescriptive, while others consider that a high level of detail would stifle innovation and create confusion with the role of the HFA. The Commission has chosen an approach mid-way between these two views; the Blueprint sets out a framework, key parameters, and principles for good service, and indicates how the detail should be determined in a 'bottom-up' way, starting with consideration of local needs and preferences.

Finding and using more effective approaches must be a key focus of all mental health services. Input resource guidelines do not and should not restrict the innovative ways in which services can be configured, delivered, or funded.

<sup>1</sup> Health Funding Authority  
National Mental Health  
Funding Plan 1998 - 2002,  
July 1998

The HFA should use the Blueprint to guide its funding decisions, and providers should use it to assess where further developments are required in their current services and practices.

## 1.6 Monitoring

The Commission is required to report to the Minister of Health on the implementation of the National Mental Health Strategy. In doing this it is required to include specific reporting on each of the following<sup>2</sup>:

- a) the extent to which the Ministry of Health has established, through negotiations with the HFA, specific targets and milestones for each of the strategic directions in the national mental health strategy;
- b) the Ministry's performance in–
  - (i) measuring delivery by the HFA, with respect to each of the strategic directions in the national mental health strategy, against the targets and milestones; and
  - (ii) responding to any failures by the HFA to meet the targets and milestones;
- c) the Ministry's performance in measuring progress by the HFA towards clearly communicating to providers, people with mental illness and their families and caregivers, and communities–
  - (i) the changes needed in order to implement the national mental health strategy; and
  - (ii) the roles to be played and the responsibilities to be undertaken by those providers, people with mental illness and their families and caregivers, and communities;
- d) the progress made by the Ministry and the HFA in promoting co-ordination and collaboration among providers to ensure that services that affect people with mental illness are provided consistently and effectively;
- e) the extent to which the Ministry, the HFA, and every other government agency that has responsibilities in relation to the delivery of services that affect people with mental illness and their families and caregivers is implementing the national mental health strategy–
  - (i) through the provision of services directly by it; or
  - (ii) through the standards it sets for the provision of services by parties which it funds to provide those services or from which it purchases services;
- f) the effectiveness of systems put in place by the Ministry and the HFA to ensure–
  - (i) that Government funding for mental health services is not diverted to other purposes; and

<sup>2</sup> Mental Health Commission Act 1998

- (ii) that Government expenditure on mental health services has demonstrable effects.

The Commission carries out these responsibilities by monitoring Ministry and HFA performance on an ongoing basis, in each of the aspects listed above.

*The Health Funding Authority National Mental Health Funding Plan 1998 – 2002* sets out how the HFA will implement the National Mental Health Strategy progressively over the next few years. Based on this plan, targets and milestones for progress to be achieved during 1998/99 have been negotiated between the Ministry and the HFA, and included in the HFA Funding Agreement for 1998/99.

Key parts of the Commission's monitoring include evaluation of the HFA's funding plan and the HFA Funding Agreement, so as to be able to report on whether these accountability documents provide for adequate progress to be made each year.

In addition, the Commission carries out periodic reviews of progress in the sector towards specific objectives and targets of the National Mental Health Strategy. In recent months this work has included: a review of progress in increasing access to new anti-psychotic medications; a review of Health and Hospital Services (HHS) policies and protocols relating to risk management and discharge planning; and a review of expenditure on mental health services. A review of consumer participation in the Health and Hospital Services, the Ministry of Health, and the HFA is currently being undertaken.

As well as formal reviews, the Commission carries out wide informal monitoring through visits and dialogue with consumers, families, service providers, the HFA, ministries, and government departments.

In this monitoring role, the Commission is also committed to working with the Ministry of Health, the HFA, and other Crown agencies to promote a better public understanding of mental illness, to reduce the discrimination and stigma suffered by people with mental illness, and to increase understanding of the goals and objectives of the National Mental Health Strategy. The Strategy's goals cannot be realised fully by mental health services alone. Achieving them requires a co-ordinated approach and complementary actions by all sectors, particularly social welfare, employment, housing, education, corrections, justice, and human rights (Human Rights Commission, Health and Disability Commissioner).

The Commission also works with key agencies to lift the image of the mental health sector as a career alternative, and to address mental health workforce issues.

# 2 Needs and Needs Groups

## 2.1 Good outcomes occur when needs are met

The primary goal of mental health services is to ensure good outcomes and recovery for those affected by mental illness. The good outcomes needed for recovery include the reduction of symptoms and disability, the reduction of discrimination, and the development of service users' personal resourcefulness in bringing about their own recovery.

Developing better outcome measures is a priority and the Commission will include evaluation of the development and use of outcome measures in its monitoring of the National Mental Health Strategy. Such outcome measures must be relevant to the concepts of health and well-being of each individual and group using the services; for example, services for Maori must have outcome measures relevant to Maori culture. The Commission will also be checking to see that the HFA and all providers are able to show that their decisions at all levels are based on maximising health outcomes and recovery.

The Mental Health Research and Development Strategy being formulated jointly by the HFA, the Health Research Council, and the Ministry of Health, with input from the Commission, includes a number of objectives related to the development and use of outcome measures.

The first step in planning for services focused on achieving improved outcomes is consideration of the needs of those affected by mental illness, including the needs of their family/whanau.

## 2.2 The cost of mental illness

Recent data from the World Health Organisation<sup>3</sup> shows that mental illness (including alcohol and drug misuse disorders) accounted for almost 11% of the total "global burden of human disease" in 1990; this is expected to rise to around 15% by 2020. World-wide, mental illness accounts for about 1.4% of all deaths and 28% of all years lived with disability.

In 1990, five of the ten leading causes of disability worldwide were psychiatric conditions: unipolar depression, alcohol misuse, bipolar affective disorder (manic depression), schizophrenia, and obsessive compulsive disorder.

<sup>3</sup> Murray C.J.L. and Lopez A.D., *The Global Burden of Disease*, Harvard University Press, 1996

## 2.3 Prevalence of mental illness and health problems

A New Zealand study tells us that around 20% of the population has a diagnosable mental illness (including alcohol and drug disorders) at any one time<sup>4</sup>. Around 3% of people have serious, ongoing and disabling mental illness requiring treatment from specialist mental health and alcohol and drug services. The equivalent figure for children and young people was estimated to be 5%<sup>5</sup>. The other 17% have less severe, moderate, and milder illnesses and problems, which usually do not need treatment from specialist mental health services.

The prevalence of mental illness may be higher among Maori. We know Maori have much higher rates of presentation to crisis, acute, and forensic services than non-Maori, and that they are much more likely to suffer from alcohol and drug disorders. There is an urgent need for studies to establish the true prevalence rates for Maori, and also for Pacific people. The Mental Health Research and Development Strategy is likely to address this need shortly; it includes an objective to ensure accurate measurement of the incidence and prevalence of mental health problems among Maori and among Pacific people.

Studies of prevalence and incidence of mental illness in New Zealand should be conducted at regular intervals to measure progress towards achieving the first goal of the National Mental Health Strategy.

## 2.4 Needs groups among those affected by serious mental illness

All those affected by serious mental illness have needs for good clinical care, and for a wide range of psycho-social assistance and support encompassing interpersonal relationships, income, housing, education, employment, transport, and leisure opportunities.

Each person's needs also include some which are specifically related to their age, ethnicity, or other individual factors. To be effective, mental health services (and public health and primary services) must have specifically tailored approaches to meet the specific requirements of the following *needs groups*:

- adults
- children and youth
- older people
- Maori
- Pacific people
- families
- other special groups.

The following sections look at the characteristics of each of these needs groups.

<sup>4</sup> Oakley-Browne M.A., Joyce P.R., Wells J.E., Bushnell J.A. and Hornblow A.R., *Christchurch Psychiatric Epidemiology Study*, Australian and New Zealand Journal of Psychiatry, 23:327-340, 1989

<sup>5</sup> *New futures: A strategic framework for specialist mental health services for children and young people in New Zealand*, Ministry of Health, May 1998

The essential service components required to meet each group's needs are outlined in Section 5.

#### 2.4.1 Adults

Many adults need support and education in order to assist them in their recovery. The scope of this will depend on their life circumstances and the nature of their mental illness.

Adults with serious mental illness have a range of differing needs.

##### *People with short term but significant illness*

Those who need access to clinical services for a limited time only.

##### *People who are acutely unwell or in crisis*

Those who are experiencing severe and acute symptoms who may need rapid access to a comprehensive range of crisis services (including when they need compulsory treatment).

##### *People with severe ongoing or recurring illness*

Includes those with recently diagnosed illness, those with illness which manifests periodically, and those with ongoing severe and complex illness. They need access to a range of services (including early intervention), within a framework which ensures continuity of care and follow-up.

##### *People with severe illness and disability, who have support needs*

Those who have support needs related to their living circumstances and level of functioning, in addition to their clinical treatment needs. They need access to comprehensive needs assessments, and to service co-ordination which ensures that their needs are met in an integrated way across the continuum of services.

A group of adults from among those most severely affected by mental illness have identified the need for services for them to give increasing focus to recovery and to provide for an improved quality of life<sup>6</sup>. They state that their main needs are for:

- more flexible accommodation options
- self help/consumer run employment and activity co-operatives
- more employment and education supports
- greater involvement in treatment and service decisions
- improved service responsiveness and integration
- a valued role in the community.

##### *People with needs for long term structured support in a safe environment*

A small group of people with ongoing problems whose behaviour poses risks to the community. In former times such people lived in psychiatric hospitals. The Commission believes there is a need for a new style of long-term safe accommodation for these people, with intensive support

<sup>6</sup> Harris C., *Rehabilitation/recovery: A report to the Mental Health Commission, 1997*

and education for recovery, run as part of general mental health services, within either hospital or community long-term care facilities.

*People with other special mental health needs*

People whose specific conditions and diagnoses require very specialised services. These conditions include: complex mental illness with severe alcohol and drug disorders; eating disorders; head injury with compounding mental disorders; borderline personality disorders; mental illness with intellectual disability; and 'mothers and babies'.

*People with alcohol and drug problems*

Those whose main mental health problem is drug or alcohol dependency, and who need access to alcohol and drug services (including methadone services).

## 2.4.2 Families

People with serious mental illness are not ill in isolation. Their families, extended whanau, and significant others, whatever they think about the illness, cannot escape being affected by it. The lives of people with serious mental illness are inextricably involved with the lives of those they love and care for, and the lives of those who love and care about them. Beyond the immediate family are other relatives, friends, neighbours, and workmates who may have a role in the life of the person and need, therefore, to be part of the healing or maintenance programme.

Some people with mental illness prefer not to involve their families in their treatment and support, when the families do not have direct care-giving roles. The extent to which family members are involved in treatment and support must be the decision of the person with mental illness. Mental health services need to respect their wishes.

Interventions that only include the individual with mental illness are making only a partial response and therefore can only ever be partially effective. Fully effective interventions acknowledge and assess the needs of everyone affected by the illness. Family-inclusive mental health services should:

- pay attention to the emotional, educational, social, and clinical needs of the whole family
- assess the strengths, problems, and goals of the person with a mental illness and key family members
- formulate a plan that co-ordinates all elements of a person's treatment and support (including medication) so that all involved, inside and outside the family, are working towards the same goals in a collaborative and supportive relationship, and the family is provided with the skills and strategies required to cope with the illness, to facilitate recovery, and to maintain good relationships within the family

- provide the person with a mental illness and key family members with information about the illness and its treatment.

Research findings have conclusively shown that there are significant clinical, social, and economic advantages in services being provided in this way.<sup>7</sup>

People involved in a person's life should aim for:

- exchanges of information, and having a process by which family members, the person with a mental illness, mental health workers, and clinicians learn from each other
- early development of an open and co-operative relationship between the family, the person with mental illness, and carers.

To achieve this, it is essential that these key people communicate and meet regularly.

As the lives of families and whanau are so directly affected by mental illness, and by the presence or absence of fully effective mental health services, it is essential that families and whanau participate in the planning of services at all levels.

Family needs are well recognised by Maori who advocate strongly for whanau support and involvement.<sup>8</sup> Whanau (family) stress can exacerbate illness and thereby increase the need for services for tangata whaiora (people seeking wellness). Identification and response to whanau need will lessen the impact of whanau disturbance on tangata whaiora, and lessen the need for services. Whanau strength can buffer the impact of illness on tangata whaiora, and thus lessen the need for services.

### 2.4.3 Children and young people

Children and young people's particular and different mental health needs require specially designed services which:

- have a developmental focus
- focus on emerging psychiatric problems
- focus on disorders which are specific to children and young people
- include intensive family involvement
- give particular attention to youth suicide risks
- offer strong consultation and liaison with other health and social services
- co-ordinate well with services from other sectors such as education and social welfare
- are delivered in an environment that recognises the special physical, cultural, and emotional needs of children and young people
- are easily accessible to young people, including being mobile.

<sup>7</sup> *Families as partners in care: World Schizophrenia Fellowship Strategy document, May 1998*

<sup>8</sup> *Maori mental health services: A proposal for change, Maori Development Commissions, September 1998*

#### 2.4.4 Older people

Older people need mental health services appropriate to their life stage and circumstances. They have different patterns of mental illness, which are often accompanied by loneliness, and physical frailty or illness.

#### 2.4.5 Maori

Maori health is a priority for improvement for the health sector, and all Crown agencies need to consolidate gains in Maori health development and accelerate Maori workforce participation.

The Commission recognises the Government's obligations under the Treaty of Waitangi, and totally supports the Government's objective of improving the health status of Maori so that the current disparities in mental health status between Maori and non-Maori are eliminated. The Commission regards the development of more and better mental health services for Maori as a crucial part of this Blueprint.

Services for Maori must be provided to reflect all three articles of the Treaty. This means provision of Maori services located within mainstream mental health services, and separate kaupapa Maori services, delivered by iwi and/or other Maori providers.

#### 2.4.6 Pacific people

Pacific people also have specific cultural needs. Services must acknowledge and affirm their languages, customs, values and cultural practices. Pacific people have identified that they need access both to mainstream services which affirm their cultures, and also to separate services run by Pacific people wherever there is sufficient local population.

#### 2.4.7 People using forensic services

Specialist forensic mental health services deal specifically with people with a mental illness (or suspected illness) referred to them by the courts or by prisons, or those people with a mental illness who are more likely to commit a criminal offence and therefore require more specialised services to ensure their own and others' safety.

#### 2.4.8 Other cultural and social groups

People from different cultural and social groups (such as refugees, asylum seekers, new immigrants, profoundly deaf people, and visually impaired people) should have access to mental health services which are planned and delivered in a manner sensitive to their needs and expectations. Culturally safe and sensitive services need to have:

- acceptance of individuals and groups with differences in language, attitudes, beliefs, and behaviour

- knowledge and understanding of other cultures' ideas about mental health
- cultural training of staff (including health professionals from overseas), and training of specialist cultural workers
- interpreters and client support workers
- provision of culturally acceptable and appropriate care and treatment options
- consideration of the role of family and a person's cultural or social group in cultural approaches and therapies
- information collection (including ethnicity) for service planning and evaluation purposes
- involvement of cultural representatives in the design, planning, delivery, and evaluation of services used by different cultural and social groups.

## 2.5 The general community's needs

Those not affected directly by mental illness need information, knowledge and assurance. They need to know:

- how to maintain good mental health and have information on mental illness
- how to support and assist those who are affected by mental illness
- how to identify and stop discriminatory behaviour towards people with mental illness
- that people with mental illness are individuals, and mostly lead positive lives
- that people have the same chance of being harmed by anyone in the community, as being harmed by a person with mental illness
- that mental illness, by itself, does not make people more dangerous than others are
- that mental health services do deliver effective treatment and support to all those seriously affected by mental illness, including secure facilities for the small number of people who are a risk to the community.

There is a widespread perception that people with mental illness are, by definition, a threat. This perception often leads to discrimination against all people with mental illness, which causes unnecessary pain and suffering, slows down recovery, and acts as a disincentive to the accessing of mental health services. But it is a wrong perception. Most people with mental illness pose no more risk to the safety of others than that posed by the general population. Overall, people with mental illness are at more risk of self-harm and harm from others than of harming others.

It is possible to identify a group among those who have a serious mental illness, who pose a slightly higher risk to others – those who have active and untreated symptoms, particularly when exacerbated by alcohol or drug use.

Mental health services must be sure that the services they offer are good, and that the community can see this and be confident in the system.

Identification of risks and strategies to improve safety in mental health services is discussed more fully in Section 5.10.

# 3 How Needs Should Be Met

## 3.1 Philosophy and values for mental health services

There are many ways in which services can be organised and delivered to meet the needs of people with mental illness. There is no one model which is ideal for all settings and for all people, but there are key values and principles which should underpin all services.

These values and principles may be easy to state, but putting them into practice is much more difficult. Services may have the right number of people, with the right skills and knowledge, in the right places, but they may still not fully respond to the needs of service users because the values and principles which should guide staff practice and behaviour are not being practised.

## 3.2 Guiding principles

*Moving Forward* sets out the following seventeen principles for guiding service delivery and development:

- encouraging services that **empower** individual consumers and their families/whanau and caregivers
- encouraging services that enable people of any age, culture, gender or individual interest to **fully participate** in society
- encouraging the development of **better specifications** for services purchased and provided to meet the needs of different groups of consumers and their families/whanau and caregivers
- ensuring **Maori involvement** in the planning of mental health services for Maori and in designing services appropriate to Maori needs
- ensuring **consistent safety standards** to protect the health of consumers and the public
- improving the **cultural safety** of services and ensuring that services accommodate cultural differences, especially Maori
- improving people's **access** to appropriate services of acceptable quality
- encouraging services to contribute to the **best possible outcomes** for consumers and their families
- respecting **personal dignity** and privacy
- encouraging services to be delivered in a way that **minimises disruption** to the lives of people with mental health problems and disabilities

- increasing the **sensitivity** of services and support systems to the changing needs and preferences of people
- giving priority to **cost-effective** services that provide the best value in terms of health gains
- encouraging services to be **integrated** at all levels and to be focused on achieving maximum wellness and independence for all consumers
- assuring the **rights of people** with mental disorders and disabilities within the context of overall community needs and rights
- encouraging programmes and services that enable individuals, families and communities to **increase control** and improve their mental health and well-being
- improving community understanding and acceptance of mental illness and helping to **create supportive social environments** for those who have a mental illness
- **working intersectorally** to encourage the development and implementation of policies and programmes that will help maintain and improve the mental health and well-being of communities.

The Commission supports these principles and their implementation throughout the sector.

### 3.3 Recovery in action

#### 3.3.1 What is recovery?

The concept of recovery can be applied to most beliefs about the origins and nature of mental illness – biological, psychological, social, or spiritual. It can be also easily applied to holistic approaches such as the Whare Tapa Wha model which identifies four dimensions of health – taha wairua (spiritual), taha hinengaro (mental and emotional), taha tinana (physical), and taha whanau (family). Some people believe the origins (or at least the prolonging) of mental illness does not just lie in the person with the illness but in the world around them. It may be their family, social injustice, unresponsive services, or a traumatic event. In these cases recovery does not just need to happen in the individual; the people and systems that contribute to the person's illness also need to change to enable that individual to live a better life.

Hope contains the seeds of recovery. It enables people to imagine a better life. People experiencing mental illness often lose hope for themselves. Others, such as their families or mental health professionals, may lose hope for them too. This loss of hope kills recovery.

Responsibility is also essential to facilitate recovery. It motivates people to do their best. People with mental illness who take responsibility for their lives can more easily learn from their mistakes, build on their successes, and

make positive choices. But personal responsibility needs to be matched with social responsibility. Families, communities, health and welfare agencies, providers of goods and services, local authorities, and the Government must support people in their recovery and ensure they do everything within their powers not to impede it. The people whose lives and decisions have an impact on people with mental illness need to act in a spirit of respect, equality, and inclusion.

Know-how is needed to sustain recovery. It enables people to put hope and responsibility into action. People with mental illness need to find their own understanding of mental illness and mental health issues. They need to know about the treatments and supports available to them. They will do better if they learn the skills to cope with life's difficulties and accumulate good experiences. Families, communities, service providers, and legislators need to learn to listen to the needs and aspirations of people experiencing mental illness, and acquire the insight and skills to find new approaches to assisting their recovery.

### 3.3.2 Mental health services and recovery

People working in mental health services must use a recovery approach in their work. The recovery approach is consistent with the guiding principles of *Moving Forward*, especially those which state that services must empower consumers, assure their rights, get the best possible outcomes for them, increase their control over their mental health and well-being, and enable them to fully participate in society. The approach is also consistent with the National Mental Health Standards, which build on the guiding principles and translate them into measurable criteria for service performance.

*Recovery happens when mental health services reflect the principles of the Treaty of Waitangi: partnership between the Crown and iwi, positive Maori participation, and active protection by the Crown of Maori interests.*

This means that the government will take responsibility for Maori health promotion and prevention of illness. The Government also needs to ensure that all mental health services provide good and culturally safe services for Maori, and that all Maori with mental illness have the opportunity to use kaupapa Maori services.

*Recovery happens when mental health services enable people to find the right help at the right time, for as long as they need it.*

This means it is easy for people to get into and to find their way around mental health services. People need an assessment of their problem that takes into account their life stage, culture, and other circumstances, and they need an understanding of how mental health services or other community services or supports can help. These things should happen quickly, especially if the person is in crisis. The treatments and supports they are given should continue for as long as they are needed.

*Recovery happens when mental health services give people the best help available, whoever they are and wherever they are.*

This means that consistently high quality services are offered by the mental health sector, in collaboration with other parts of the health sector and other community supports and services. All the treatments and supports that service users receive will give the most possible benefits and the least possible adverse effects.

*Recovery happens when mental health services provide for people in the context of their whole lives, not just their illnesses.*

This means services help people reduce unwanted symptoms of mental illness; however, they should also put as much effort into assisting people to counter their isolation, poverty, unemployment, discrimination, and anything they have lost in the wake of their mental illness. Services should tailor their responses to people's varying life stages, cultures, and life-styles. Reducing symptoms alone is not enough to ensure recovery.

*Recovery happens when mental health services protect service users' rights and treat them with respect and equality.*

This means mental health services offer the most possible independence and choice to service users in their treatment and the support they need in their recovery. They involve service users as equals in all decisions made within the services that affect users' lives. Mental health services should provide the least restrictive setting and use the least possible coercion and restraint. When service users are unhappy with a service, they must have a fair and easy process for making complaints.

*Recovery happens when mental health services are staffed by people who are compassionate and competent to assist people in their recovery.*

This means the mental health sector collaborates with other sectors in training the workforce to have a focus on recovery, so that services can recruit people with as much knowledge and skill in facilitating wellness as in treating illness. The cultural backgrounds of people working in mental health services should reflect the cultural backgrounds of people using the services. To be effective and empowering, people working in mental health services need manageable working conditions and the support required to maintain their own wellness.

*Recovery happens when mental health services enable people with mental illness to take on competent roles.*

This means people with experience of mental illness are given every opportunity to use their competence in the mental health sector. As individuals, they take an active part in their assessments and in decisions about their treatment and support. As a collective, they are involved in the planning and evaluation of services at all levels. People with experience of mental illness, with the right aptitude and skills, should be encouraged to seek employment in mental health services, and the

mental health sector should support the consumer movement to develop support networks and consumer-run services. When service users take up these kinds of competent roles, they assist their own recovery - and through the role models they offer, they also assist the recovery of others.

*Recovery happens when mental health services can prevent people from using them unnecessarily or from staying in them for too long.*

This means the mental health sector, in collaboration with other sectors and the rest of the community, works to identify and improve the personal risk factors and the social conditions that contribute to the development of mental illnesses. People developing mental health problems need early intervention to reduce the risk of long-term, disabling illness. People currently using services need recovery education to reduce their future dependence on mental health services. This should include education on mental illness and health, treatments, crisis planning and prevention, maintaining a healthy lifestyle, countering discrimination, rights and self-advocacy, communication and problem solving skills, using support networks, and using community resources to find such things as work and housing.

*Recovery happens when mental health services can look outward and assist people to find and use other community services, supports, and resources.*

Mental health services exist to carry out specialist tasks and roles the rest of the community is unable or unwilling to perform. Services should never try to replace natural communities; instead, they must start to see themselves as a part of the community, just as the community must start to see mental health services as part of itself. The biggest barrier to this happening is discrimination. People working in mental health services need to understand that, for people with mental illness, recovery means having the same rights and responsibilities as other citizens. And they need to promote this understanding in other parts of the community.

## 3.4 Discrimination

### 3.4.1 Discrimination is a barrier to recovery

One of the biggest barriers to recovery is discrimination. That is why stopping discrimination and championing respect, rights, and equality for people with mental illness is so important. It is as important as providing the best treatments or therapies. Please refer to Appendix I for exits from the Commission's *Map of the journeys*.

Discrimination erodes people's life chances. People with mental illness are sometimes subjected to ridicule, harassment, and abuse. They may have to contend on a daily basis with negative images of people like them in the media, films, literature, and conversation. They are likely to be feared and avoided because of their perceived violence and unpredictable behaviour.

Their expressions of anger and pain can be dismissed by others as symptoms of their illness. They are sometimes subjected to excessive pity and the belief that their lives are sad and have little value. They are sometimes told they will never get better. They know that if they talk about their experience of mental illness they may face rejection. Or they may be simply forgotten or ignored, and denied access to the opportunities most citizens take for granted, such as an adequate income, decent housing, work, family life, and a valued place in their communities.

People with mental illness can experience discrimination in any interaction they have with any other human being. These people may be their families, neighbours, employers, the police, judges, health professionals, government officials, community welfare agencies, other people with mental illness, landlords, bank managers, insurance agents, politicians, journalists, friends, partners, immigration officials, workmates, lawyers, bureaucrats, or sports associates, anyone.

And people with mental illness, in painful collusion with others who discriminate, often see themselves as others see them.

Discrimination stunts recovery whereas respect, rights, and equality for people with mental illness help to feed recovery:

- Discrimination treats people as objects without full human status. Recovery happens when others treat people with mental illness as equally human.
- Discrimination excludes people from full participation in society. Recovery happens when people have a secure sense of belonging, and have valued roles in their communities.
- Discrimination perpetuates untruths about people, and people with mental illness often feel they have to hide their 'difference' from the rest of the world to be acceptable. Recovery happens when society stops tolerating the untruths about people with mental illness and makes it safe for people to be open about who they are.
- Discrimination punishes people with mental illness for something they did not choose. Recovery happens when people with mental illness feel no shame and know that they are accepted and valued by others.

### 3.4.2 Mental health services and discrimination

The Commission advocates zero tolerance of discrimination. This means refusing to accept it, in any shape or form. A discrimination free environment is necessary if the Government's Mental Health Strategy is to be implemented and the mental health workforce is to be strengthened.

Recent government policy documents such as the Ministry of Health's *Looking Forward, Moving Forward*, and *National Mental Health Standards*, and the Health and Disability Commissioner's *Code of Rights* set out the mental health sector's responsibilities for righting discrimination.

In summary, government policy demands that the mental health sector must actively eliminate discrimination against service users by:

- ensuring that people using mental health services are given respect, equality, and rights protection, and involvement in decisions at all levels
- working with other sectors to prevent discrimination which may contribute to poorer mental health
- removing the discriminatory barriers to people accessing mental health services
- removing discriminatory barriers to people with mental illness participating fully in society.

Government policy recognises that the mental health sector is both part of the problem of discrimination, and part of the solution. As the mental health sector begins to treat all people with dignity and respect, it will be more able to help right the discrimination against people with mental illness by others in the wider community.

It is widely acknowledged that discrimination generated by the mental health sector against people using services is a major issue. At the policy and funding levels, discrimination has historically contributed to services that exclude people from society and to the chronic under-funding of mental health services. At all levels, discrimination leads to decision-making by the workforce without the involvement of service users. At the individual level, service users often complain that mental health workers fail to give them respect, protection of rights, and equality.

It is almost inevitable that when people experience discrimination from others, they will internalise the messages they are given. The mental health workforce must recognise this, and develop a recovery approach that gives service users hope, a sense of self-worth, and a sense of belonging.

Some service users are part of the mental health workforce although many do not openly identify as people with experience of mental illness for fear they will be discriminated against by their colleagues. They often work in traditional professional roles. Others use their service user experience as a way into the workforce and often work in newly created advocacy, support, or advisory roles in consumer run organisations or mainstream services. The workforce development needs of both these groups must be recognised and addressed at all levels.

The mental health sector has huge potential to develop an advocacy role to right discrimination against service users by people in all sectors of society. The workforce needs to model positive attitudes and behaviour towards service users. The sector also has some responsibility to alert the community to other forms of discrimination (such as on the grounds of ethnicity or gender), which can negatively affect people's mental health. The sector also needs to remove the barriers to people disclosing their mental health

problems or seeking help because of their fears of discrimination.

Discrimination affects the whole mental health sector. Eliminating it will encourage an environment where mental health services get a fair share of the resources, where mental health workers are valued as much as other health professionals, where they feel they do make a positive difference to people's lives, and where morale is high. When mental health workers are themselves valued and respected, they will create an environment of respect, equality, and rights for service users.

### 3.5 The National Mental Health Standards

The Ministry of Health published *The National Mental Health Standards* in June 1997<sup>9</sup>; they are expected to be achieved by all providers by 2001, and provide the quality parameters for the service components described in this Blueprint. The HFA and providers need to clearly identify how they will move towards the achievement of the Standards over the next three years, including how full implementation of the Standards will be resourced.

Services must continue to improve and the Standards will need to be reviewed to make sure that positive change is promoted. The Ministry of Health, the HFA, mental health providers, and consumers need to work together so that the Standards are fully integrated into all monitoring and audit processes and that they are regularly revised to keep pace with evidence based practices.

### 3.6 Providers' responsibilities for quality improvement

In addition to achieving and maintaining the National Mental Health Standards, all providers need to operate continuous quality improvement programmes with a focus on recovery and improving outcomes for people with mental illness. Such programmes can benefit significantly from co-operation between agencies, peer support and review, and using the advice of people with mental illness as a guide to improving services.

Quality improvement will be assisted by:

- co-ordination between agencies which will provide processes for information sharing, and the identification and dissemination of best practices
- the assigning of responsibility for oversight and assistance with quality and practice issues in local areas.

The HFA may need to provide incentives for such programmes.

Clear protocols need to be developed to guide providers in situations where they have serious concerns about the quality of service provided by another agency.

<sup>9</sup> The Standards are listed in Appendix III

# 4 Who Should Meet the Needs

## 4.1 Responsibility is shared by everyone and by all sectors

Everybody has a responsibility to treat people experiencing mental illness with respect. Those who are in a position to make decisions affecting the lives of people with mental illness – whether they are employers, landlords, media, neighbourhood groups, or providers of goods and services – must ensure that people with mental illness have equal opportunities and that their rights are protected. The mental health sector must spread this message out into the community, backed up by the active involvement of agencies such as the Human Rights Commission and the Health and Disability Commissioner.

The HFA programme to counter stigma and discrimination against people with mental illness will help the wider community and all the service sectors understand their responsibilities.

All areas of public policy and all sectors have an impact on the nation's mental health; the most direct impact comes from health, housing, welfare, work and income, education, employment, justice (including courts and corrections), police, local government, and community agencies.

Improving mental health services alone will not solve all mental health problems; the very best outcomes can only be achieved by all sectors making a commitment to contribute to the mental health needs of New Zealanders. Good mental health requires the elimination of violence, abuse, poverty, and inequity, and the promotion of opportunity, education, and participation in all aspects of life. Other sectors have a key role in creating this environment. Provision of services for people with mental illness by providers outside the mental health services are a way of creating greater gains for people with mental illness. Responsibility for providing the broad range of supports and recovery options required rests not only with health, but also with other sectors. Services such as accommodation, employment, vocational training, or recreation that are provided or funded by housing, employment, or local government are as important to the recovery of people with mental illness as those services provided by mental health services. The mental health sector needs to actively encourage the development of partnerships with other sectors to assist them in their responsibilities.

One of the seventeen principles underpinning *Moving Forward* is that the mental health sector should be:

“Working intersectorally to encourage the development and implementation of policies and programmes that will help maintain and improve the mental health and well-being of communities.”

The spirit of this principle needs to be adopted by all sectors. It is the responsibility of the Ministry of Health and the HFA to ensure that this happens. One way of achieving this is for new policy proposals in key sectors to include mental health impact assessments, incorporating evaluation of the likely effects of the proposals on progress towards the national mental health goals.

## 4.2 Public health services' responsibilities

The costs of mental illness to individuals and the community are likely to increase substantially in the next twenty years.<sup>10</sup> Stemming and reversing this tide requires more than effective and innovative clinical interventions for those who already have early signs of disorders, and prevention programmes for those at risk. While some serious disorders are not easily prevented, others can be, including alcohol and drug problems. Other examples include some types of depression, some suicides, and a number of the disorders which result from poor social circumstances, poverty, abuse and violence, alcohol and drug influences, and discrimination and alienation.

Maori are disproportionately represented in the statistics for preventable disorders, and strong public health initiatives are urgently needed for Maori to empower communities to address these problems. A fuller discussion of the role public health services can have in Maori health is in Section 6.3.6.

There are a number of policy and discussion documents which the Commission believes should influence future service provision. For example, it is well documented that:

- those young people who display early signs of conduct disorder are more vulnerable to later alcohol and drug disorders, mood disorders, and risk taking behaviours including suicide<sup>11</sup>
- Maori show higher rates than non-Maori for self-harm; structured education and family/whanau support programmes can minimise this risk<sup>12</sup>
- being a victim of violence and sexual abuse increases the likelihood of later mental illness. Public health initiatives aimed at reducing violence in all its forms could prevent later mental illness and psychological distress.

The Government's strategy for the prevention of youth suicide<sup>13</sup> provides a framework for understanding suicide prevention, and suggests ways of reducing suicide rates. While the importance of more effective mental health services and clinical intervention is acknowledged, the strategy also emphasises the importance of wider public health initiatives. The strategy for Maori clearly identifies the importance of strengthening Maori participation in all aspects of society.

<sup>10</sup> Murray, C.J.L. and Lopez A.D. (Eds), *The global burden of disease*, Harvard University Press, 1996

<sup>11</sup> *New futures: A strategic framework for specialist mental health services for children and young people in New Zealand*, Ministry of Health, May 1998

<sup>12</sup> Durie M.H., *Puahou: A five part plan for improving Maori mental health*, paper delivered to Maori Mental Health Summit, August 1997

<sup>13</sup> *In our hands: New Zealand youth suicide prevention strategy: Kia piki te ora o te taitamariki*, Ministry of Youth Affairs, Ministry of Health, Te Puni Kokiri, 1998

A five point plan has been proposed for a public health approach to strengthen mental health for Maori:<sup>14</sup>

1. Strengthening, identifying, and providing young people with access to the institutions of Maori society such as language, land, and a strong whanau
2. Active participation in society and the economy with increased participation in education and employment
3. Rrealignment of health services with Maori realities which includes increased access to effective primary health services, and increased emphasis on mental health in general primary service provision for Maori
4. A strengthened Maori workforce including professionals and community workers working at all levels
5. Increased autonomy and control so that communities are empowered to develop their own approaches to problems.

### 4.3 Primary health services' responsibilities

Primary health services need to recognise their responsibility to provide treatment and support for the majority of people affected by mental illness and mental health problems, and to deliver on those responsibilities. They need to:

- be more accessible to those with mental health problems
- use a recovery approach
- have zero tolerance for discrimination against people with mental illness
- take increasing responsibility for identifying and treating people with less severe mental health problems
- provide more adequate follow-up to people who have ongoing yet stable mental health conditions
- take a lead in co-ordinating service delivery for these people
- provide information, advice, and support on how to protect and promote individuals and families' mental health
- promote better understanding of mental illnesses, both within the workforce and in the community
- foster mutual support and self-help initiatives for people affected by mental illness.

Primary health care must provide more effective support to the families and carers of people with mental illness. They often have concerns of their own, which must be identified, and for which early support must be offered.

There have been a number of pilot programmes around the country which have aimed to enhance the contribution made by primary health services to

<sup>14</sup> Durie M.H., *Puahou: A five part plan for improving Maori mental health*, paper delivered to Maori Mental Health Summit, August 1997

mental health delivery. The knowledge gained from these pilots must be made available throughout the sector, particularly information on the conditions (and training) required for the full involvement of general practitioners. The issue of user charges for primary health services must also be addressed; these charges can be a barrier to the use of primary health services (by encouraging people with mild or moderate illness to try to access mental health services, when they could be treated more appropriately by their primary medical services), or indeed stop people going to any service at all.

Primary health care should be able to provide ongoing clinical care after specialist services have provided assessment and diagnosis, treatment plans are in place, support is available, and conditions are stabilised. Best primary mental health care will not necessarily save money, it will result in better care, people being identified and referred earlier, and more comprehensive follow-up and support.

General practitioners are a first port of call for accessing mental health services. However, there are many in the community (particularly among the Maori and Pacific people communities), who do not use general practitioner services, and thus do not have access to the pathways into mental health care early enough. Primary health services need to address this fundamental problem.

Many of the primary mental health services are offered by community social service agencies or school counselling services. They are important contributors to the spectrum of comprehensive mental health services and they should be included in mental health service planning. The increasing range of Maori primary health services must be able to meet mental health needs, including having the capacity to provide early clinical interventions when appropriate.

The HFA is establishing a full service development plan for primary mental health services by July 1999<sup>15</sup>. This plan will provide for:

- improved identification, assessment, treatment, and referral by primary mental health care services for people who have early signs of mental illness
- increasing access to effective primary mental health services for Maori (particularly rangatahi), and for Pacific people
- increasing access to effective primary mental health services for young people, including assessment of suicide risk
- encouragement of links between all primary health services and other community agencies
- discussion of any changes that may be required to the General Medical Services subsidy, access to pharmaceuticals, or funding of psychological therapies
- workforce development and education.

<sup>15</sup> Health Funding Authority  
National Mental Health  
Funding Plan 1998–2002,  
July 1998

#### 4.4 Mental health services' responsibilities

Mental health services are responsible for delivery of a range of services to those affected most severely by mental illness, and for provision of specialist assistance and support to families and other services caring for people with mental disorders. All mental health services in all areas must include the capacity for:

- using the recovery approach
- zero tolerance of discrimination
- early intervention
- assessment and treatment
- crisis response
- risk identification, risk reduction, and safety
- consultation and liaison between primary services and other secondary health services
- recovery education and support, including self-help options
- protecting service users' rights.

These components must be co-ordinated to ensure all people with mental illness receive services which meet their needs.

In addition mental health services must be able to provide the specialised clinical responses and support (or access to such specialised expertise at a regional centre) for the particular needs of individuals (such as those outlined in Section 2, Needs and needs groups).

# 5 Essential Service Components

## 5.1 Access targets

### 5.1.1 Ministry of Health access benchmarks

The Ministry of Health has set access benchmarks for adults and for children and young people. These access benchmarks are discussed in both *Looking Forward* and *Moving Forward*. The Ministry's access benchmark for adults, set in 1994, is based on the Tolkien Report<sup>16</sup> and is in line with the best evidence that was available at the time. The 3% benchmark for adults (over 18 years old) is for access to specialist mental health services in any one month. It does *not* include access to drug and alcohol services.

The Ministry's access benchmark of 5% for children and young people (0 - 19 years), set in 1996, is based on the McGeorge Report<sup>17</sup>. This *does* include access to drug and alcohol services.

The Ministry has now confirmed that, for current planning purposes, it supports using access targets for different age groups for children and young people<sup>18</sup>. These targets, outlined in the table below which represent prevalence trends, equate to almost 3% access. This is in line with the 1996 report of the Mental Health Strategy Advisory Group which suggested that a realistic access target to specialist child and youth mental health services of 3% by the year 2000/01 be set, moving to 5% in subsequent years. The 5% target, by the year 2005 is incorporated in *Moving Forward*.

Ministry of Health access targets will continue to be revised, as better information and evidence becomes available.

Age group	Access target (percentage of the total population)
0-9	1.0%
10-14	3.9%
15-19	5.5%
20 plus	3.0%

<sup>16</sup> Andrews G., *The Tolkien Report: A description of a model mental health service*, University of New South Wales at St Vincent's Hospital, Sydney, Australia

<sup>17</sup> McGeorge P., *Child, adolescent and family mental health services*, Ministry of Health, 1995

<sup>18</sup> *New futures: a strategic framework for specialist mental health services for children and young people in New Zealand*, Ministry of Health, 1998

### 5.1.2 Mental Health Commission service components and resource guidelines

The Commission has developed resource guidelines for services to provide access to mental health services (including alcohol and drug services) for 3% of the total population over any six month period, as confirmed by the Commission’s review of the current services funded by the HFA, and estimates of need based on international epidemiological studies. This need varies between age groups, in line with the Ministry’s access targets quoted above.

The core service components and resource guidelines in this Blueprint are intended for national planning (including estimating total national mental health funding and resource needs) and for monitoring purposes (including measuring the adequacy of national progress in service growth). The Commission considers that these revised resource guidelines are the current best estimate of the resources required to meet the Strategy access targets contained in *Moving Forward*. It is intended that the guidelines should be used primarily for estimation of the services required at the national level, and for regional populations. They are not intended for use for smaller populations. Please refer to Section 8 ‘Bringing it all together: providing a comprehensive continuum of services’, and Section 5.1.4 ‘Local and innovative solutions’.

Present resource levels are well below what is required to meet the Ministry’s access targets which are far from being achieved. The HFA expects to make good progress in substantially increasing access and services over the next three years, but at the end of this period there will still be a long way to go, as is shown in the following figures for current and planned access from the *Health Funding Authority Mental Health Funding Plan 1998-2002*:

	Children and youth (0-19 years)	Adults (20 years and above)
National access targets	3.0%	3.0%
Estimated current access	0.7%	1.5%
Planned access 2000/01	1.6%	2.2%

### 5.1.3 Service needs within age groups

The need for services is different for each age group, and the Commission examined the evidence about patterns of mental illness in different age groups. They have differing levels of likely prevalence of all kinds of mental illness, experience different types of illness, and have differing levels of multiple diagnoses. For example the mental illnesses found in children differ from those seen in adults, and youth have the highest levels of co-existing disorders.

The resources required for any group of people depends on the total number of people in that group, and the number of people within the group likely to experience a mental health disorder. The following table shows both the percentage of the total New Zealand population in each of four age groups, and the percentage of those likely to experience a mental health disorder requiring treatment (based on the available epidemiological research<sup>19</sup>):

Mental health services for:	Age (years)	Proportion of NZ population	Proportion of disorders requiring treatment
Children	0-14	23.0%	14.2%
Youth	15-19	7.1%	11.9%
Adults	20-64	58.1%	67.0%
Older people	65 and over	11.8%	6.9%
<b>TOTAL</b>		<b>100%</b>	<b>100%</b>

These figures clearly show that youth are more affected by mental illness than any other age group; they are only 7% of the population but account for almost 12% of those who have a mental illness requiring treatment.

Mental health service resources should be distributed between age groups on the basis of the estimated number of people likely to have a mental illness and requiring treatment in each group, and the number of people in that group. The following table shows an analysis of the New Zealand population by age group, by HFA region, and by ethnicity<sup>20</sup>:

<sup>19</sup> These figures have been estimated from a range of epidemiological studies. More information is contained in the *Review of the Resource Guidelines*, Mental Health Commission, 1998.

<sup>20</sup> Source: Department of Statistics, revised population estimates for 1998

Age (years)		HFA Region				Total
		North	Midland	Central	Southern	
0–9	Maori	48,750	47,520	35,710	14,680	146,660
	Pacific Island	34,650	2,680	8,340	2,600	48,270
	Other	124,300	74,700	96,950	93,220	389,170
10–14	Maori	19,350	20,310	14,850	6,380	60,890
	Pacific Island	12,740	1,160	3,370	1,200	18,470
	Other	61,510	39,030	48,580	47,220	196,340
15–19	Maori	17,520	17,990	13,830	6,280	55,620
	Pacific Island	12,410	1,170	3,420	1,180	18,180
	Other	61,870	35,440	48,150	51,040	196,500
20–64	Maori	93,810	89,270	68,710	30,620	282,410
	Pacific Island	69,210	6,200	19,080	5,920	100,410
	Other	610,680	323,730	450,410	440,060	1,824,880
65 plus	Maori	5,390	6,620	4,010	1,690	17,710
	Pacific Island	4,420	4,40	1,100	2,80	6,240
	Other	123,890	83,040	104,290	104,230	415,450
Total		1,300,500	749,300	920,800	806,600	3,777,200

#### 5.1.4 Local and innovative solutions

No single service model is the most appropriate in all situations. What is best will vary according to local needs and conditions. Local funding and service provision decisions must be based on meeting local needs in the most effective, flexible, innovative, and creative ways, so as deliver the best possible recovery for service users.

The Commission expects the focus to be on the changes needed to achieve the best possible outcomes for those accessing mental health services in each locality, not on locking into any particular service model or set of numbers. Always, we need to seek better ways of doing things.

The Commission’s resource guidelines should not stifle local innovation. The guidelines are based on a regional model of service provision, in line with the way services are funded and provided currently. The HFA National Mental Health Funding Plan is also based on this model.

General practitioners and other primary health services are increasing their services to people with mental illness, and this trend is expected to grow. This is acknowledged and supported in this Blueprint through increased resource guidelines for specialist mental health service liaison, and consultation and support for primary health services.

Various models of integrated service delivery are being explored around the country. These need to be tested through pilot schemes and evaluated so that future funding and service configuration decisions can be based on sound evidence of how well each model contributes to recovery.

Recovery requires greater integration of all health services at local levels, and with other (non-health) community services. Better mental health cannot be achieved by mental health services alone. In developing the resource guidelines in this section it has been assumed that other sectors are doing their bit to support effective provision of mental health services.

The number of people in the local population is only one factor to be considered in determining local service needs. The distribution of mental illness and mental health service needs does not always match the distribution of the total population. For example, people with serious mental illness and/or significant disability are more likely to live in the larger cities than elsewhere in New Zealand, and the number of staff needed locally for general hospital liaison is dependent on the number of hospital beds in the local area. Similarly forensic services may be provided for the area in another location. Historical service level in the local area is also an important factor.

It is the responsibility of the HFA, providers, and consumers to develop the best possible mix and model of services to meet local needs, within the resource constraints.

#### 5.1.5 Service components and resource guidelines in this document

In the following parts of this section, brief descriptions of service components are given with tables which outline the overall resource guidelines for the mental health services necessary to serve 3% of the population over a six month period. Firstly, specific services for each of the four age groups referred to above are discussed, and secondly, regional specialist services which are not age group specific.

Resource guidelines in this Blueprint are expressed as service inputs required per 100,000 population, assuming this 100,000 has the same age and ethnic mix as the overall New Zealand population.

## 5.2 Services for adults

### 5.2.1 Services for people who are acutely unwell or in crisis

Services for this group are focused on rapid response, assessment, stabilisation, ensuring safety, and reduction of the risk of harm. They must include an ability to respond effectively to the needs of Maori.

#### Crisis teams

Specialised clinical services capable of 24 hour, 7 day, mobile rapid response, providing emergency assessment, stabilisation, treatment, and referral to other services. Crisis teams serve all age groups.

#### Crisis respite

Home based or other community based service options for people in crisis as an alternative to admission to an acute inpatient service.

#### Acute inpatient services

Services for people with severe and acute symptoms who need 24 hour care in a safe environment.

#### Intensive inpatient services

Hospital services for people with severe and acute symptoms who require a short period of intensive care and treatment.

### 5.2.2 Services for people with severe ongoing or recurring illness, and those with short-term but significant mental health problems

Services for those with newly diagnosed severe illness, those with intermittently recurring severe illness, and those with ongoing illness who are prone to periodic severe episodes. These people's needs are very varied and are best met by multidisciplinary community based teams. The community teams need to be able to engage and work effectively with all groups of service users and their families and extended whanau. In some circumstances where very specific skills are required, separate specialty teams may be desirable. However there is a trade off between greater specialisation and the opportunities for a more holistic approach and the greater continuity of care offered by a combined team. Presently, Maori are under-represented in the use of community services; these services can address this issue.

People in this group also need to access the services described in Section 5.2.1 when they are acutely unwell or in crisis.

#### A Local level services

The following services should be available everywhere.

##### Medium-term and extended inpatient services

Hospital services (as an adjunct to community team services) for those with high disability support needs whose complex symptoms and high support needs require 24 hour treatment and support.

### Community teams

Multidisciplinary clinical teams, working from a range of settings, and providing assessment, treatment and therapeutic interventions, care co-ordination, and key worker support. If not provided for separately, community team services must include special services for:

- early intervention for those experiencing psychotic illness for the first time (aimed at reducing the development of on-going illness)
- active outreach and follow-up for those who are difficult to engage
- primary care and general hospital liaison for those with mental illness or health problems not accessing specialist mental health services
- people with combined alcohol and drug and mental health problems.

Local community teams also link to and refer to regional centres for specialised regional services, such as those for people with severe anxiety disorders, borderline personality disorders, eating disorders, and 'mothers and babies'. There must be appropriate provision for Maori needs, including separate kaupapa Maori services where possible.

### Access to new treatments

People with serious mental illness must have access to effective modern pharmaceuticals and psychological treatments, such as cognitive behavioural therapy, when there is evidence that these approaches would confer greater benefits than other treatments. An example of this is recognised in the National Mental Health Strategy which has a specific objective and targets for increasing access to new anti-psychotic medications. These new drugs have fewer side-effects, enable much greater improvements in people's health and lives, and reduce the wider economic and other costs of severe psychosis. New anti-psychotic drugs should be prescribed for all those for whom they are clinically indicated. The Commission endorses the targets for access to new atypical anti-psychotic medications set out in *Moving Forward*.

### Early intervention services

All services working with people who have developing mental illnesses need to practise early intervention strategies aimed not only at preventing or limiting relapses, but also at reducing or preventing the development of high support needs or disability. In some circumstances these services may be offered separately from community teams. Whilst some of these services have a time limit on their use (for example, 12 months), ideally they should be available to people for as long as they require an intensive level of input in order to prevent illness episodes, maintain a full life in the community, and prevent disability. These services should have one clinical staff person for each 10-15 service users.

### Primary care services liaison

Consultation and liaison with primary care services including general practitioners. The majority of people with mental health needs who want to access any service will access primary care services. As mental health services expand, part of their role will be to work with primary care providers to assist them in the detection and management of mental health problems. Consultation and liaison services include assistance with supervision and training of staff in primary care agencies, including training in identification of suicide risk. Mental health community teams may also offer clinics in primary care practices and provide on-site advice and input.

Services for people with mental illness and alcohol and drug disorders  
Services for people with mental illness and alcohol and drug problems (up to 60% of mental health service users) and education for all people with mental illness about the risks of alcohol and drug use and the likely exacerbating effect on their mental illness.

In view of the high number of people with alcohol and drug problems using mental health services, all community mental health staff need to be able to assess and treat mild to moderate alcohol and drug disorders. In addition, professional staff with special expertise in mental illness with severe drug or alcohol disorder must work within the community mental health teams, seeing the most seriously affected people. They also provide consultation and liaison with other mental health and alcohol and drug services. Provision of such specialist expertise within the general mental health service is preferable to the establishment of separate dual diagnosis services.

Community teams need to have very good links with alcohol and drug services, with strong consultation and liaison, and continual development of skills in both services.

Maori present more often with dual diagnosis problems than other people<sup>21</sup>. Dual diagnosis services must be effective for Maori, and include kaupapa Maori approaches.

### General hospital liaison

Consultation and liaison with non-mental health services within general hospitals.

The resource needed for general hospital liaison depends on the range of services provided within the local general hospital. Research has shown that a significant number of people who attend for physical intervention often have underlying psychiatric problems. Investment in general hospital liaison can have a significant impact on reducing unnecessary physical interventions. Liaison services also need to have a role in ensuring that people with mental illness using general health services are not discriminated against and get the attention they need for their physical problems.

<sup>21</sup> *Nga ia o te oranga: Trends in Maori mental health, 1984-1993*, Te Puni Kokiri, 1996

## B Regional specialist services

Community mental health services need to be able to meet needs, either from within the team, or by linking people to separate specialist services at local or regional levels. Whether a service is most appropriately provided locally or from a regional centre depends on a number of factors.

Local specialist teams may be appropriate where the demand for a service is relatively high, and there are very specific skills required. Early intervention, primary liaison, and dual diagnosis services have been listed above as examples of services which may be provided within a general community team or as specialised services at the local level.

Regional specialist services may be appropriate where the demand for a service in local areas is very small, and very specific and relatively rarely required skills are needed. When they are located only in regional centres, these services must provide outreach to other areas. The following services are examples of those which may be more appropriately provided at a regional level.

### 'Mothers and babies' services

Services for 'mothers and babies' are required for three groups: those mothers who develop puerperal psychosis; those who suffer from severe post-natal depression; and those who have a pre-existing ongoing mental illness. Special expertise is needed to provide appropriate services for this group (including services for Maori), and may be provided at the regional level, with consultation and liaison provided to local services. Services should include respite care options. The resource guidelines include provision for a specialist service in each region.

### Eating disorders services

Most people with eating disorders are treated within general mental health services. A small number of people with severe problems require access to specialist services which should be provided as regional services, with consultation and liaison provided to local services. The resource guidelines include provision for a specialist service in each region. A residential inpatient resource has been included; there are currently a variety of models for how this might be used, from hospital inpatient to community facility. It is important that safety is the paramount consideration for people with eating disorders as they are sometimes physically very unwell because of the disorder.

### Services for people with disabling personality disorders

People with personality disorders, particularly those with severe and disabling personality disorders, are heavy users of mental health services, but are currently not served well. The purpose of a regional service is to provide assessments, treatment planning and co-ordination, and some specialist psychotherapy. The intention is that this should be a specialist resource to assist general mental health services and would not have long-term users.

#### Services for people with severe anxiety disorders

Each mental health service (including alcohol and drug services) and primary health services should have the capacity to recognise, assess, and provide at least initial treatment for all anxiety disorders. However, people with severe anxiety disorders can often not be assisted adequately within general mental health services and are often high users of mental and physical health services. The purpose of a regional service is to provide assessments, treatment planning and co-ordination, and some short-term specialist treatments.

#### Services for people with mental illness and with an intellectual disability

Services for people who have both a mental illness and significant intellectual disability require high levels of support. Special expertise is needed to provide appropriate services for this group, which should be provided at the regional level, with consultation and liaison with smaller centres, and with services for people with intellectual disability.

#### Services for people with head injury or neurological disorder with behaviour problems and/or psychosis

Special expertise is needed to provide appropriate services for this group. Some special residential services may be needed also, in hospitals or the community. How much resource is needed depends on what other recovery, education and support services are available. Specialist expertise should be provided at the regional level, with consultation and liaison with smaller centres. ACC is responsible for the funding and purchase of services for people whose problems result from injury. Local service planning for this group needs to be carried out in close consultation with ACC.

#### Services for profoundly deaf people who have a mental illness

People who are profoundly deaf have their own culture and their own patterns of mental illness. They need special services and expertise (including interpreter services), which should be provided as regional services. The resource guidelines include provision for 4.5 full-time-equivalent mental health professionals (with interpreters) nation-wide to provide a consultation and liaison service for the deaf community and mental health services. These staff should be located near the main deaf communities (Auckland and Christchurch) in a primary healthcare setting or a resource centre for the deaf community.

#### Services for refugees who have a mental illness

Mental health services for refugees are most effective when they are well integrated with other services. The resource guidelines include provision for a mental health component to a comprehensive service that also includes physical health, housing, employment, education, translation services, and immigration services. The service would provide mainly consultation and liaison services for other refugee and mental health services. These services should be concentrated where refugees are living in significant numbers (for example, Auckland and Wellington).

### 5.2.3 Services for people with ongoing severe mental health problems and disability support needs

People in this group need access to the general assessment and treatment services described above (in 5.2.1 and 5.2.2) as well as the following support services.

#### Needs assessment

Comprehensive assessment and review of the housing, vocational, income, and general support requirements needed to assist each individual in their recovery. Needs assessment may be provided as part of comprehensive and integrated community services.

#### Service co-ordination

Co-ordination of individual support services, and negotiation of access to services and community resources required for identified individual needs.

#### Home based support service

There are many ways in which people's needs for assistance with housing and daily living can be met, from support for individuals who live alone or share their home with family/whanau or friends, to services for people whose homes are in intensively supervised residential services in the community or hospitals. The range of service options should include specific choices for Maori, including kaupapa Maori services and services to meet the needs of those with concurrent alcohol and drug problems.

Four service descriptions are given here; they should be interpreted flexibly to include other services designed to meet housing and support needs. The resource guideline numbers given later should also be interpreted flexibly for these categories, in order to deliver the most appropriate package of care for each individual. Over time, there needs to be a shift away from residential services towards more provision of services to people in their own homes.

#### *1 Mobile support for people living in independently*

Mobile support services for people with mental illness living with their families or in independently rented or owned houses. These services provide support and education for recovery designed to assist that person live well independently, including skills for self management and participation in, and integration with, the person's community.

#### *2 Day time support for people living in homes run by residential providers*

Daily support from experienced non-clinical staff, or 24 hour support from non-clinical staff (who may sleep on the premises).

3 *Full time support for people living in homes run by residential providers*

Twenty four hour awake support by non-clinical staff with some clinical staff input, or intensive 24 hour support by a mix of clinical and non-clinical staff. These services include 24 hour access to medication, behaviour management strategies, daily consultation with a clinical team, and harm reduction strategies.

4 *Residential intensive long term support*

Services which provide a structured closely supervised environment and assistance with behaviour problems, and where residents may live indefinitely. Services provide 24 hour awake staffing including some clinical staff cover at all times.

Employment and education support

Services providing people with mental illness with access to education, vocational training, and work opportunities, and supporting them in their use of these opportunities, with the primary goal of continuous paid employment in the mainstream workforce.

Provision of education, and employment services is not the responsibility of the health sector. However, support to access and use these services is essential to achieving better health outcomes and recovery, and leads directly to reduced levels of illness and disability.

Health services need to ensure people affected by mental illness have access to employment and education services. Specific strategies are needed to address this issue of access for Maori.

The HFA should facilitate collaboration between different sectors to ensure these needs are being met at both national policy and local service levels.

Support and education for recovery

Services which offer advice on strategies and skills, and information on:

- mental health
- mental illness and how to cope with it
- crisis planning and prevention
- maintaining a healthy lifestyle
- best use of mental health services and community resources
- countering discrimination
- rights and self-advocacy
- communication and problem solving
- cultural education and support for Maori.

### Outreach (Rural)

Mobile services for people in rural areas, offering elements of clinical consultation and liaison, employment and education support, and support and education for recovery for individuals, their caregivers and primary health services.

### Planned respite

Alternative care and support services to provide:

- a) relief for family and caregivers, or
- b) prevention of relapse where current living arrangements are deemed to be contributing to a deterioration, and a short term alternative may be preventative.

### Consumer advisory services and consumer run initiatives

Consumer advice and input into the planning, development, and monitoring of services, and into the recruitment and training of staff. These services can also provide peer support, education and training services, and employment initiatives, and are run by consumers for consumers, with a focus on recovery.

### Family advisory services and family run initiatives

Peer support, and education and training services, run by family members for family members.

The Commission endorses the national objective and targets for increasing consumer and family responsiveness and participation which are set out in *Moving Forward*.

## 5.2.4 Alcohol and drug services

These services are for people whose primary diagnosis is drug and/or alcohol dependency. There is a higher prevalence of alcohol and drug problems among Maori, and therefore a particular need for kaupapa Maori alcohol and drug services.

Some people with a dual diagnosis of mental illness and alcohol and drug problems may present to alcohol and drug services rather than mental health services, and may not want to be associated with mental health services; alcohol and drug services need to be capable of meeting these people's multiple needs too. Alcohol and drug service staff need to have training in the assessment and management of mental illness and have access to consultation and liaison support from mental health services.

### Community assessment and treatment (non-residential services)

Specialist, time-limited alcohol and drug counselling and other therapeutic services to individuals and families. Services include:

- comprehensive assessment and treatment planning
- provision of a range of time-limited treatment interventions (for individuals and groups)
- support for home-based detoxification
- day programmes
- referral to other services as required
- liaison and consultation with other services, particularly mental health services, corrections services, and other health and social services
- provision of alcohol and drug information and harm reduction strategies
- services working to a Maori kaupapa.

### Methadone treatment

Comprehensive services for people who are dependent on opioids, run in accordance with the National Protocol for Methadone Treatment in New Zealand (1996). These services focus on harm reduction and stabilisation of the service user's health status, and include specialist methadone clinics, and general practitioner methadone services for those whose dependency condition has been stabilised.

The Commission endorses the national objectives and targets for methadone treatment which are set out in *Moving Forward*.

### Residential services and treatment

Intensive and targeted community residential treatment programmes of varying length of stay and intensity:

- Short-term programmes of up to 4 weeks duration
- Medium-term programmes of 4-16 weeks duration
- Long-term programmes of 16+ weeks duration, using a therapeutic community model
- Supported living
- Respite services.

Some kaupapa Maori programmes must be included.

### Detoxification Services

A range of services of varying intensity which assist people with drug and/or alcohol dependency to safely negotiate a process of substance withdrawal. Services include:

- ***Home and community detoxification***  
Support for detoxification in community settings. Service includes assessment, facilitation of medical input if indicated, support, and monitoring.

- ***Social detoxification***  
Detoxification in a supervised and supportive residential facility. Service includes assessment, medical intervention, medication as indicated, non-medical interventions including complementary therapies, supervision, monitoring, and support.
- ***Medical detoxification***  
Detoxification in an inpatient medical facility in which acute or potentially acute physical complications of detoxification are medically managed.
- ***Dedicated inpatient detoxification***  
Detoxification in a dedicated inpatient facility for those with complex drug or alcohol dependency and related issues.

### 5.2.5 Resource guidelines

The following table gives an overview of the resources and services considered necessary to provide a comprehensive service which meets the needs of 3% of the adult population (aged 20-64 years). More detail of these guidelines is given in Appendix IV.

The guidelines include provision for some specialist services which may be available at a regional level only.

Service component	Resource guideline per 100,000 total population
Inpatient services	24.8 beds or 'care packages'*
Community based day and residential services	69.1 beds or 'care packages'
Community based mental health teams	49.22 full time equivalent staff (FTEs)
Community support services	30.5 FTEs
Consumer advisory services and consumer run initiatives	3.4 FTEs
Families advisory services and family run initiatives	2.1 FTEs
Access to newer anti-psychotic medication	175.7 people
Alcohol and drug detoxification services	2.8 beds or 'care packages'
Alcohol and drug residential treatment services	9.1 beds or 'care packages'
Alcohol and drug community based teams	13.95 FTEs
Methadone treatment	140 places

\* *The most common measure for these services resources is 'beds'; however, a shift to the provision of 'care packages' is needed.*

Where services for adults include youth or older adults, resources will need to be increased accordingly. Numbers in general community mental health teams will be reduced by the numbers in separate specialty services provided locally or regionally, and in kaupapa Maori services, and in Pacific people services.

## 5.3 Services for younger people

### 5.3.1 Service components

Children and young people need their own separate specialist mental health services which are provided in an age-appropriate environment and cater for their developmental needs. In these services, the guiding principles of the National Mental Health Strategy and the recovery approach need to be incorporated in an appropriate way. Service provision for younger age groups differs from service provision for adults in the following ways:

- developmental needs of the child or young person must be taken into account
- good communication with children and young people takes more time and different skills
- the range of disorders is different, although the symptoms of many ‘adult’ disorders are apparent from around the age of 15
- some disorders, such as depression, manifest differently in younger people
- the need for care to be provided within the context of family and whanau is even greater than for other age groups
- a higher level of co-ordination and involvement with non-health services is required.

Dedicated specialist services for children and youth – Child and Adolescent Mental Health Services (CAMHS) – are needed throughout New Zealand. Where possible they should be provided as two separate services – child and family services for those aged around 0-14 years and Youth Specialty Services (YSS) for those aged 15-19 years. Age ranges for these services, and for access to adult services, must be interpreted flexibly, according to individual needs, developmental stage, and maturity, rather than by chronological age.

The 15-19 years age group has the highest likely prevalence of mental illness and higher levels of need for services than any other age group. This reflects both the type of disorders which are more prevalent in this age group and the effects of alcohol and other substance use and dependence.<sup>22</sup>

Services for youth are much the same as those provided for children, but require a different focus and skills, and must include specific alcohol and drug services. To be accessible and appropriate to youth, these services may

<sup>22</sup> *New futures: a strategic framework for specialist mental health services for children and young people in New Zealand*, Ministry of Health, 1998

need to be physically separate from services provided for younger age groups. However it is essential that CAMHS, YSS, and adult services work closely together to ensure all children and youth are helped in ways appropriate to their ages and developmental stages. Boundaries between services need to be flexible.

Specific requirements of youth services are:

- strong knowledge of the developmental stages of adolescence, and skills in dealing with them
- skills in identifying and treating alcohol and drug abuse and dependence
- skills in identifying and treating illnesses which are likely to first present in this age group, such as schizophrenia
- skills in identifying and managing young people at risk of suicide
- effective liaison with both child and adult mental health services, and with other agencies, to ensure the most appropriate supports and treatment processes are put in place for each service user
- skills in working effectively with families/whanau.

Maori have a much younger demographic profile than non-Maori, and have specific needs for CAMHS services. They need to make provision to meet the cultural needs of Maori, either through direct involvement of Maori clinical staff within the service or by access to cultural support from other Maori services. Where possible kaupapa Maori services for children and young people should be developed.

Pacific people in New Zealand are also a relatively young population, and have specific cultural needs. In areas where there are large numbers of Pacific people services need to make specific provision for this, and employ cultural advisers to work with Pacific families.

CAMHS and YSS must have the following service components:

#### Crisis Services

Services must be able to respond effectively to crises. Initial crisis contact and response may be provided by adult services with 24 hour consultation and liaison support from CAMHS and YSS.

#### Acute inpatient

Services for children and young people with acute and severe symptoms, who need 24 hour treatment in a safe and/or secure environment. Inpatient facilities need to be separate from those for adults and staffed by clinicians with specific experience and skills in inpatient assessment and treatment of children and youth.

Secure inpatient

Services for young people who have offended, which provide the full range of psychiatric and mental health services within a secure inpatient environment.

Community team – child and family

Multidisciplinary teams providing professional assessment, treatment, and support (including for alcohol and drug disorders) for children, young people, and their families and extended whanau. Consultation and liaison with primary and paediatric services, and with other agencies dealing with children and young people, such as Education, the Children, Young Persons and their Families Service (CYPFS), and other health agencies are needed. Day programmes may be provided.

Respite services

Residential services for children and young people whose therapeutic needs require that they have a break from their normal living situation. Includes both planned and crisis respite.

Community day and residential services

Dedicated day and residential programmes for children and young people providing for those whose social support system is seriously deficient and/or whose condition requires intensive monitoring and supervision.

5.3.2 Resource guidelines for services for children

The following table shows guidelines for the resources that should be available for mental health services for children and young people aged 0-14 years and their families. As noted above, this upper age limit must be interpreted flexibly (see Appendix IV for details).

Service component	Resource guideline per 100,000 total population
Inpatient services	1.3 beds or 'care packages'
Community based day and residential service	3.7 beds or 'care packages'
Community based mental health teams	16.6 FTEs

In each region a proportion of the resource guidelines should be allocated to kaupapa Maori services, according to the proportion of Maori in the local population. Similarly, a proportion should be allocated to Pacific people services.

### 5.3.3 Resource guidelines for services for youth

The following table shows guidelines for the resources that should be available for mental health services for youth aged 15-19 years. Once again, these age limits must be interpreted flexibly (see Appendix IV for details).

Service component	Resource guideline per 100,000 total population
Inpatient services	3.0 beds or 'care packages'
Community based day and residential service	8.35 beds or 'care packages'
Community based mental health teams	20.75 FTEs
Community support services	2.2 FTEs
Advice and support for consumers and families	0.4 FTEs
Access to newer anti-psychotic medication	31.2 people
Alcohol and drug detoxification services	0.2 beds or 'care packages'
Alcohol and drug residential treatment services	0.9 beds or 'care packages'
Alcohol and drug community based teams	0.9 FTEs
Methadone treatment	10.0 places

In each region a proportion of the resource guidelines should be allocated to kaupapa Maori services, according to the proportion of Maori in the local population. Similarly, a proportion should be allocated to Pacific people services.

## 5.4 Services for older people

### 5.4.1 Service components

Older people (aged 65 and above) who have a mental illness also require services which provide for their needs in a way which takes account of the particular life stage they have reached. For some, including those who have had a mental illness for some time, their mental health service needs will be the same as those of younger adults. Other older people presenting with symptoms of mental illness will have specific needs associated with their aging and need to be assessed by people with special skills in the psychiatry of older people. There should be flexibility about whether a particular person's mental health needs are provided by specialist services or by adult mental health services. Services may be provided by an integrated mental health service covering all adults (regardless of age).

Mental health services for older people are currently the responsibility of mental health services in some HFA regions but not in others; in some Hospital and Health Services, services for older people are within mental health services, in others they are combined with older people services. Any arrangement is acceptable, so long as there is clarity in the purchasing and provision of services, the considerable advances being made in psychiatry for older people are drawn upon, and there is close consultation with others working in this area.

Services for older people have the following core service components:

Acute inpatient assessment and treatment

Dedicated inpatient service to provide time-limited assessment and treatment of mental illness in older people.

Support for people in homes run by residential providers

Residential treatment and support services for older people with on-going and disabling mental illness. This is usually provided by Disability Support for Older People services rather than mental health services.

Daytime support for people outside their homes

Day treatment and support services for older people with ongoing and disabling mental illness. This may take place in a hospital or community setting.

Community team

Multidisciplinary clinical teams, working from a range of settings, and providing assessment, treatment and therapeutic interventions, and co-ordination of care.

#### 5.4.2 Resource guidelines

The following table shows guidelines for the resources that should be available in services for people aged 65 and over. As noted above, there should be flexibility about which service provides these resources.

Service component	Resource guideline per 100,000 total population
Inpatient services	5.3 beds or 'care packages'
Specialist day care services	4.0 places
Community mental health teams	13.0 FTEs
Community support services	1.3 FTEs
Advice and support for consumers and families	0.6 FTEs
Access to newer anti-psychotic medication	18.1 people
Alcohol and drug community based teams	1.4 FTEs

The inpatient service guideline includes provision for 4 beds in dedicated older people's mental health units and 1.3 beds in general adult acute mental health units (see Appendix IV for details).

In each region a proportion of the resource guidelines should be allocated to kaupapa Maori services, according to the proportion of Maori in the local population. Similarly, a proportion should be allocated to Pacific people services.

## 5.5 Forensic services

### 5.5.1 Service components

Forensic services meet the needs of those people with a mental disorder, or a suspected mental disorder, who are:

- referred from the criminal justice system and/or
- exhibiting very violent or dangerous behaviour, likely to offend, and requiring specialised assessment and management.

Mental illness often remains undetected for many Maori until a crisis occurs. This is true for Pacific people too. Because of this, many come to the attention of mental health services once they have offended, and therefore both groups are presently over-represented in forensic services.

#### Secure inpatient services

Services providing full psychiatric and mental health services, within a secure inpatient environment. These services must be effective for Maori. They must cover the following levels of security and acuity:

1. Acute inpatient (medium secure)
2. Minimum secure
3. Long stay (maximum secure).

All levels must provide education and support for recovery.

### Community based residential recovery support and education

Specialist supported accommodation and support and education for recovery services for those who no longer require secure inpatient services, but whose risk management and safety needs indicate a further period of intensive supervision in a community setting is required.

### Court liaison

Attendance at court by forensic services staff to provide advice, assessment, reports, and recommendations to court judges.

### Prison services and liaison

Specialist psychiatric services for people within prisons, and consultation and support for prison service staff (based on 1FTE per 200 prison muster).

### Forensic community services and liaison

Forensic service community assessment, treatment, and follow-up, for forensic clients in the community, incorporating consultation and liaison with, and assessments and advice, for general mental health services.

Forensic inpatient services should be delivered on a regional basis with close working relationships with local general mental health services. It must be ensured that people in rural areas receive forensic services equivalent to the resource guideline level. This may require a flexible approach with some resourcing from the general mental health team. Where this occurs, the division of roles and responsibilities between the local service and forensic services must be well defined.

The forensic services' skills in the prevention and management of behaviour disturbance and violence should also be available to general adult mental health services, through consultation and liaison, and as a back-up service.

Prison treatment and liaison has a growing role, partly due to an apparent increase in the number of people with mental illness within the prison system, and partly due to the better recognition of mental illness within prisons. Forensic services should provide regular clinics in prisons and those experiencing severe mental health problems who require inpatient services should be transferred to a secure forensic service for treatment. Follow-up treatment when the service user has returned to prison should continue for as long as is necessary. Forensic services have a key liaison role working with prison staff (including medical, nursing and psychology staff) to assist with the treatment and support of prisoners showing behavioural disturbance.

There should be explicit criteria for the movement of service users between general mental health services and forensic services. Former service users of forensic services should not automatically be treated as forensic service users when they require further mental health services.

## 5.5.2 Resource guidelines

The following table shows guidelines for the resources that should be available in forensic services.

Service component	Resource guideline per 100,000 total population
Inpatient services	6.25 beds or 'care packages'
Community based residential services	0.75 beds or 'care packages'
Community mental health teams	2.17 FTEs

The Ministry of Health is developing resource guidelines for forensic services.

## 5.6 Mental illness prevention

### 5.6.1 Service components

New mental illness prevention services are proposed, to address the first goal of the National Mental Health Strategy, the reduction of the prevalence of mental illness. Mental health clinicians will be funded to carry out preventive work and to liaise with other services and programmes to put preventive strategies in place for groups and individuals who are at risk, including suicide prevention work. The Commission envisages this service will be developed as an outreach part of specialist mental health services. Staff must have skills in assessing whether mental illness is present, in identifying factors which may cause later mental illness or disorder, and in developing comprehensive prevention interventions.

Mental illness prevention for identified at-risk groups should not be confused with population wide **mental health promotion** which continues to be the responsibility of public health services.

Evidence based mental illness prevention programmes have the potential to lower the likely prevalence of illness and consequently reduce demand for treatment services in the medium to long term.

Mental illness prevention services are needed to:

- provide education about risk factors and signs of developing mental illness, mental illness prevention, and suicide prevention
- facilitate mental illness prevention in areas where there are higher levels of likely incidence of illness, for example:
  - children and young people who are socially disadvantaged, from dysfunctional family environments, displaying problematic behaviours, and failing in their educational setting

- people at risk of experiencing traumas which are known to have a high risk of a subsequent mental illness.

There should be designated mental health specialist staff for delivery of these components, linking in with and supporting the work of:

- non-government agencies working in the community, including family/whanau and parent support groups, and cultural and church support groups
- educational services, including early childhood and pre-school levels
- Maori, Pacific people’s, and other ethnic health and social services.

Services must include particular provision for Maori, including, where possible, services delivered by Maori for Maori.

Since these services will be new, a strong emphasis on programme evaluation will be needed.

### 5.6.2 Resource guidelines

The following table shows guidelines for the resources that should be available in the new mental illness prevention services for all age groups. These guidelines are not targeted at the 3% access target, since prevention services will work with people who do not yet have a mental illness, but are identified as being at risk.

Service component	Resource guidelines per 100,000 total population by age group			
	0–14	15–19	20–64	Total
Mental illness prevention services	3.3 FTEs	2.8 FTEs	3.9FTEs	10.0 FTEs

Currently there are no specific prevention services purchased by the HFA.

## 5.7 Summary of all resource guidelines for all age groups

The table below summarises the total resources required per 100,000 total population, and the total resources indicated for the New Zealand population in 1998. The resources currently funded by the HFA (as at June 1998) are also shown.

		Resource guidelines per 100,000 population by age group					National target	National current
		0-14	15-19	20-64	65+	Total		
Inpatient	Beds or 'care packages'	1.3	3	31.05	5.3	40.65	1,535	1,424
Residential	Beds or 'care packages'	3.7	8.35	69.85	4	85.9	3,243	2,576
Community mental health	FTEs	16.6	20.75	52.79	13.0	103.14	3,822	1,923
Community support	FTEs	0	2.2	30.5	1.3	34	1,284	388
Advisory services and initiatives (consumer and family)	FTEs	0	0.4	5.5	0.6	6.5	246	63
Access to newer anti-psychotic medication	People	0	31.2	175.7	18.1	225	8,500	3,547
Detoxification	Beds or 'care packages'	0	0.2	2.8	0	3	113	96
Residential alcohol and drug	Beds or 'care packages'	0	0.9	9.1	0	10	378	376
Community alcohol and drug FTEs	FTEs	0	0.9	13.95	1.4	16.25	614	262
Methadone treatments	Places	0	10	140	0	150	5,666	3,030
Mental illness prevention FTEs	FTEs	3.3	2.8	3.9	0	10	378	0

Please refer to Appendix IV for more detail of these resource guidelines.

## 5.8 Services for Maori

Maori, as Treaty partners, are entitled to choice of access to both the full range of mainstream services, and to kaupapa Maori services. Both kinds of services must respond in ways appropriate to Maori. *Moving Forward* sets a national target:

By July 2005, 50% of Maori adults will have a choice of a mainstream or a kaupapa Maori community support mental health service.

Achievement of this target needs to be given high priority, in order to begin to address disparities between Maori and non-Maori in service utilisation and outcomes.

Please refer to Section 6 of this Blueprint for a full discussion of the developments needed in services for Maori.

All the resource guidelines in preceding sections include provision for services to Maori, including kaupapa Maori services and mainstream services.

## 5.9 Services for Pacific people

Pacific people need access to both the full range of mainstream services (which should acknowledge and affirm Pacific cultures) and, where viable given local population needs and numbers, separate Pacific people's services. In areas with larger Pacific people populations, priority should be given to the development and funding of mental health services for Pacific people.

Further detail on Pacific people's needs and services is given in Section 7.

## 5.10 Providing services safely

### 5.10.1 The risk of harm

It is a given that all health services should ensure that service users and providers are safe from harm and abuse. The Commission has identified that mental health services need to improve their ability to reduce the following risks of harm:

- risk of people with mental illness harming themselves (for example, self-injury and suicidal behaviour, self neglect)
- risk of others harming people with mental illness (for example, physical, sexual, or psychological abuse )
- risk of people with mental illness harming other people.

When addressing these risks, services should consider service management and delivery issues as well as the particular needs and circumstances of each individual. Safety is increased when an individual's needs are known and there are sufficient good services to meet them.

### 5.10.2 Managing safe services

Services have a duty of care to have formal policies and procedures in place which identify and reduce the risk of abuse or harm occurring. Unsafe aspects of the service setting could include discriminatory behaviour from staff, low staff morale, overcrowding, inadequate support, people with very different needs being inappropriately accommodated together, unclear boundaries around unacceptable behaviours and inconsistent responses to them, and inadequately trained staff.

The key to a safe service is to have staff with the right personal attributes, and to support them. This is achieved by having clear recruitment and vetting procedures, ongoing training that assists staff to deal with conflict, and clear protocols and processes for performance review of staff who do not carry out their responsibilities safely.

Services need to monitor and evaluate the outcomes of their risk reduction procedures, both at the service level (by management, incident reporting, and clinical audit), and at the individual level (through review of assessment and treatment plans).

### 5.10.3 Clinical responsibilities for reducing the risk of harm

The potential for an individual to harm themselves or others, or to be harmed by others, is sometimes increased as a result of a mental illness and the change in life circumstances it may create. For this reason, procedures designed to reduce the risk of harm are an integral part of clinical practice (and the recovery approach); they should be stated as formal requirements for the provision of any clinical service in any setting, in order to maximise safety for all people.

Services should implement the *Guidelines for clinical risk assessment and management in mental health services* (1998) which have been developed by Ministry of Health in partnership with the Health Funding Authority specifically to provide a basic framework to guide and aid mental health clinicians to better assess and manage clinical risk.

Guidelines for community and hospital services need to cover the following:

- ***Individual assessment of the potential for harm***  
Services require clear protocols for assessing the risk of harm for all people on first contact with mental health services and then regularly as part of their ongoing treatment. This assessment should be based on all available information about past and present harmful behaviour.
- ***Individual plans for reduction of risk of harm***  
Once the risks of harm have been identified in an assessment, steps to address them need to be clearly set out in individual agreed recovery plans. A designated key worker works with the individual to oversee the design, implementation and review of the plan, and, where

appropriate, family/whanau and others are involved in the development and actioning of it.

- ***Discharge planning and management***

No one should leave a service (or transfer between services) without a plan that outlines treatment, and recovery strategies, which include information on how to reduce risk of harm. A discharge plan includes clear relapse prevention and crisis management strategies that have been prepared in partnership between the individual and the service. Family/whanau and others should be involved where appropriate.

- ***Follow-up and review***

Individuals who have been assessed as having high support needs require active follow-up to make sure their needs are being met and that their risk reduction plan is working and is responsive to changing needs.

#### 5.10.4 Protecting people and sharing personal information

In the interests of safety and recovery for the individual, information may need to be shared with all those involved in providing treatment or support. Such disclosures need to comply with the Privacy Act 1993, and the Health Information Privacy Code 1994 (especially Rule 11(2)(d)).

Services are advised to implement the *Mental health professionals and patient information guidance notes for agencies in the mental health sector (1997)*<sup>23</sup>. They are intended to clarify mental health professionals' responsibilities relating to disclosure of personal information.

<sup>23</sup> Prepared for the Mental Health Commission by the Privacy Commissioner

# 6 Services for Maori

## Mihi

Tihei Mauri Ora

E nga mana e nga poutokomanawa te taahu o nga whakaaro nui o te hauora hinengaro tena koutou, tena koutou, tena koutou katoa.

Waiho ma te whakaaro hei tiki te ahuatanga te mamae te pouri mo te hunga kua haere ki te po. Te hunga mate kia ratou, haere, haere, haere oti atu. Ko tatou enei e manako nei i roto i nga kaupapa Maori o te hauora hinengaro tena koutou, tena koutou, tena tatou katoa.

## 6.1 Introduction

The Government's desired outcome for Maori health is to achieve improvement in their health by increased responsiveness to their needs and by developing appropriate professional, administrative, and organisational expertise. Improving Maori mental health is a Government health priority with explicit goals in policy documents such as *Moving Forward*. This commitment to providing more and better mental health services for Maori must be translated into tangible and culturally appropriate mental health outcomes and recovery for Maori.

The Mental Health Commission recognises the Government's obligations under the Treaty of Waitangi, and totally supports the Government's objective of improving the health status of Maori so that the current disparities in mental health status between Maori and non-Maori are eliminated. The National Mental Health Standards are consistent with the Treaty principles and reflect the unique needs of tangata whenua. Service provision for Maori must recognise the status of Maori as a Treaty partner, work towards the Government's objectives, and ensure the implementation of the National Mental Health Standards.

From a Maori perspective, mental well-health is not just the absence of illness; more effective work must be undertaken to address those issues which directly impact upon mental wellness such as housing, unemployment, and cultural isolation. They require a constructive, co-ordinated approach in order to achieve positive changes in Maori mental health status.

This section of the Blueprint is intended to provide guidance on how mental health services should be delivered so that Maori have a choice of high quality kaupapa Maori or culturally effective mainstream services. It provides direction for both funders and providers on the implementation of the National Mental Health Strategy to "encourage Maori involvement in planning, developing and delivering mental health services", and on the

achievement of other national objectives and targets set out in *Moving Forward*.

Whilst the *Blueprint for Mental Health Services in New Zealand: Working Document 1997* reflected some of the needs of Maori, in the Commission's view it did not deal adequately with the major impediments to good service delivery for Maori, and it did not take into account the nature and amount of resources required to make a difference. Consequently, the Commission made a commitment to confer with Maori and obtain feedback for this new Blueprint.

To do this and to understand the nature of kaupapa Maori services better, the Commission visited seven providers in various parts of the country, and organised nine hui around the country. Hui participants were asked to give general feedback, to consider service provision within kaupapa Maori services, and to make particular comment on workforce needs.

The hui participants' knowledge of issues affecting Maori mental health, together with their many years of working in the mental health sector or using services under extremely difficult and frustrating circumstances, enabled an invaluable contribution to be made to strengthen the Maori content in this Blueprint.

The Commission regards the focus on the development of more and better mental health services for Maori as crucial. All Crown agencies need to consolidate gains in Maori health development and accelerate Maori workforce development, and services for Maori must reflect all three articles of the Treaty. A commitment to action is needed, aimed at achieving specific goals to overcome difficult problems.

## 6.2 Key Issues

### 6.2.1 Increasing concern about poor mental health

Mason Durie writes that "mental health problems are now the number one health concern for Maori. Psychiatric admissions, alcohol and drug disorders, suicides and attempted suicides are increasing at a time when other health problems such as heart disease are decreasing".<sup>24</sup>

Maori have many needs which are not being met by mental health services, and there are disproportionate numbers of Maori in crisis, acute inpatient, and forensic services. Maori have substantially higher rates of re-admission than non-Maori; these rates have risen steadily in recent years and are continuing to rise. Maori are also greatly over-represented in alcohol and drug services; alcohol and drug abuse and psychosis are the main reasons for Maori being admitted to a psychiatric ward or hospital.

<sup>24</sup> Durie M.H., *Puahou: A five part plan for improving Maori mental health*, paper delivered to Maori Mental Health Summit, August 1997

### 6.2.2 Access

Until an appropriate epidemiological study is completed in New Zealand, the extent of access needs for Maori is unknown.<sup>25</sup> In the meantime, the Commission suggests that the target for access to mental health services for Maori should be double that for the general population; 6% of the Maori population should be able to access services appropriate to their needs, compared with 3% for the total population (Maori and non-Maori). Since 15% of the total population are Maori, 26% of all mental health service provision in New Zealand should be for Maori.

### 6.2.3 Culturally effective services

For services to be effective for Maori they must reflect and respect the four dimensions of Whare Tapa Wha:

taha wairua (spiritual health)

taha hinengaro (mental and emotional health)

taha tinana (physical health)

taha whanau (whanau health).

Services must also integrate clinical treatment with Maori development. Mason Durie<sup>26</sup> lists five principles for funding culturally effective services:

Principle	Focus
1. Choice	The need for a range of services so that options for different types of services are available
2. Relevance	Services that are culturally meaningful and able to address actual needs
3. Integration	Mental health services should not exist in isolation from other health services and intersectoral connections should be made
4. Quality	In any service, high standards of care and treatment are necessary and this should be reflected in outcomes
5. Cost effectiveness	Services must give value for money and limited resources make economies of scale important

<sup>25</sup> The only known epidemiological study to report on the different rates of likely prevalence for Maori and non-Maori is the Christchurch Health and Development Study which found that at age 18, 49.5% of the Maori in the cohort had a mental health disorder, compared to 33.1% for non-Maori. (Fergusson D., Horwood J. and Lynskey M., *Children and adolescents: in Public health report number 3: Mental health in New Zealand from a public health perspective*, Ministry of Health, October 1997: Table 5.2, page 141)

<sup>26</sup> Durie M.H., Gillies A., Kingi Te K., Ratima M.M., Waldon J., Morrison P.S. and Allan G.R., *Guidelines for purchasing mental health services for Maori: A report prepared for the Ministry of Health*, June 1995

#### 6.2.4 Funding and contracting constraints

Many kaupapa Maori service providers are frustrated at the apparent inconsistency between government policy and its translation into actual contracts (and the contracting process).

Short-term contracts, policy changes based on non-Maori models, limited recognition of the Maori process of addressing mental health, and not accepting that cultural differences have a dramatic affect on the cost and nature of service delivery, all contribute to the danger of funding to Maori providers being done in a way that will set them up to fail.<sup>27</sup>

The high Maori re-admission rates into hospitals attest to the fact that Maori needs are not being met and something dramatically different needs to happen. Accepting Maori concepts of healing and ensuring that service contracts are supportive of this are essential if significant improvements in Maori mental health status are to be achieved.

Contracts need to include targeted development funding. This could be used for clinical training, cultural training, and administrative development. Multi-year contracts are required that realistically reflect and support Maori health processes, fund services equitably for Maori and at a level that recognises the unique nature and cost of the services, and assist providers during their development phase.

#### 6.2.5 Workforce development

Maori are significantly under-represented in the professionally qualified mental health workforce, particularly psychologists, psychiatrists, and occupational therapists. As a result, there are reduced opportunities for cultural difference to be fully appreciated in assessment, treatment, and support and education for recovery. It is possible to call on outside expertise and to rely on whanau for advice and assistance; however, to gain the positive results needed, the number of Maori delivering mental health services for Maori must be significantly increased. In addition, short-term training is urgently required to strengthen the skills of mental health support workers. However, this should not detract from the long-term need for highly skilled professionals.

The disparity between Maori and non-Maori health status is not assisted by the under-representation of Maori in all disciplines of the workforce. One response to this has been the emergence of Maori community mental health workers, who often bring invaluable new skills to the sector. However some providers have failed to provide career pathways and have not encouraged the acquisition of additional formal qualifications. This situation must change. There is an urgent need to facilitate entry into programmes of study by Maori community mental health workers, so that they are not trapped at a low level of qualification, or be unable to offer the full range of services needed. Maori with experience of mental illness with the right qualities and skills should be encouraged to work in mental health services.

<sup>27</sup> Report of key messages to the Mental Health Commission from Hui held February–April 1998, Mental Health Commission

### 6.2.6 Inappropriate performance measures

Performance measures must have the capacity to include all the range of achievements and results produced by Maori mental health services.

Performance measures developed on western based paradigms are unlikely to fully appreciate many of the concepts and activities which are crucial to recovery for tangata whaiora; not taking these issues into account places Maori mental health services at a distinct disadvantage, particularly when seeking further funding and endorsement of their particular approach.

The Whare Tapa Wha model is currently being further developed by Mason Durie and others to assess whether it can be used as a measurement tool.

A Maori perspective of health is broad; performance measures must go beyond the immediate clinical parameters to encompass wider measures of good health, and health services must pursue recovery and good health, not simply the removal of symptoms.<sup>28</sup>

Whatever performance measures are adopted they must ensure that Maori views of health and cultural identity are not further ignored.

### 6.2.7 Discrimination and recovery

The Commission advocates zero tolerance of discrimination. This means refusing to accept it, in any shape or form. Through feedback from hui, Maori have made it clear that equity in service delivery is a starting point for reduction of discrimination, and the Commission supports this view. The Commission's *Map of the Journeys* illustrates the kind of changes that need to be made; it shows seven destinations, each with a set of paths. For Maori, these are:

- Active Maori participation  
ensuring Maori (including tangata whaiora) have the opportunity to make the decisions for, manage, and implement mental health services for Maori
- Positive Maori development  
recognising the need for relevant standards, policies, and practices targeted at delivery of services to Maori
- Elimination of disparities  
unlocking the mental health system to ensure Maori priorities have equal consideration in the mental health sector.

Appendix I contains more detail about these paths.

Maori views on mental illness are consistent with the recovery approach and all services delivered to Maori need to reflect this. Maori who have mental illness face discrimination as Maori and as tangata whaiora. Discrimination is a major barrier to recovery. Services for Maori need to reduce the impact of both kinds of discrimination if they are to succeed with the recovery approach.

<sup>28</sup> Durie M.H. et al.  
*Guidelines for purchasing  
mental health services for  
Maori*

## 6.3 Essential service components

### 6.3.1 Meeting the needs of Maori

Maori not only need to have more mental health services provided for them. They need to be able to choose whether they use mainstream services, kaupapa Maori services, or both of these. The services they access must meet their needs and expectations, and strengthen their identity. To work effectively with Maori it is necessary to know and understand the components that contribute to their well-being. This includes knowing how Maori cultural identity is defined, and the values, beliefs and behaviours which are part of that identity.

The range of components shown in the table below must be incorporated into all mental health services to meet the needs of Maori.

Component	Description	Purpose
Cultural assessment	Assessment of cultural status and cultural needs to enable Maori values and healing practices to be offered as an addition to treatment for tangata whaiora.	Ensures the most appropriate and effective services are available to Maori.
Whanau and tangata whaiora participation	Whanau and tangata whaiora participation in: <ul style="list-style-type: none"> <li>– assessment and treatment plans</li> <li>– provision of treatment and support and education for recovery</li> <li>– early intervention programmes and training and education support for whanau.</li> </ul>	Fosters whanaungatanga which is emphasised as the basis for healing.
Maori language	Tangata whaiora have the choice to converse in te reo Maori.	Enables Maori language to be used in the expression of Maori beliefs and values, as an important part of the healing process.
Tikanga Maori	An environment in which Maori protocols and processes are acknowledged and which allows for both physical and spiritual healing to take place.	Provides an environment for Maori which acknowledges their values and beliefs as integral to the healing process for Maori.
Treatment process	Maori need the full range of choice of Maori healing methodologies, processes, and natural medicines, as well as clinical treatments including access to new medications, and recovery approaches.	Acknowledges the positive impact culturally based treatments have on the healing process for Maori.
Workforce	Maori participate in the workforce as health professional, clinicians, managers, and decision makers.	Creates an environment and service standards that are more suitable for dealing with tangata whaiora.
Performance measures relevant to Maori	The Te Whare Tapa Wha model is incorporated in performance measures.	Ensures performance measures go beyond the immediate clinical parameters and encompass the wider measures of good health for Maori.

### 6.3.2 Mainstream services

Maori with a mental illness who go to mainstream services have the right to expect that those services acknowledge, value, and take into account Maori healing approaches as a relevant choice within the service.

Assessment processes and decisions have often hindered the speedy recovery of Maori in mainstream services. It is therefore vital to ensure that a Maori health worker or kaumatua is always part of the first contact and is present at the start of the assessment process. It is important for mainstream service clinicians to develop working relationships with tohunga and Maori therapists so that Maori have these services available to them as well.

The recruitment and retention of Maori workers in mainstream services need to be addressed urgently to foster and increase the pool of existing people in the workforce, and encourage and support them to become professionally trained. This is critical to enabling services to meet all Maori needs effectively.

### 6.3.3 Kaupapa Maori services

These services may offer a range of treatment and support services, but include as base elements: whanaungatanga, whakapapa, cultural assessment, empowerment of tangata whaiora and their whanau, te reo Maori, tikanga Maori, kaumatua guidance, access to traditional healing, access to mainstream health services, and use of quality performance measures which are relevant to Maori. Maori services will need to find ways to attract and retain Maori with clinical skills.

Fundamental to the success of these services is having sound management systems in place with people who have the management and entrepreneurial skills necessary to run them.

Kaupapa Maori services can be provided within mainstream services.

### 6.3.4 Maori advocacy and support services

Maori advocacy and support workers are needed to work in and with mainstream services, kaupapa Maori services, and funding agencies. They would work with the funder, providers, health and social service agencies, and other statutory agencies to enable them to meet the needs of tangata whaiora and whanau. They would work with tangata whaiora and whanau to assist them to access services and to understand their rights.

### 6.3.5 Early intervention

Maori access mental health services at a far later stage of their illness and consequently are more likely to be seriously ill by the time they present to a service. Maori are also more likely to be admitted into psychiatric institutions as a result of compulsory admission for assessment and treatment.<sup>29</sup>

<sup>29</sup> Under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

An important means of dealing more effectively with the high admission and re-admission rates is through the introduction of early intervention programmes and services.

While there is no evidence that serious mental disorders such as schizophrenia or bipolar affective disorders can be prevented through education, counselling, or cultural enrichment, nonetheless better management under less restrictive conditions could be possible through early diagnosis and treatment.<sup>30</sup> There are three areas where Maori mental health services are likely to be more effective than others. They are related to serious mental disorders.

- Early intervention through community mental health centres which are able to offer expert diagnostic services within an appropriate cultural context could have a significant impact on late and compulsory admission rates by developing more appropriate management plans
- Community support by Maori workers through follow-up and liaison with people who have an established psychiatric disability and who require community support and education for recovery; these workers are more likely to be familiar with Maori networks and community resources, and to be able to relate to whanau and hapu<sup>31</sup>
- More accessible disability support services including supported accommodation and employment services which offer Maori a choice of kaupapa Maori services.

There is an urgent need for information to be accessible to Maori about the onset of mental illness, about the warning signs of youth suicide, and about what services are available and where.

### 6.3.6 Public health services

Mason Durie emphasises that public health and wider social policy responses are critical to lowering the number of young Maori becoming affected by serious mental illness (including alcohol and drug disorders). He writes that public health programmes are needed to:

- build greater community understanding of mental illness and reduce discrimination
- reduce risk factors and encourage early intervention
- address the wider issues in society which disproportionately affect those with mental illness, such as discrimination, poverty, social alienation, substance abuse, and homelessness
- promote consultation and liaison with other health services and other sectors
- promote mental well-being.<sup>32</sup>

Strong public health initiatives are urgently needed for Maori; they should aim to empower communities to address problems for themselves, rather

<sup>30</sup> Durie M.H. et al, *Guidelines for Purchasing Personal Mental Health Services for Maori*

<sup>31</sup> Durie M.H. et al, *Guidelines for Purchasing Personal Mental Health Services for Maori*

<sup>32</sup> Durie M.H., *Puahou: A Five Part Plan for Improving Maori Mental Health*,

than waiting for the intervention of medical and health experts.

A five point plan has been proposed for a public health approach to strengthen mental health for Maori.<sup>33</sup>

1. Strengthening, identifying, and providing young people with access to the institutions of Maori society such as language, land, and a strong whanau.
2. Active participation in society and the economy with increased participation in education and employment.
3. Realignment of health services with Maori realities which includes increased access to effective primary health services, and increased emphasis on mental health in general primary service provision for Maori.
4. A strengthened Maori workforce including professionals and community workers working at all levels.
5. Increased autonomy and control so that communities are empowered to develop their own approaches to problems.

#### 6.3.7 Services for Maori with mental illness and alcohol and drug problems

Alcohol and drug abuse and psychosis are the major reasons for Maori first admissions, and made up 32% of all Maori first admissions in 1993. There was a 49% increase in first admissions of Maori women for alcohol and drug disorders between 1984 and 1993. Drug induced psychosis admissions make up 21% of all Maori psychiatric hospital admissions for alcohol and drug disorders, compared with 5% for non-Maori.<sup>34</sup> The National Acuity Review noted that it was evident Maori were not accessing services early enough, and those with both mental illness and alcohol problems were particularly disadvantaged.<sup>35</sup> Services must be effective for Maori with both conditions, and include kaupapa Maori approaches. All mental health alcohol and drug services must include kaupapa Maori programmes in services such as community assessment and treatment, and residential care.

There is an increasing problem of drug misuse which is not being addressed in current psychiatric services when Maori, presenting acutely, are treated only for their mental illness. There are also serious concerns about the current and increasing use of cannabis and hallucinogens among Maori and the relationship of these drugs to Maori psychiatric admissions.

#### 6.3.8 Forensic services

Maori are over-represented in forensic services and these services need to give particular focus to meeting the needs of Maori. Maori are viewed and treated as being more dangerous than non-Maori; 38% of Maori referrals come from law enforcement or welfare services compared to 27% of non-Maori referrals.<sup>36</sup> One third of admissions of Maori men are compulsory, 2.5

<sup>33</sup> Durie M.H., *Puahou*

<sup>34</sup> Ryan E., *Maori mental health services: A proposal for change*, Maori Health Commission, September 1998

<sup>35</sup> *National acuity review final report on New Zealand's mental health acute inpatient services*, Ministry of Health, July 1997

<sup>36</sup> *Ibid*

times higher than those of non-Maori. Prison populations regularly show a disproportionate number of Maori; they comprise over 50% of the prison population.<sup>37</sup>

The HFA and service providers (both kaupapa Maori and mainstream) must focus on:

- prevention
- development of early intervention programmes that include kaupapa Maori focus
- comprehensive and integrated treatment approaches
- effective risk management processes
- attention to cultural needs
- comprehensive needs assessment and ongoing support and education for recovery to meet these needs
- co-ordinated discharge planning
- intersectoral collaboration, especially between the HFA, mental health service providers, Corrections, Police, Courts, Education, Housing, and Work and Income NZ
- providing the Maori workforce with skills in this specialty area.

### 6.3.9 Children and young people

Mental health services must particularly recognise and provide for the needs of tamariki and rangatahi. Maori children and young people need access to both kaupapa Maori and appropriate mainstream services. Maori have a younger age profile than non-Maori; in the 1996 census, 23.6% of the total 0-14 years age group, and 19.7% of those aged 15-17 identified as Maori. Specialised multi-disciplinary community teams which provide services for children and young people need to include provision of services for alcohol and drug problems, and make specific provision for Maori (including provision of kaupapa Maori services).

Suicide among Maori youth is increasing. The recently released Government strategy<sup>38</sup> for the prevention of youth suicide identifies a range of strategies that need to be implemented to reduce suicide rates. While the importance of more effective mental health services and clinical intervention is acknowledged, the strategy also emphasises the importance of wider public health initiatives.

### 6.3.10 Maori workforce

If appropriate services are to be available to Maori, a substantial Maori presence (with the knowledge base and clinical skills adequate to meet the required standards) throughout the whole range of the professional workforce is necessary. In addition, the establishment of Maori providers with skills in management and administration is also imperative. Research in Maori mental

<sup>37</sup> *National acuity review final report on New Zealand's mental health acute inpatient services*, Ministry of Health, July 1997

<sup>38</sup> *In our hands: New Zealand youth suicide prevention strategy: Kia piki te ora o te taitamariki*, Ministry of Youth Affairs, Ministry of Health, Te Puni Kokiri, 1998

health and the evaluation of clinical practice is a critical part of establishing and maintaining excellence.<sup>39</sup>

Although Maori are higher users of mental health services, Maori are less visible as health professionals, managers, or decision-makers. There is ample evidence to show how the cultural background of providers influences the results they achieve. There is an urgent need to fund specific resources for recruitment strategies to encourage more Maori into the mental health sector, including Maori with experience of mental illness. Strategies are also needed to ensure the retention of the current workforce, and the provision of ongoing training for them.

Maori must be able to access mental health services which are aligned to Maori cultural expectations. To achieve this, there must be an increase in the number of trained Maori mental health workers with knowledge of te reo and tikanga Maori. At present, there are too few Maori in mental health professions and disciplines. Maori in secondary and tertiary education institutions must be provided with more information on career options available in the mental health sector. In addition, a greater focus in the partnerships between education and health will help increase the number of training places specifically targeted to Maori, in line with the national target set out in *Moving Forward*:

By July 2005, the Maori mental health workforce (including clinicians) will have increased by 50% from the baseline in 1997/98.

Key messages from hui feedback include the need for:

- establishing training programmes for Maori health workers
- training programmes to include an understanding of te reo and tikanga Maori
- measures to ensure the retention of the current Maori workforce
- training programmes in rural areas
- providing scholarships to encourage Maori to train in those areas where Maori are least represented such as psychiatry, clinical psychology, nursing, and social work
- accelerating the development of skills of Maori currently in the workforce, including training in management, administration, computer, and financial skills
- ensuring that non-Maori people in the mental health workforce have sufficient knowledge to work in a culturally safe way with the Maori people in their care.

*A strategic plan for post-entry clinical training for Maori*, commissioned by the Clinical Training Agency (CTA) and published in December 1997, notes that Maori health workforce development needs to start using Maori development models, driven by Maori priorities and processes. The strategy is aimed at enhancing mainstream responsiveness to Maori needs, and

<sup>39</sup> Ryan E., *Maori mental health services – A proposal for change*, Maori Health Commission, September 1998

encouraging Maori participation in CTA business and throughout the mental health sector.

Last year the CTA contracted a pilot training programme with Te Wananga O Raukawa. This is an advanced training programme aimed at raising the skills of Maori who have a health professional qualification. Subject to evaluation of that pilot and consideration by the HFA of the CTA's Maori health workforce strategic plan, the CTA intends to continue funding this programme in 1999 and to purchase such programmes more widely.<sup>40</sup>

## 6.4 Translating principles into action

Improving Maori mental health cannot be achieved by health services alone. As Mason Durie has pointed out in Puahou, a strong community development approach which covers the wider socio-political-economic spectrum is required.

However, a part must be played by strong, appropriate, and accessible health services. There are a number of critical success factors for effective mental health services for Maori. They cover the necessary conditions for:

- effective funding and provision of mental health services for Maori
- the sustainable development of Maori provider organisations
- the need for a Maori mental health service strategy to be nested within wider public and primary health strategies for Maori.

These critical success factors should be used as the basis for evaluation of funder and provider performance. A matrix showing the kinds of questions which may be asked when auditing funder and provider performance against each of these critical success factors is given in Appendix II.

<sup>40</sup> *Purchasing intentions for mental health post entry clinical training for the 1999 training year*, Letter of Purchasing Intentions, Clinical Training Agency, July 1998. The CTA is an agency of the HFA.

# 7 Services for Pacific People

## 7.1 Philosophy

Pacific people believe that mental well-being is dependent on all aspects of a person's life being in harmony. Spiritual, physical, emotional, and family well-being together represent the holistic way with which mental health needs are addressed. Pacific people expect acknowledgment and genuine commitment from all agencies to ensure that mental health services provided to Pacific communities reflect this holistic approach to mental wellness that is inherent in their belief systems.

The Commission supports services using this holistic approach, and increasing ownership and provision of services designed by Pacific people for Pacific people and delivered by Pacific people as the best means of achieving improvements in the quality of life for Pacific users of the mental health services and their families in New Zealand. However, the Commission recognises that provision of separate services is not feasible in all areas.

There must also be good provision for Pacific people in mainstream mental health services.

## 7.2 Priorities for Pacific people

Mental health providers serving areas with large Pacific populations must increase their commitment to meeting Pacific mental health needs more effectively. The release of the National Mental Health Standards provides a mechanism for ensuring accountability of mental health service providers to Pacific communities. These Standards must be put into operation immediately. Pacific communities need to continue to redefine standards of care for themselves but addressing the following priorities will go some way towards closing the gap that currently exists in the provision of mental health services for Pacific people.

### 7.2.1 Workforce development

Development of an appropriately skilled workforce is a prerequisite to providing more and better services to Pacific service users and their families. Providers' employment policies must facilitate the recruitment of Pacific people with skills in languages, cultures, and customs. Pacific mental health professionals are in such short supply that increasing their numbers is clearly a priority.

The following active measures are seen as the most effective means of addressing the problem:

- genuine commitment to training Pacific people with experience of mental illness for meaningful jobs in the sector
- giving priority to the training of Pacific Mental Health Support Workers. Anecdotal evidence reveals high levels of Pacific service user satisfaction and mental health gains as a direct result of access to Pacific support workers
- active collaboration between mental health education providers and Pacific providers and communities, and providing equitable access for Pacific people to undertake training
- providing positive affirmation and funding to attract Pacific undergraduates in the health sciences to choose a career in mental health
- management training for Pacific people to take on management roles in mainstream and ethnic specific services
- acceptance and funding for credible traditional healers.

Increasing the understanding and knowledge of Pacific cultures must be facilitated by continuing education and training, and the employment of more Pacific people in mental health services.

### 7.2.2 Models of service delivery which work for Pacific people

Not only a skilled workforce is required, but also new models of service delivery must be developed in collaboration with Pacific people. Pacific communities know better than anyone else the specific service needs of their people.

Pacific workers in mainstream services currently describe rigid work practices and job descriptions that do not allow them to meet the unique needs of service users. More responsive and flexible models of employment and service delivery would lead to more effective outcomes for Pacific people. Piloting and auditing already existing Pacific best practice methods across the sector and disseminating information about successful methods are the solutions to this problem.

### 7.2.3 Culturally appropriate audit tools

The development of an appropriate national audit tool is critical for the culturally appropriate and safe practice of Pacific professionals in the sector. This will provide a clear analysis and guideline to which they can hold themselves accountable and which they can base their practice on. It will also enable the HFA, service users, support people, and families to understand how they should judge the performance of health professionals and what to expect from practitioners.

#### 7.2.4 Research

Pacific people have different perceptions and definitions of mental illness from those held by other cultures. The best approach to understanding the peculiarities of Pacific mental health issues is to commit resources to the support and training of Pacific researchers to investigate and thereby reveal the true status of Pacific people's mental health.

For a variety of reasons, many of the people experiencing mental health problems in Pacific communities never access mainstream services; consequently the statistics, which only record those who present to services, do not show the true picture of what is happening.

Pacific people need to define for themselves the extent and nature of mental illness among Pacific people, and then develop the types and methods of service delivery that will best meet their needs. The first step in this process is sound and culturally safe epidemiological research. The Health Research Council and the HFA have the responsibility to ensure this occurs. Mechanisms must be put in place to train Pacific people to successfully undertake research, and to ensure their collaboration and involvement in any research that directly involves Pacific people.

Running parallel to epidemiological research should be research evaluating models of service delivery that best overcome known obstacles to delivering appropriate and safe mental health services to Pacific service users and their families. To this end the leaders of the mental health sector must encourage and support Pacific best practice initiatives.

#### 7.2.5 Discrimination and recovery

The Commission advocates zero tolerance of discrimination. Equity in service delivery must be a starting point for reduction of discrimination. The Commission's *Map of the Journeys* illustrates the kind of changes that need to be made. The map shows seven destinations, each with a set of paths. For Pacific people, these paths include:

- supporting Pacific people to deal with discrimination within the health sector against mental health service users
- supporting and actively assisting Pacific people to deal with discrimination against Pacific people with mental illness
- recognising and countering the double discrimination against Pacific people with mental illness.

Pacific people's views on mental illness are consistent with the recovery approach and all services delivered to Pacific people need to reflect this. Pacific people who develop mental illness face discrimination as Pacific people and as service users. Services for Pacific people need to reduce the impact of both kinds of discrimination if they are to succeed with the recovery approach, since discrimination is a major barrier to recovery.

### 7.2.6 Service provision

Mainstream services must provide effectively for Pacific people and must respect and meet their health needs and be able to use appropriate cultural assessment tools.

Pacific people's services are provided by Pacific people for Pacific people in ways which meet their cultural, language, spiritual, and family needs. There may be a range of treatment and support services but they always include cultural assessment, understanding of cultural identity, empowerment of Pacific heritage, cultures, languages, and values, access to Matua and traditional healers, training for and by Pacific people, and fono participation. Pacific people's services may be operated by separate Pacific organisations or as part of another organisation (for example, within a hospital service). They should offer service users the choice of using alternative providers (for example, a mainstream service).

In the absence of any other information, the Commission assumes the prevalence of mental illness among Pacific people is the same as the rest of the population. Therefore provision of services to Pacific people should be in proportion to the number people within the total population. For example, in the Auckland region 12.5% of the total population are Pacific people, and the Commission expects Pacific people's and mainstream services to have the capacity to provide effective culturally based services to meet their needs.

The Pacific people population is growing rapidly and has a considerably younger age profile than the general population. In Porirua and parts of Auckland, half of all children and youth are Pacific people, in the Wellington region and South Waikato around a quarter of all children and youth are Pacific people. This must be recognised by appropriate dedicated mental health service provision for Pacific children, young people, and their families.

The Commission's Pacific People Advisory Group has recommended the following additional services for areas with significant numbers of Pacific people:

- Pacific people support and education for recovery services
- Pacific people residential services for those with higher support needs
- Pacific child and youth assessment, treatment, inpatient, and community residential services including 'at-risk' youth residential services
- Pacific people alcohol and drug residential treatment services (including 'dual diagnosis'), supported living services, and community residential services
- the employment of Pacific people with skills in languages, cultures, and customs, as well as skills in crisis assessment and treatment intervention, dual diagnosis, early intervention, alcohol and drug assessment and treatment, recovery, and specialist skills in the areas

- of intellectual disability, child and youth mental health, and forensic mental health within all mental health services
- training and education on service issues and cultural safety by Pacific professionals (including consumers) for all staff in mainstream services
- provision of Pacific community support workers, and support for Pacific people consumer services
- support for traditional health services offering alternative treatment options.

The increase in skilled staff required to meet these Pacific people's service needs is enormous and there is an urgent need for the development of a strategy to build the Pacific workforce and guarantee the sector receives the skilled Pacific people it needs.

When viable and indicated by local Pacific people population numbers, mainstream services should also create Pacific people teams within their services that encompass all that has been described above.

#### 7.2.7 Evaluation and Monitoring

There have been historical inadequacies in the delivery of mental health services to Pacific people that are only now starting to be rectified. Evaluation of service delivery and monitoring of the mental health sector therefore has great significance for Pacific people, and must include measures of cultural effectiveness for Pacific people.

The HFA needs to evaluate the responsiveness of services to Pacific people, and ensure that the second National Mental Health Standard is met fully by 2000. This Standard requires that "the mental health service delivers and facilitates appropriate services to meet the needs of Pacific people affected by mental illness, their families, carers and others as nominated by the consumer". To do this there needs to be an audit tool developed to assess the cultural safety of services for Pacific people. This audit tool will provide guidelines on how culturally safe services should be delivered to Pacific people, in both mainstream and Pacific services. This tool is a priority for the Pacific community; it could be developed as part of a best practice initiative, and must have the capacity to evaluate individual and institutional cultural practices.

Pacific people (including service users) must take part in all policy making processes, and service funding and delivery decision making.

# 8 Bringing It All Together

Providing a comprehensive continuum of services

## 8.1 Pathways for appropriate and timely access to services

It is neither possible nor sensible to provide all services for everybody, everywhere. However it is important that everyone has access to services appropriate to their needs, and that each service provider is clear about its responsibilities. Service specifications need to describe very clearly:

- how people access the service
- the target population whose needs the service is designed to meet – how many people, where they are, and what kinds of needs they have
- people who should be given priority within the target population
- required response times, for example the time from referral or initial contact to the first assessment
- criteria for entry to and exit from the service, and criteria for onward referral, including to regional specialist services
- discharge planning requirements
- interfaces with other services and agencies, and mechanisms and processes for ensuring they work smoothly
- arrangements for accessing and providing consultation and liaison with other services, including regional responsibilities.

The HFA should monitor the links between services and ensure that:

- the links are clear and effective
- pathways into appropriate services for each individual exist
- all services accept and maintain a service user list
- all services refer appropriately and seek appropriate assistance from other services, as required.

## 8.2 Providing services in rural settings

The demography of New Zealand, with many areas with small rural populations isolated from the major centres, creates a major challenge in the provision and delivery of mental health services. The design of services must recognise the special requirements of rural areas, including the fact that rural areas have a high proportion of Maori.

A major challenge is the delivery of all the special services required to run a comprehensive mental health service; it is often impossible for rural services

to do this by themselves. Arrangements must be made for the provision of such special services on a regional basis. This already happens in some areas, but needs to be developed further to ensure that everyone has access to specialist services through referral and through consultation and liaison between local providers and regional specialist service centres. New technologies such as video conferencing should be considered as a means of overcoming some of the professional isolation problems, not only for online advice from specialists, but also for staff training, and professional liaison.

Another challenge is in the recruitment and retention of the workforce outside the main centres, where the rostering implications of the need to provide 24 hour cover, along with the lack of peer support, and professional isolation create difficult working conditions. This means that staff resourcing must be given special consideration. In areas with populations of 40-50,000, an allocation of two psychiatrists might be necessary, even though, on a population basis, this would seem to be generous in comparison to larger areas.

Special incentives may be required, in salaries, conference leave, and procedures for peer contact. Professional training schemes must give trainees experience of rural settings. The placement of clinical students (including registrars) in rural settings, and with comprehensive support, may help with later recruitment of these people into isolated areas.

### 8.3 Service planning for local populations

Decisions about what is provided locally should be based on full consideration of local population needs and how these may be met in the most cost-effective way. This requires:

- estimates of the numbers of people severely affected by mental illness in different local population sub-groups, including those not currently in contact with services
- understanding the range of needs of individuals with mental illness in these different local population sub-groups
- knowledge of how different services and service structures contribute to recovery
- knowledge of service costs.

For mental health services to be termed comprehensive, the needs of each main sub-group of the population (children and youth, adults, older people, Maori, Pacific people) should be met in all aspects of the service, in a co-ordinated way. When accessing a service, an individual should find a complete continuum of services available to meet their specific needs and assist their recovery.

This continuum will extend beyond mental health services. To ensure this is achieved, the HFA and providers of mental health services, as the lead

agencies for mental health, have to work across agencies and intersectorally. Planning for mental health services should take into account what other services such as housing, employment, education, and leisure activities are available locally, or could be provided from other sectors and local authorities.

The good functioning of an individual part of the mental health service is dependent on adequate amounts of all the service components being present. For example, if there is insufficient supported community accommodation, or such accommodation is not used appropriately, then this will impact on the acute inpatient service's ability to discharge when appropriate, causing blockages and reduced access for new acute patients.

The services offered should reflect local needs and demographics. Both the level and type of services offered in any particular area must take into account the minimum catchment populations required for clinical safety, best practice, and best utilisation of staff and physical resources. Clearly, separate services for distinct cultural groups can be provided only where the population base is sufficient. Similarly, specialised services for less common or highly complex disorders cannot be provided everywhere.

However, residents in all areas and communities should have access to the full range of services through referral from local communities to main centres and on to regional centres for progressively more specialised service needs. Similarly, community services should be provided with advice and support from regional and main centres, through good consultation, liaison, and integration of care arrangements.

When determining required local levels of service provision, a comparison of actual local population numbers against national resource guideline figures will indicate the guideline input quantities for the local population. Additional information about specific local needs and characteristics and service costs must then be incorporated to determine local resource allocation.

Where the local population is too small to support a viable service component, then that service should be accessible at a larger centre which serves more than one local area.

# 9 Infrastructure

## 9.1 The necessity for co-ordination

The health and social support services required for people with serious mental illness are often scattered among various community agencies. Thus there are risks of duplication and gaps, and difficulties in maintaining continuity of services. These risks and difficulties have been accentuated by changes following the 1993 health reforms such as the re-locating of services from hospital to community environments, the fast growth in the number of service providers, services responding to service user needs in more diverse ways, and a non-collaborative environment. The more recent changes in government policy promote more co-operation and collaboration between services and open up the opportunity for better co-ordination between mental health services.

The HFA must ensure systems and incentives are put in place to achieve good co-ordination between services. Development of such systems may be time consuming and costly, and may need to be separately funded.

Co-ordination needs to occur at three levels:

- in provision of services for the individual service user
- between mental health service providers
- between sectors.

## 9.2 Co-ordination for the individual

*Moving Forward* includes a national objective:

*To have an identifiable individual or agency responsible for co-ordinating individualised care, with priority given to people with high support needs.*

There is a challenge when an individual uses the services of more than one agency. Plans developed in partnership with the individual must be clear about who is responsible for meeting each of the individual's needs, and about how the agencies involved interact on behalf of the individual.

There are a number of ways in which responsibilities and interfaces can be arranged, but how it is done is not as important as the *fact* that it is done; there should be no gaps for service users to fall through. For example, a 'lead provider' could be assigned for each service user when more than one agency is involved in the care and support of that individual. This lead provider becomes the co-ordinator of services for that individual.

Such co-ordination requires close working relationships between providers. Memorandums of understanding or protocols between providers are required, covering the co-ordination of clinical and support services in each

geographical area. Contracts should identify these linkages, and be explicit about the expectations providers may have of each other.

The memoranda or protocols must also be clear about communication between agencies, and have explicit guidelines for limitations on how much information each agency needs to have about an individual, and on what is *appropriate* information sharing. The individual concerned must have a role in determining what information is shared.

Co-ordination of services for individuals from different parts of a single provider organisation can also be a problem. This is generally an internal management issue which needs to be monitored closely.

### 9.3 Co-ordination between agencies

*Moving Forward* includes a national objective:

*To promote co-ordination among all agencies associated with mental health services and to ensure that clear lines of accountability exist.*

There needs to be collaboration and partnership in service development, with regional and local service providers working together to contribute to recovery, and sharing information on best practice and quality improvement. In general, the services and strengths of different local mental health agencies are complementary and they need to work together to ensure the benefits of this are realised.

Each agency should have a nominated staff member responsible for promoting and overseeing inter-agency co-ordination. In addition there needs to be one provider responsible for leading inter-agency co-operation and information sharing within each local area. The HFA is responsible for ensuring a mechanism exists in each local area to enable all mental health service providers to meet and share in discussion of service development and other issues; this may need to be purchased explicitly.

### 9.4 Co-ordination between sectors

Co-ordination between sectors and the clarification of responsibilities for issues related to mental health are difficult to achieve, but essential. Good mental health cannot be achieved by mental health services alone. The services and policies of other sectors (particularly social welfare, housing, and employment) influence an individual's overall ability to benefit from mental health services, and sometimes other sectors require mental health service assistance in meeting the needs of service users. The HFA, as a national body, can take a lead role in addressing these issues.

The delivery of services to children and young people raises particular issues since those with severe mental health problems are most likely to come to the attention of more than one sector, for example, education, CYPFS, youth

justice, or police. The funding and purchase of supported employment and vocational services for people with psychiatric disability also raises intersectoral issues.

## 9.5 Mental health workforce

The skills, values, morale, and attitudes of the mental health workforce have an enormous impact on the cost, quality, and efficacy of mental health services. The on-going restructuring of mental health services over the past decade has weakened the morale of the workforce and their effectiveness. Hence, the significant growth in services indicated in this Blueprint must be achieved in ways which boost morale and increase effectiveness, both in the work of each individual and in their understanding of the sector as a whole.

The service growth must also be matched by growth in the size and competence of the existing workforce through effective recruitment and retention strategies, including strategies to recruit people with experience of mental illness. The mental health sector must actively respond to the challenges of developing, attracting, and retaining a high calibre workforce; all involved share this responsibility, in collaboration with the education sector.

Recent strategy development has focused primarily on devising a national mechanism to minimise fragmentation of the sector, and ensure clarity of roles and responsibilities in workforce development throughout the sector.

### 9.5.1 Mental Health Workforce Development Strategy

The National Mental Health Workforce Development Co-ordinating Committee was established early in 1998 to co-ordinate workforce development throughout the sector and develop and implement a definitive framework on which to build the national regulation of mental health workforce development, and the allocation of resources for it. The Committee is led by providers and represents key stakeholders in the sector. It aims to devise a strategic framework which will meet the future needs of the mental health workforce through a flexible, competency based approach. Particular emphasis is being placed on determining attributes of effective organisations and best practice and the workforce development needs of children and young people, Maori, and Pacific people. An increase in recruitment and retention of qualified, experienced personnel is required, with the provision of relevant services to meet their specific needs.

The Committee will have a role in the integration and co-ordination of tertiary education sector providers to ensure the effectiveness and appropriateness of mental health workforce training. Training curricula need to reflect the changed emphasis from institutional care to community and primary care.

The mental health workforce development strategy is designed to promote a shared understanding of workforce requirements, and put in place strategies to ensure they can be achieved. It will provide the structure and processes necessary to enable health workforce information to be gathered and shared, policy to be debated, guidelines developed, implementations monitored, and outcomes assessed.

### 9.5.2 National Certificate in Mental Health (Support Work)

This qualification has been offered since 1998 and is included in the New Zealand Qualification Framework. It provides a major workforce development opportunity for the non-clinical workforce. It will help support workers to gain basic competencies. The increase in numbers and skills of support workers will enable the work of health professionals to be more focused to specific clinical areas. The programme is being specifically targeted to priority workforce areas, for example Maori and Pacific people.

As a pre-entry training programme, the certificate programme will encourage recruitment of a broad range of people into the mental health sector, including people with experience of mental illness.

### 9.5.3 The role of the funder

If the goal of ensuring that everyone in the mental health workforce is qualified with the required competencies within five years is to be achieved, adequate support for the training of clinical and support staff needs to be available from the HFA.

It is essential that there is affordable access to training for the mental health workforce. Increasing the funding and support for small or new non-government organisations to release staff to undertake the National Certificate in Mental Health (Support Work) over the next couple of years is likely to provide maximum return on investment for the HFA. Funding at levels which will ensure that workers can be released in sufficient numbers to build their skills and competencies is important, particularly where organisations use significant numbers of untrained staff.

The Clinical Training Agency has steadily increased its funding for clinical training for mental health professionals over the past two years. It is important that this funding continues to increase, and is targeted towards raising the workforce expertise in areas such as nursing, alcohol and drug (including 'dual diagnosis'), children and youth, Maori, cognitive therapies, and child psychiatry.

### 9.5.4 Health providers

Providers should accept responsibility for developing the mental health workforce through education and planned strategies for recruitment and retention of staff. This will work where health providers collaborate with

tertiary education providers to ensure that students obtain appropriate training and practical experience, and that qualifications are relevant to health providers' needs. This is critical in developing all aspects of the mental health workforce but particularly both the Maori and Pacific people's workforce. The development needs of the emerging consumer workforce also need to be addressed.

Providers need to use staff more effectively. Maximum effectiveness in service delivery can be enhanced by staffing policies which encourage co-operation, effective use of teams, and integration of services across the sector.

#### 9.5.5 Accelerated workforce development for Maori

There is an urgent need for Maori to have a much greater role in all parts of the workforce. Maori workforce development issues are discussed in more detail in Section 6.2.5.

#### 9.5.6 Pacific people's workforce

All mainstream services need to make better provision for the cultural needs of Pacific service users. Pacific workforce development issues are discussed in more detail in Section 7.2.1.

#### 9.5.7 The consumer workforce

There needs to be an expansion of opportunities for people with experience of mental illness to take up roles in the mental health workforce. Training programmes and recruitment strategies need to explicitly encourage people with experience of mental illness to apply for training or positions. They can be employed as consumer advisors, in clinical roles, or support roles.

#### 9.5.8 The workforce, recovery, and discrimination

The workforce is now expected to use a recovery approach in their work and to focus on achieving wellness instead of just treating illness. The workforce needs to understand that discrimination can be as great a threat to recovery as mental illness is, and must address its own discrimination against people with mental illness. At the same time the people in the workforce will need to become much more active and skilled in helping to reduce service users' internalised discrimination, and discrimination against people with mental illness by the wider community.

These developments will require major changes to training standards, training programmes, and recruitment and retention of the workforce. They will require a new look at service quality and new ways of involving service users, especially as part of the workforce.

## 9.6 Evaluation and monitoring of service effectiveness

Consistent and thorough evaluation of the effectiveness of services (particularly new services) is urgently required to identify the specific factors which make good services work well, and to ensure advances in mental health service delivery. In the past two years the Health Research Council has funded some research on mental health service issues including:

- casemix: examining the cost of providing services for people with a range of needs
- outcomes: measuring the outcomes of service interventions
- epidemiology: measuring mental illness in New Zealand.

In addition, the Commission is currently undertaking a project to identify and share best practices in mental health services.

It is recommended that contracts for the provision of services have evaluation of the service included as an explicit requirement. Training in evaluation and outcome measurement also needs to be provided.

## 9.7 Mental health information

At present there is a lack of good information about what services are being provided, where, for which diagnoses, and for whom. This is being remedied. The Ministry of Health and the New Zealand Health Information Service (NZHIS) have completed a successful pilot of the new national mental health data collection system, and the Minister of Health has now approved full national implementation which will be completed by the end of 1999. This implementation is being led by the NZHIS.

The new system collects information about services used by people, and is linked to their National Health Index (NHI) number. All HHSs and NGO mental health service providers will provide data on:

- descriptive information about service user groups (age, ethnicity, domicile code, gender)
- diagnoses – to get a clearer picture of the problems which are being addressed by mental health services
- services provided – based on the National Mental Health Common Base Definitions
- referral source
- where the service is being provided.

Information collected will be made available to all those who provide data and to the Ministry of Health, the Mental Health Commission, and the HFA through a series of standard reports. Issues of privacy are being addressed as part of the project to ensure service users get good information

about their rights, and about what data is being collected and how it will be used.

This new Mental Health Information Service will greatly aid service planning and measurement of progress towards achievement of the goals, objectives, and targets of the National Mental Health Strategy. For the full benefits of the data collections to be realised it is vital that providers forward data which is as accurate as possible.

# Appendix I

Towards equality respect and rights for people who experience mental illness

The Commission launched its *Map of the Journeys* in June 1998. It illustrates the kind of changes New Zealanders need to make at personal, political, and social levels, if we are to gain equality, respect, and rights for people with mental illness. It shows where we all need to get to and how we can get there. The complete *Map* and companion *Travel Guide* (which are available from the Commission<sup>41</sup>) demonstrate the complexity and scope of the problem; we need to be on guard against simple solutions.

The *Travel Guide* includes a working analysis of discrimination. The Commission talked to many people who experienced discrimination, and to people who have tried to deal with it. The Commission has also dealt directly with some instances of discrimination, and gathered information about overseas experience. The analysis of the problem has drawn on initial work<sup>42</sup> which looked at discrimination against other groups of people, and at the kinds of solutions discovered for dealing with those discriminations. It looks at how discrimination works, and identifies the particular dangers and risks which face anyone trying to deal with this problem.

The *Travel Guide* also includes an invitation to become travellers on these journeys. Everyone can be a traveller and it doesn't really matter how small or large your journey is. It may involve just a single challenge to someone who makes a casual discriminatory remark or it could be a whole lifetime's work to end discrimination.

Like all major journeys, this journey means overcoming challenges both in our external environment and also in our personal worlds. This means we will need to face our fears, find ways through extremely wicked problems, and not blame each other when we make mistakes. Instead, we must learn from them and move on, better informed. The success of the journey will depend on being creative, having the courage of our convictions, working together, supporting each other, and sharing our discoveries with each other. The Commission is working with the whole sector to right discrimination, working *as a team* to deal with it, sharing strategies and combining efforts. And most of all, supporting each other.

The *Travel Guide* lists the many people and agencies who need to understand their role if New Zealand is to travel the journeys towards equality and respect and rights for people with mental illness. This list includes the health sector:

service-users/tangata whaiora and survivor's organisations, family organisations, the Ministry of Health, the HFA, Hospital and Health Services, the Mental Health Commission, the Mental Health Foundation, professional colleges and associations, alcohol and drug agencies,

<sup>41</sup> *Travel guide for people on the journeys towards equality respect and rights for people who experience mental illness*, Mental Health Commission, June 1998

<sup>42</sup> Thompson M. and Thompson T., *Discrimination against people with experiences of mental illness*, discussion paper for the Mental Health Commission, July 1997

Pharmac, schools of medicine, workforce training institutions, and non-government organisations

as well as people and agencies in other sectors:

Education, Social Welfare, employment, housing, youth organisations, Women's Affairs, Treasury, community trusts, Police, legal organisations, Parliament, rights organisations, arts organisations, sports organisations, the media, financial institutions, retailers, service providers, community and service clubs, churches, Maori organisations, Pacific people's organisations ...

... and, above all, INDIVIDUALS – each and everyone of us.

The following excerpt from the *Map* shows the seven *Destinations*, with a set of *Paths* to each. Examples of ways to travel each path are available in the full *Travel Guide*. In the *Guide* and *Map*, the term 'service-user/tangata whaiora' is used to refer to people who experience or have experienced mental illness and who have used or are using mental health services.

DESTINATION 1:

A COUNTRY IN WHICH PEOPLE WITH MENTAL ILLNESS HAVE THE PERSONAL POWER TO GAIN EQUALITY, RESPECT, AND RIGHTS

THIS MEANS people with mental illness:

- value their experiences, their strengths, and their abilities
- understand their rights and how to protect themselves from discrimination
- know how to find and create opportunities to lead a fulfilling life
- have access to health services which meet their needs.

PATHS

Equip people who experience mental illness with the tools to increase their personal power, to fight discrimination, and to protect themselves from its effects.

Equip people with mental illness with the tools to maintain or improve their health, well-being, relationships, housing, work, leisure, and income.

Support service-users/tangata whaiora initiatives that help reduce discrimination.

Ensure that service-users/tangata whaiora do not discriminate against other people with mental illness.

Research, document, and raise discussion about the personal impact of discrimination on service-users/tangata whaiora, and about their successes in reducing it.

## DESTINATION 2:

A HEALTH SECTOR WHICH VALUES PEOPLE WITH MENTAL ILLNESS AND TREATS THEM FAIRLY

THIS MEANS people in the health sector understand how its systems, processes and personnel can discriminate against people with mental illness, and put into place measures which ensure:

- adequately resourced mental health services
- equitable access to all health services for people with mental illness
- respect for people with mental illness
- recognition and promotion of their rights
- service-users/tangata whaiora influence decision making.

## PATHS

Ensure that people with mental illness have equitable choice in all publicly funded health services.

Actively increase the participation of mental health service-users/tangata whaiora at all levels and phases of policy development, funding, and service provision.

Mobilise the mental health workforce to stop discrimination against people with mental illness.

Ensure discrimination awareness and related issues are integrated into all education, training, and development of health workers.

Support Pacific people to deal with discrimination within the health sector against mental health service users.

Research, document, and raise discussion about discrimination within the health sector including successful ways to reduce it.

Recognise and reward the best non-discriminatory practices.

Ensure there are adequate advocacy services and complaints procedures for service-users/tangata whaiora in all publicly funded health services.

## DESTINATION 3:

## LAWS AND PRACTICE WHICH UPHOLD THE RIGHTS OF PEOPLE WITH MENTAL ILLNESS

THIS MEANS there are laws which protect the rights of people with mental illness, and these laws are adequate, understood, promoted, and used effectively to deal with discrimination.

## PATHS

Identify gaps in legal protection and rights, and promote law reform.

Equip legal professionals with the tools to provide useful services to people with mental illness.

Promote better use of existing laws and complaints processes to increase legal protection for people with mental illness in the community.

Promote better use of existing laws and complaints processes to increase legal protection for people within mental health services.

Produce information for people with mental illness on legal issues relating to their rights.

## DESTINATION 4:

## PUBLIC ORGANISATIONS WHICH ARE ACCESSIBLE AND FAIR FOR PEOPLE WITH MENTAL ILLNESS

THIS MEANS public organisations (for example Police, Work and Income NZ, Corrections) are aware of the needs and rights of people with mental illness, and put in place measures in their service which ensure:

- respect for people with mental illness
- recognition of the rights of people with mental illness
- understanding of the effects of discrimination against people with mental illness.

## PATHS

Disseminate information and provide advice on discrimination against people with mental illness to public organisations.

Develop anti-discrimination awareness and initiatives in public organisations to ensure equitable service provision.

Increase co-operation and sharing of information on discrimination issues between public organisations.

Support Maori to deal with discrimination by public organisations against Maori with mental illness.

Support and actively assist Pacific people to deal with discrimination against Pacific people with mental illness.

DESTINATION 5:  
PRIVATE ORGANISATIONS WHICH ARE ACCESSIBLE AND FAIR TO PEOPLE  
WITH MENTAL ILLNESS

THIS MEANS private organisations (for example, insurance companies, retailers, landlords, community welfare agencies) are aware of the needs and rights of people with mental illness and put in place measures which ensure:

- respect for people with mental illness
- recognition of the rights of people with mental illness
- understanding of the effects of discrimination against people with mental illness.

PATHS

Disseminate information and provide advice on discrimination against people with mental illness.

Work with the Human Rights Commission to address discrimination against people with experience of mental illness.

Identify and use opportunities to raise discrimination issues in private, commercial, and community organisations.

DESTINATION 6:  
COMMUNITIES WHICH BEHAVE FAIRLY AND INCLUSIVELY TOWARDS PEOPLE  
WITH MENTAL ILLNESS

THIS MEANS the people of New Zealand will:

- respect the experiences of people with mental illness
- recognise the value of people with mental illness
- understand the negative effects of discrimination against people with mental illness
- take personal responsibility for acting in non-discriminatory ways.

PATHS

Undertake a personal journey to understand discrimination and to challenge discriminatory behaviour.

Educate people through accurate and accessible information on mental illness and recovery, and through contact with people who experience mental illness.

Work with the media to improve the representation of mental illness.

Create strong links between people in the mental health sector in order to present a united voice to the public.

Use Mental Health Awareness Week creatively.

Develop non-discriminatory popular language for mental health issues.  
Recognise and counter the double discrimination against Maori with mental illness.

Recognise and counter the double discrimination against Pacific people with mental illness.

DESTINATION 7:  
ARO KI TE HA O TE TANGATA

## INTRODUCTION

This destination describes a country which treats Maori with mental illness fairly; it was developed by a group of experts in Maori mental health. This group has listed a wide range of issues which relate to discrimination and moreover cover the need for equity and self-governance for Maori.

The traveller on these journeys needs to empower, affirm, and listen to tangata whaiora, and to act positively and be pro-active about recognising Maori processes and practices.

## PATHS

### 7A ACTIVE MAORI PARTICIPATION

THIS MEANS ensuring that Maori have the opportunity to make the decisions for, manage, and implement mental health services for Maori.

Enable cultural assessments for all tangata whaiora to be undertaken by Maori.

Encourage participation by Maori at all levels and phases of policy making and service delivery.

Acknowledge and provide for iwi and urban Maori diversity.

### 7B POSITIVE MAORI DEVELOPMENT

THIS MEANS recognising the need for relevant standards, policies, and practices targeted at delivery of services to Maori.

Develop the body of knowledge about Maori mental health concepts and service delivery.

Recognise and encourage successful Maori mental health providers.

Develop effective relationships between kaupapa Maori and mainstream services to provide the best services for tangata whaiora.

Recognise the need for kaupapa Maori mental health services.

Distribute information and provide education on Maori mental health issues.

## 7C ELIMINATION OF DISPARITIES

**THIS MEANS** unlocking the mental health system to ensure Maori priorities have equal consideration in the mental health sector.

Develop and implement a process that measures the quality of services which tangata whaiora receive.

Work towards strengthening Maori owned and operated mental health services.

Accelerate Maori mental health workforce development.

Provide services that meet tangata whaiora needs.

## Appendix II

A matrix for translating principles into action for Maori mental health

The following table shows the identified critical success factors which should be used as the basis for evaluation of funder and provider performance. It shows the kinds of questions which may be asked when auditing funder and provider performance. The development of this matrix (in 1997-98) was facilitated by Te Puni Kokiri in partnership with the Ministry of Health, the Commission, and the Maori Health Commission.

Critical success factors	The funder	Mainstream mental health service providers	Kaupapa Maori mental health service providers
<p>Outcome measures that reflect Maori realities</p>	<ul style="list-style-type: none"> <li>Can the funder demonstrate that mental health, public health, and primary health funding decisions are designed to reduce disparities in mental health status between Maori and non-Maori?</li> <li>Does the funder have a strategy to identify which services (and mix of services) are most effective for Maori?</li> <li>Does the funder evaluate services and its funding decisions using outcome measures which incorporate, or are consistent with the four dimensions of Whare Tapa Wha?</li> <li>Does the funder prioritise a framework use measures relevant to Maori?</li> </ul>	<ul style="list-style-type: none"> <li>Does the service use outcome measures which include meaningful measures of service effectiveness for Maori, developed by, or in partnership with Maori?</li> <li>Do these include measures of: <ul style="list-style-type: none"> <li>Whare Tapa Wha</li> <li>tangata whaiora satisfaction</li> <li>symptom reduction and wellness in individuals, as perceived by the service user, clinicians, and whanau</li> <li>whanau satisfaction?</li> </ul> </li> <li>Do providers use the results of outcome measurement to identify service delivery and treatment strategies which are most effective for Maori?</li> </ul>	<ul style="list-style-type: none"> <li>Does the service use outcome measures which include: <ul style="list-style-type: none"> <li>Whare Tapa Wha</li> <li>the perspectives of service users, clinicians, and whanau?</li> </ul> </li> <li>Are results of these outcome measures reported regularly to the funder?</li> <li>Does the service use the results of its outcomes measurement to inform its service development?</li> </ul>
<p>Culturally relevant and Maori focused treatment practices</p>	<ul style="list-style-type: none"> <li>Are service specifications and other contract requirements designed to encourage culturally relevant service delivery?</li> <li>Can contract output measures and contracted volumes be shown to reflect the reality of effective service delivery processes for Maori (e.g. allow for sufficient time for comprehensive assessments and whanau participation)?</li> </ul>	<ul style="list-style-type: none"> <li>Are there processes, care planning, and treatment protocols in use for Maori, which meet Maori cultural requirements and incorporate the components of Whare Tapa Wha at each step of the clinical pathway: <ul style="list-style-type: none"> <li>referral</li> <li>assessment</li> <li>treatment planning</li> <li>treatment intervention</li> <li>discharge</li> <li>follow-up?</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Are there processes, care planning, and treatment protocols in use which meet Maori cultural requirements and incorporate the components of Whare Tapa Wha and Maori traditional health practice at each step of the clinical pathway: <ul style="list-style-type: none"> <li>referral</li> <li>assessment</li> <li>treatment planning</li> <li>treatment intervention</li> <li>discharge</li> <li>follow-up?</li> </ul> </li> </ul>

Critical success factors	The funder	Mainstream mental health service providers	Kaupapa Maori mental health service providers
<p>Culturally relevant and Maori focused treatment practices (cont)</p>	<p>Do funding and contracting strategies and processes demonstrably promote Maori centred clinical practice, and include requirements for:</p> <ul style="list-style-type: none"> <li>• cultural assessment</li> <li>• traditional Maori treatment processes</li> <li>• access to tohunga</li> <li>• access to kaumatua?</li> </ul> <ul style="list-style-type: none"> <li>• Is the demographic profile of Maori reflected in funding decisions?</li> <li>• Does the funder provide for the different needs of rural and urban Maori?</li> </ul>	<ul style="list-style-type: none"> <li>• Do providers have processes and protocols to ensure that clinical interventions promote cultural integrity?</li> </ul>	<ul style="list-style-type: none"> <li>• Does the clinical service incorporate:                             <ul style="list-style-type: none"> <li>– cultural assessment</li> <li>– Maori treatment, including rongoa and mirimiri</li> <li>– access to tohunga</li> <li>– access to kaumatua?</li> </ul> </li> </ul>
<p>Maori access</p>	<ul style="list-style-type: none"> <li>• Are funding decisions designed to reduce disparities in access to services between Maori and non-Maori with similar levels of need?</li> <li>• Are specific services or strategies in place to ensure access by Maori to early intervention services?</li> <li>• Do funding decisions provide the opportunity for whakawhanaungatanga to take place?</li> </ul>	<ul style="list-style-type: none"> <li>• Can the provider demonstrate strategies are in place to ensure that access to the service is as easy and effective for Maori as it is for non-Maori?</li> <li>• Does the provider check that Maori know when and how to access services?</li> <li>• Can the provider show that there are strategies in place to encourage Maori to access services at early stages of their illness?</li> </ul>	<ul style="list-style-type: none"> <li>• Does the service have strategies in place to ensure Maori know when and how to access it?</li> <li>• Does the service have strategies in place to ensure other (mainstream) providers know when and how to refer Maori to it?</li> <li>• Does the service welcome non-Maori who wish to access a kaupapa Maori Service?</li> </ul>

Critical success factors	The funder	Mainstream mental health service providers	Kaupapa Maori mental health service providers
<p>Whanau participation</p>	<ul style="list-style-type: none"> <li>Can funding and contracting strategies be shown to encourage whanau participation and whanau development in practical and concrete ways?</li> <li>Do such strategies acknowledge and provide for varying concepts of whanau?</li> <li>Do such strategies encourage services to meet the needs of whanau?</li> <li>How does the funder ensure that its own workforce has sufficient Maori knowledge and experience?</li> </ul>	<ul style="list-style-type: none"> <li>Can the provider demonstrate that whanau participation in the planning, development, and monitoring of services as a whole, and services for tangata whaiora, is encouraged and facilitated?</li> <li>Can the provider demonstrate understanding of the particular local concepts of whanau?</li> <li>Does the provider make specific provisions to meet the needs of individual whanau?</li> </ul>	<ul style="list-style-type: none"> <li>Can the provider show that whanau participation is actively developed, and based on the following concepts of whanaungatanga: <ul style="list-style-type: none"> <li>tatau tatau (collective responsibility)</li> <li>mana tiaki (guardianship)</li> <li>manaakitanga (caring)</li> <li>whakamana (enablement)</li> <li>whakatakoto tutoro (planning)</li> <li>whai wahi tanga (participation)?</li> </ul> </li> <li>Does the provider identify and respond to individual whanau needs?</li> </ul>
<p>Skilled Maori workforce</p>	<ul style="list-style-type: none"> <li>Does the funder set annual targets and allocate funding for: <ul style="list-style-type: none"> <li>– growth in the Maori mental health workforce</li> <li>– additional training opportunities for the existing Maori mental health workforce?</li> </ul> </li> <li>Do the funder's service specifications require all providers to ensure their staff have appropriate knowledge and experience to meet the cultural and clinical needs of Maori?</li> <li>Does the funder require all service providers to ensure staff receive continuing education in both cultural and clinical matters?</li> </ul>	<ul style="list-style-type: none"> <li>Are appropriately qualified staff available to deliver the cultural components of treatment?</li> <li>Do all clinical staff receive continuing education in tikanga Maori?</li> <li>Do Maori health workers receive both clinical and cultural supervision?</li> <li>Does the organisation have specific recruitment and retention strategies for Maori staff?</li> <li>Does the service have strong consultation and liaison arrangements with local Maori services?</li> </ul>	<ul style="list-style-type: none"> <li>Is there clinical and cultural supervision provided for all staff?</li> <li>Is there access provided to continuing education and upskilling for all staff, in both cultural and clinical knowledge?</li> <li>Does the service have a strong consultation – liaison arrangement with mainstream services?</li> </ul>

Critical success factors	The funder	Mainstream mental health service providers	Kaupapa Maori mental health service providers
<p>Effective consumer advocacy</p>	<ul style="list-style-type: none"> <li>Does the funder ensure there is tangata whaiora participation in its planning and funding processes?</li> <li>Can the funder demonstrate that this participation is encouraged, supported and incorporated in decision making?</li> </ul>	<ul style="list-style-type: none"> <li>Do tangata whaiora participate in the service planning, development, and monitoring processes?</li> <li>Can the provider demonstrate that this participation is encouraged, supported, and incorporated into decision making?</li> </ul>	<ul style="list-style-type: none"> <li>Do tangata whaiora have effective input into the service's development of strategic directions, service management, service delivery decision protocols, and service evaluation?</li> </ul>
<p>Quality assurance processes relevant for Maori – tangata whaiora and whanau</p>	<ul style="list-style-type: none"> <li>Does monitoring and audit of services by the funder use processes and tools developed by Maori, and include assessment of the cultural effectiveness of services?</li> </ul>	<ul style="list-style-type: none"> <li>Is the provider implementing a continuous quality improvement strategy which includes measures and tools developed by and administered by Maori?</li> <li>Are targets set for improvement of tangata whaiora and whanau satisfaction?</li> </ul>	<ul style="list-style-type: none"> <li>Is there a quality improvement process strategy in place which ensures people's best performance in cultural, clinical and managerial competencies, and ensures they are accountable for their actions?</li> </ul>
<p>Co-ordination and collaboration – community integration</p>	<ul style="list-style-type: none"> <li>Do funding and contracting strategies promote and provide for inter-agency and inter-sectoral collaboration and co-operation?</li> <li>Do service specifications support and require strong linkages between local services?</li> </ul>	<ul style="list-style-type: none"> <li>Does the mental health service have explicit links with other health and social services, both mainstream and Maori?</li> <li>Are these links formalised in a Memorandum of Understanding or Manawhenua charter?</li> <li>Are these links sufficient to ensure tangata whaiora are able to access a continuum of services in response to their changing needs?</li> </ul>	<ul style="list-style-type: none"> <li>Does the service have close links and understandings with other mainstream and Maori health and social services to enable the wider needs of tangata whaiora and whanau to be met?</li> <li>Does the service have close links with other Maori providers so that the agency's peer support needs can be met?</li> </ul>

Critical success factors	The funder	Mainstream mental health service providers	Kaupapa Maori mental health service providers
Sustainable service provider development	<ul style="list-style-type: none"> <li>• How does the funder ensure that the provider service will be sustainable over the foreseeable future?</li> <li>• Does the funder ensure that the provider has an acceptable business plan, sufficient capital base, and appropriate business skills and systems in place?</li> <li>• Does the funder make specific provision for Maori service provider development?</li> <li>• Are standards set for business and management practice?</li> </ul>	<ul style="list-style-type: none"> <li>• Do Maori health workers and other Maori staff have the opportunity to receive training in business development and management?</li> </ul>	<ul style="list-style-type: none"> <li>• Do those working for the provider have sufficient skills in business planning, management, and administration to ensure they can be held accountable for their actions?</li> <li>• Do management and administration staff receive continuing education and regular professional appraisal?</li> </ul>
Public health and primary health care programmes targeted to meeting needs of Maori	<ul style="list-style-type: none"> <li>• Is the mental health funding plan supported by strong public and primary health funding and contracting strategies which increase access by Maori to public and primary health care programmes?</li> <li>• Are there specific goals to build greater understanding of mental illness, reduce risk factors, and encourage early primary care intervention for Maori?</li> </ul>	<ul style="list-style-type: none"> <li>• Does the mental health service work actively with local public and primary health care services to promote mental health for Maori?</li> </ul>	<ul style="list-style-type: none"> <li>• Does the service work with local public and primary health care services to ensure increased access by Maori to primary health services which are effective for them, and effective delivery of relevant public health information?</li> </ul>

## Appendix III

### Implementation of the National Mental Health Standards

The National Mental Health Standards<sup>43</sup> are intended to apply to all mental health service providers throughout New Zealand. Achieving the Standards will mean the principles set out in *Looking Forward* are implemented. The Minister's Foreword to the Standards states that:

“The aim of the National Mental Health Standards is to upgrade the quality of mental health services and ensure consistency for every New Zealander who needs to use the mental health service. People who use mental health services are not usually able to influence the quality of that service. Therefore providers have an obligation to ensure high quality services that respect the dignity of the individual.”

Full implementation and evidence of achievement is expected by 2000. Under the Funding Agreement between the HFA and the Minister of Health, the National Mental Health Standards will be included in contractual arrangements between mental health service providers and the HFA from 1999. This will be monitored by the Ministry of Health.

The twenty National Mental Health Standards are:

#### 1. Tangata whenua

The mental health service will provide appropriate services to meet the needs of whanau, hapu, and iwi.

#### 2. Pacific people

The mental health service delivers and facilitates appropriate services to meet the needs of Pacific people affected by mental illness, their families, carers and others nominated by the consumer.

#### 3. Cultural awareness

The mental health service delivers treatment and support which is appropriate and sensitive to the cultural, spiritual, physical, environmental and social values of the consumer and the consumer's family and community.

#### 4. Children and young people

The mental health service delivers assessment, treatment and support to children, young people and their families, who are affected by mental illness or mental health problems. The mental health service also delivers consultation and liaison services to other professionals involved with children and young people with mental health problems.

<sup>42</sup> *The National Mental Health Standards*, Ministry of Health, June 1997

## 5. Rights

The rights of people affected by mental illness and mental health problems are respected, acknowledged and upheld by mental health services.

## 6. Safety

The activities and environment of the mental health service are safe for consumers, their families, carers, staff and the community.

## 7. Consumer record and documentation

Clinical activities are documented to assist in the coordinated delivery of care.

## 8. Privacy and confidentiality

The mental health service ensures the privacy and confidentiality of consumers and their families.

## 9. Consumer participation

Consumers are involved in the planning, implementation and evaluation of the mental health service.

## 10. Family and carer participation

Families and carers are involved in the planning, implementation and evaluation of the mental health service.

## 11. Prevention and early intervention

The mental health service works with groups in the community in prevention, early detection and early intervention.

## 12. Leadership and management

The mental health service is led and managed effectively and efficiently to facilitate the delivery of coordinated service.

## 13. Access

The mental health service is accessible to the community.

## 14. Entry

The process of entry to the mental health service facilitates timely and ongoing assessment for consumers.

#### 15. Consumer assessment

Consumer care, treatment and support is based on a comprehensive assessment which is completed by a health team with appropriate knowledge and skills.

#### 16. Quality care and treatment

Consumers and their families are able to access a range of high quality mental health care, treatment, and support options.

#### 17. Community support options

The mental health service provides access to a range of community support options which maximise choice, safety and quality of life for the consumer.

#### 18. Discharge planning

Consumers are assisted to plan for their exit from the mental health service to ensure that ongoing follow-up is available if required.

#### 19. Follow-up and re-entry

The mental health service assists consumers to exit the service and ensures re-entry is facilitated and occurs according to consumer needs.

#### 20. Promoting mental health and community acceptance

The mental health service promotes mental health and community acceptance of people affected by mental illness and mental health problems.

## Appendix IV

A summary of the resource guidelines by age group

Adult Services		Current resources: Total NZ	Resource guideline: Total NZ	Resource guideline per 100,000 total population	Age Group				
					0–14	15–19	20–64	65+	
1.1	Acute inpatient	Beds or 'care packages'	603.0	566.6	15.00		0.90	12.80	1.30
1.2	Community mental health teams	Adult – FTEs	1,271.5	1,575.8	41.70		2.50	35.50	3.70
1.3.1	Community residential Level I/II	Beds or 'care packages'	1,124.0	1,133.1	30.00		2.00	28.00	
1.3.2	Community residential Level III+	Beds or 'care packages'	1,392.0	1,510.8	40.00		2.70	37.30	
1.4	Access to newer anti-psychotic medication	Treatment places	3,547.0	8,498.3	225.00		31.20	175.70	18.10
1.5	Home based support services	FTEs	187.6	566.6	15.00		0.90	12.80	1.30
1.6	Residential intensive long-term	Beds or 'care packages'	41.0	60.4	1.60		0.10	1.50	
1.7	Medium term and extended inpatient services	Beds or 'care packages'	446.0	453.2	12.00		0.80	11.20	
1.8	Employment and education support	FTEs	15.0	377.7	10.00		0.70	9.30	
1.9	Support and education for recovery	FTEs	185.7	339.9	9.00		0.60	8.40	
1.10	Outreach (rural)	FTEs	0.0	56.7	1.50		0.10	1.30	0.10
1.11	Consumer advisory services and consumer run initiatives	FTEs	30.1	151.1	4.00		0.20	3.40	0.40
1.12	Family advisory services and family run initiatives	FTEs	32.8	94.4	2.50		0.20	2.10	0.20
1.13	General hospital liaison	FTEs	26.9	75.5	2.00	0.30	0.20	1.40	0.10
1.14	Primary service liaison	FTEs	19.4	94.4	2.50	0.40	0.30	1.70	0.20
1.15	Early intervention services	FTEs	33.6	170.0	4.50		2.70	1.80	
5.1	Alcohol and drug – community assessment and treatment	FTEs	259.2	585.4	15.50		0.90	13.20	1.40
5.2.1	Alcohol and drug – methadone specialist	Treatment places	2,756.0	3,339.3	90.00		10.00	80.00	
5.2.2	Alcohol and drug – methadone G.P.	Treatment places	274.0	2,266.2	60.00			60.00	
5.3	Alcohol and drug – residential treatment	Beds or 'care packages'	307.5	207.7	5.50		0.40	5.10	
5.4	Alcohol and drug – supported living services	Beds or 'care packages'	68.0	75.5	2.00		0.10	1.90	
5.5	Alcohol and drug – home and community detoxification	FTEs	2.8	28.3	0.75			0.75	

continued over

*continued*

Adult Services		Current resources: Total NZ	Resource guideline: Total NZ	Resource guideline per 100,000 total population	Age Group				
					0–14	15–19	20–64	65+	
5.6	Alcohol and drug – social, medical, and dedicated inpatient detoxification	Beds or 'care packages'	95.6	113.3	3.00		0.20	2.80	
6.1	Mental health and alcohol and drug services – specialist expertise	FTEs	2.3	<sup>44</sup> 68.1	2.00		0.30	1.30	0.20
6.2	Mental health and alcohol and drug – community residential services and treatment	Beds or 'care packages'	0.0	94.4	2.50		0.40	2.10	
6.3	Mental health and alcohol and drug – community teams	FTEs	0.0	56.7	1.50		0.20	1.20	0.10
7.1	Mental health and intellectual disability – specialist expertise	FTEs	18.4	37.8	1.00		0.60	0.40	
TOTAL BEDS			4,077.1	4,215.0	103.10		7.10	94.70	1.30
TOTAL CLINICAL FTEs			1,634.1	2,748.7	56.90	0.70	6.90	44.90	4.40
TOTAL NON-CLINICAL FTEs			451.2	1,529.7	40.50		2.60	36.10	18.10
METHADONE TREATMENT PLACES			3,030.0	5,605.5	150.00		10.00	140.00	

Services for children, youth and their families		Current resources: Total NZ	Resource guideline: Total NZ	Resource guideline per 100,000 total population	Age Group				
					0–14	15–19	20–64	65+	
2.1	Acute inpatient – child and youth	Beds or 'care packages'	24.0	75.5	2.0	1.1	0.9		
2.2	Secure inpatient – child and youth	Beds or 'care packages'	0.0	15.1	0.4	0.2	0.2		
2.3	Community mental health teams – child, youth and their families	FTEs	300.2	1,080.2	28.6	15.6	13.0		
2.4	Respite services – child and youth	Care packages	0.0	30.2	0.8	0.4	0.4		
2.5	Day programmes – child and youth	Care packages	0.0	151.1	4.0	2.2	1.8		
2.6	Community residential services – child and youth	Beds or 'care packages'	0.0	75.5	2.0	1.1	0.9		
TOTAL BEDS OR 'CARE PACKAGES'			24.0	196.3	5.2	2.8	2.4		
TOTAL FTEs			300.2	1,080.2	28.6	15.6	13.0		
TOTAL DAY PROGRAMME			0.0	151.1	4.0	2.2	1.8		

<sup>44</sup> Note that 7.4 FTEs are listed as part of forensic services

Services for older people			Current resources: Total NZ	Resource guideline: Total NZ	Resource guideline per 100,000 total population	Age Group			
						0–14	15–19	20–64	65+
3.1	Older people – assessment and treatment	Beds or 'care packages'	142.9	151.1	4.0				4.0
3.2	Older people day time support	'Care packages'	0.0	151.1	4.0				4.0
3.3	Older people – Community teams	FTEs	49.3	321.0	8.5				8.5
TOTAL BEDS OR 'CARE PACKAGES' <sup>45</sup>			142.9	302.2	8.0				8.0
TOTAL FTEs			49.3	321.0	8.5				8.5

Regional specialist services – Forensic			Current resources: Total NZ	Resource guideline: Total NZ	Resource guideline per 100,000 total population	Age Group			
						0–14	15–19	20–64	65+
4.1	Forensic – acute medium secure inpatient	Beds or 'care packages'	108.0	141.6	3.75			3.75	
4.2	Forensic – long stay, maximum secure, inpatient	Beds or 'care packages'	43.0	47.2	1.25			1.25	
4.3	Forensic – minimum secure	Beds or 'care packages'	39.2	47.2	1.25			1.25	
4.4	Forensic – community residential recovery support and education	Beds or 'care packages'	19.0	28.3	0.75			0.75	
4.5	Forensic – court liaison	FTEs	19.5	30.2	0.80			0.80	
4.6	Forensic – prison liaison	FTEs	9.2	25.4	0.67			0.67	
4.7	Forensic – community liaison services	FTEs	35.6	18.9	0.50			0.50	
6.1	Mental illness and alcohol and drug disorders – specialist expertise	FTEs	0.0	7.4	0.20			0.20	
TOTAL BEDS or 'CARE PACKAGES'			209.2	264.3	7.00			7.00	
TOTAL FTEs			64.3	81.9	2.17			2.17	

<sup>45</sup> Including daycare

Regional specialist services		Current resources: Total NZ	Resource guideline: Total NZ	Resource guideline per 100,000 total population	Age Group			
					0-14	15-19	20-64	65+
9.1	'Mothers and babies' service Beds or 'care packages'	7.6	18.9	0.50		0.10	0.40	
9.2	'Mothers and babies' – community staff FTEs	22.8	66.1	1.75		0.25	1.50	
9.3	'Mothers and babies' – respite services or intensive home support Beds or 'care packages'	0.0	28.3	0.75		0.15	0.60	
8.1	Head injury or neurological disorder with behavioural problems Beds or 'care packages'	0.0	75.5	2.00		0.30	1.70	
8.2	Head injury or neurological disorder with behavioural problems – community teams FTEs	0.0	7.6	0.20			0.20	
10.1	Eating disorders – community teams FTEs	15.4	90.6	2.40		0.40	2.00	
10.2	Eating disorders Beds or 'care packages'	10.0	18.9	0.50		0.10	0.40	
10.3	Services for profoundly deaf people who have a mental illness – community consultation/ liaison FTEs	1.5	4.5	0.12			0.12	
10.4	Services for refugees who have mental health disorders – community staff FTEs	2.8	7.6	0.20			0.20	
10.5	Services for people with disabling personality disorders – community teams FTEs	10.2	11.3	0.30			0.30	
10.6	Services for people with severe anxiety disorders – community teams FTEs	8.0	11.3	0.30			0.30	
11.2	Mental illness prevention services – community staff FTEs	0.0	377.7	10.00	3.30	2.80	3.90	
TOTAL BEDS		17.6	141.6	3.75		0.65	3.10	
TOTAL CLINICAL FTEs		60.7	576.7	15.27	3.30	3.45	8.52	

## Appendix V

### Development of the input resource guidelines

The November 1997 *Blueprint for mental health services in New Zealand: working document* estimated the overall staff resources for community mental health services. These estimates were based on a theoretical model of how many staff were required to meet the treatment and support needs of people experiencing mental illness. The output of the model was tested against a selection of mental health services. The Blueprint was then released as a consultation document and submissions were requested. The Commission received submissions from 59 individuals and organisations during the consultation. The Commission then undertook further work, and re-examined the resource guidelines, including the following steps:

- a review of the epidemiological literature and development of a model which predicted the number of people with particular groups of mental health disorders (including severity and likely uptake of services) by age group
- a comparison of the resource guidelines with the services currently purchased by the HFA
- from the information gained in the first two steps, a set of proposed resource guidelines (including information on the historical and current level of services purchased and estimates of prevalence) were then reviewed by a panel of twelve experts.<sup>46</sup> The panel voted on each proposed guideline, rated their confidence about the accuracy of their estimate of the services required, and rated the opportunity for marginal gains in mental health status of the community should extra resources be allocated to purchase services at the level of the resource guideline
- consultation with staff of critical services areas (services for children and youth, older people, deaf people, 'mothers and babies' and other special populations) about the revised resource guidelines and the implications for their particular service (for example, whether the proposed level of resources would meet the needs of their area as they understood them)
- consultation with staff of the Ministry of Health and HFA (some of whom were also included in the expert panel).

The Commission considers these revised resource guidelines to be the current best estimate of the resources required to meet the access targets of *Moving Forward*.<sup>47</sup> It is intended that the guidelines should be primarily used for estimation of the services at the national, or a particular regional, population. They are not intended for use with smaller populations (individual Hospital and Health Services) without taking into account the particular local and regional components provided by other services.

<sup>46</sup> The group's members were Professor Peter Ellis (chair), Dr Bruce Adlam, Professor Gavin Andrews, Dr Barbara Disley, Christine Elliot, Dr Sue Hallwright, Meroa Mar, Professor Graeme Mellso, Dr Doug Sellman, Dr Elisabeth Wells, Dr Janice Wilson, and Derek Wright. Professor Mason Durie was a corresponding member of the group.

<sup>47</sup> During the course of this revision of the resource guidelines, the Ministry of Health proposed a modification to the access targets for the age group 0 - 19 years. The proposed access targets are contained in the Ministry's 1998 publication *New Futures*.

The table below outlines a summary of the resources that are expected to be required to provide an adequate publicly funded specialist mental health services for a group of 100,000 New Zealanders.

Service type	Resource guidelines per 100,000 total population by age group				
	0-14	15-19	20-64	65+	Total
Inpatient – beds or ‘care packages’	1.3	3	31.1	5.3	40.7
Residential – beds/care and daycare packages	3.7	8.3	69.1	4	85.9
Community mental health – FTEs	16.3	20.8	51.4	12.9	101.2
Community support – FTEs	0	2.2	30.5	1.3	34
Consumer and family advisory services and initiatives – FTEs	0	0.4	5.5	0.6	6.5
Access to newer anti-psychotic medication – people	0	31.2	175.7	18.1	225
Alcohol and drug detoxification – beds or ‘care packages’	0	0.2	2.8	0	3
Alcohol and drug residential – beds or ‘care packages’	0	0.9	9.1	0	10
Alcohol and drug community teams – FTEs	0	0.9	13.9	1.4	16.2
Alcohol and drug methadone treatments – places	0	10	140	0	150
Mental illness prevention – FTEs	3.3	2.8	3.9	0	10

## Estimating the number of people likely to access mental health services

In order to translate the Ministry of Health’s access targets into a description of the services required, the Commission developed a model to estimate the number of people in different age and needs groups who might access services in a given period. Models were developed for both the total population experiencing a mental health disorder, and for specific groups of disorders. The intention was to identify the best estimate of the number of people per 100,000 who are likely to require access to publicly funded mental health services during a specific period of time.

The Commission holds documents detailing the workings on which these ‘best estimates’ were based.

The development of this model was based on the model developed by Bushnell and others.<sup>48</sup> Bushnell's work was in turn developed from the earlier *Tolkien Report*.<sup>49</sup>

The model for estimating the number of people likely to access mental health services takes into account three bodies of evidence:

1. The prevalence of mental health disorders in the New Zealand community. This provides an upper level of demand – the total number who are expected to reach criteria for a DSM-IV diagnosis and may, at some time, require treatment.
2. The severity of the disorder (or associated disability and needs). All the major epidemiological studies show that those with more severe disorders are likely to need (and present for) treatment, whereas many people with less severe disorders either cope by themselves or access assistance from community resources. People who experience more than one disorder at a time (the so-called co-morbid or dual diagnosis group) will usually have a higher severity (or associated disability).
3. Demonstrated utilisation rates for different services by people with different disorders and severity ('uptake'). Most recent mental health epidemiological studies have investigated what services people with certain disorders have accessed. A proportion will access the specialist mental health services (mostly those with more severe disorders), others will use primary healthcare, some access mental health professionals working in the private, voluntary, or charitable sectors, and some will seek, and get, the help they need from family, friends, and informal networks.

There has been considerable debate about the relevance of utilisation rates in estimating the required level of publicly funded mental health service, since utilisation patterns are influenced by so many factors. This work has been based on the observed utilisation rates in a group of international studies using a common methodology, including the Christchurch Psychiatric Survey 1986 (known as ECA studies). This is probably an under-estimate of the level of service uptake that might be expected although it is higher than the current level of service uptake. Equally, not to take account of utilisation rates will lead to an over-estimate of the services required at any one time.

The Bushnell model had three groups of disorders (severe, moderate, and mild) and three levels of care:

1. High – at least weekly contact with services
2. Medium – regular professional contact less than weekly but more than occasionally
3. Low – primary non-professional community or social agency support with occasional professional consultation.

<sup>48</sup> *Barriers to mental health care in the community: Towards an economic model*, Health Services Research Centre, Victoria University of Wellington

<sup>49</sup> Andrews G., *The Tolkien Report: A description of a model mental health service*, University of New South Wales at St Vincent's Hospital, Sydney, Australia

In the current model two modifications to Bushnell's model were made:

1. to include six age groups<sup>50</sup> on the basis that the morbidity of each group is considered to be significantly different. This has been acknowledged in the Ministry of Health's revised access targets for children and youth where three different targets have been set for 0-9 years (1%), 10-14 years (3.3%) and 15-19 years (5.5%)
2. to extend the concept of 'uptake' to include four levels of service based on the ECA service utilisation studies.<sup>51</sup> This estimated the uptake likely by:
  - specialist secondary service
  - primary healthcare
  - mental health professionals working in the community and private sectors
  - support provided by community agencies and members of the persons community.

Only the specialist secondary services and consultation (including consultation and liaison provided to the other three levels of services) have been included in generating the resource guidelines, as only these services are publicly funded and purchased by the HFA within the mental health budget.

The model was used to develop estimates of:

- the number of people in each of the age bands with a mental health disorder by the severity of the disorder (expressed either as a total for New Zealand or per 100,000 total population). These are based on the Bushnell estimates of severity
- the number of people likely to access the four categories of service for assistance with a mental health disorder – specialist, primary healthcare, other mental health professionals, and community agencies. These are based on the service utilisation information from the ECA studies.<sup>52</sup> These studies did not include service utilisation for young people under 15 years. Therefore a conservative estimate was used; that young people 0-14 years access services at up to twice the rate of those aged 15 years and over.

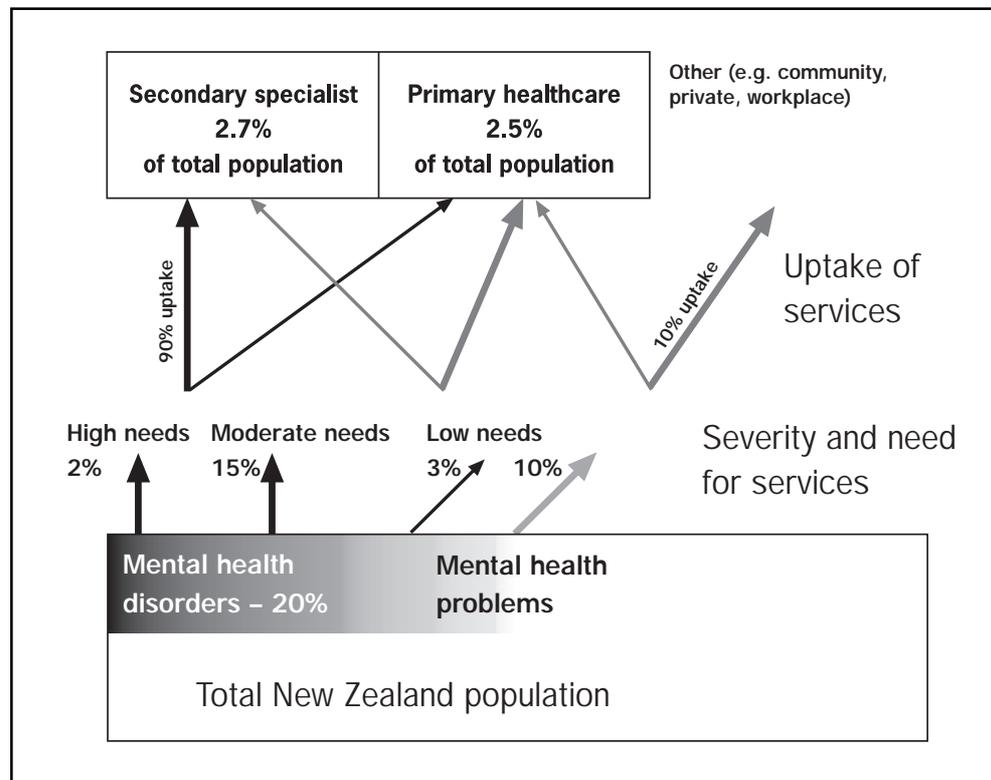
The model used in this revision of the Blueprint is schematically represented on page 107.

<sup>50</sup> 0-9 years, 10-14 years, 15-19 years, 20-64 years, 65-84 years, and 85 years plus.

<sup>51</sup> These studies reported on the use of mental health, other health, and community services during the previous 6 months.

<sup>52</sup> In effect, what services people with mental health disorders used in the mid-1980s in the United States.

An overview of the prediction of the percentage of the population accessing mental health services at any time.



The model predicts that at any time 20% of the population will be experiencing a mental health disorder, but that only 2% will have high needs. Ninety percent of those with high needs are likely to access secondary specialist treatment services. The majority of people experiencing a mental health disorder will have moderate treatment needs which can mostly be managed within primary healthcare, with occasional support (especially assessment, stabilisation, and consultation services) from secondary specialist services. Finally, there will be a group of people who have either a low severity mental health disorder or difficulties which are not severe or specific enough to be classed as a 'disorder'. Only a small proportion of this group (11%) are likely to seek treatment services and this will be mostly from non-medical services operating within the community.

This model predicts that the following number of people, in each of six age groups, are likely to utilise secondary specialist and primary healthcare services over a six month period:

Number of people per 100,000 population requiring access to two levels of mental health services		
Ages	Specialist <sup>53</sup>	Primary
0-9	122	116
10-14	101	92
15-19	213	167
20-64	1,956	1,896
65-84	261	210
85+	32	27
TOTAL	2,685	2,508

### Testing the validity of the access targets and resource guidelines

These figures are consistent with those published more recently in the 1997 Australian survey on mental health and well-being of adults (ABS).<sup>54</sup> This survey provides information about all mental health disorders the people were experiencing together with a measure of associated disability. This is a better predictor of need for treatment than previous surveys which have used presence of a disorder alone. The survey considered the previous 12 months.

The following table gives an overview of the Australian survey.

	ABS 12 month prevalence	12 month prevalence by disability severity as percentage of population aged 18 and over			
		None	Mild	Moderate	Severe
Anxiety disorders only	2.9	2.08	0.27	0.41	0.14
Affective disorders only	1.4	1.10	0.10	0.15	0.05
Substance use disorders only	3.6	2.73	0.43	0.39	0.05
Combination of above disorders	2.3	1.27	0.53	0.32	0.19
Total mental disorders	10.2	7.18	1.33	1.28	0.42

The Australian study did not include psychotic disorders (but did include manic disorders). Bushnell (1994) estimated the six month prevalence of psychotic disorders to be 0.04% and that the proportion of these psychotic disorders which were of high severity was 0.024%, of moderate severity 0.012%, and of mild severity 0.004%. If these are included with the above

<sup>53</sup> Includes HHS community mental health teams

<sup>54</sup> McLennan W., Mental health and well-being: Profile of adult Australians, Australian Bureau of Statistics, 1998. The table is a summary of data from Table 14, page 33.

Australian data then it is expected that 3.07% of the population over 18 years will have a mental health disorder with associated disability in any 12 month period. Of these, 0.444% will have severe disability, 1.292% moderate disability, and 1.334% mild disability.

Another method of checking the validity of the predictions is to assess the implications of the resource guidelines for meeting access targets by evaluating the service user to community mental health worker ratio for the different age groups, if the Ministry's access targets were achieved.<sup>55</sup> The table below summarises the findings of such an analysis.

	0-14	15-19	20-64	65+	Total
Ministry of Health access targets	1.0% and 3.9%	5.5%	3.0%	3.0%	2.9%
Number of people accessing services per 100,000 total population	446	392	1,744	353	2,935
Number of FTEs in community services (excluding support services)	16.3	20.5	50.0	12.8	99.6
Service users per mental health worker <sup>56</sup> (excluding support services)	27.4	19.1	34.9	27.6	29.5

All these lines of evidence confirm the Commission's view that the 'best current estimate' is that 3% of the population will need to access publicly funded specialist mental health services in any 6 month period and that the resource guidelines as outlined are the best current estimate of the service required to meet this target. It should be noted that as more information becomes available, these estimates should be revised.

<sup>55</sup> Assumptions upon which the following calculations are based:

- that the Ministry of Health targets relate to people accessing secondary mental health and consultation and liaison services
- that the Ministry of Health targets do not relate to people who access peer support but do access secondary mental health and liaison services
- that all people admitted to hospitals and entering residential services and accessing support services will also access community mental health services

<sup>56</sup> Note that this assumes each staff member would have sole responsibility for this number of people, but that in practice a team of staff would provide the required services.

## Appendix VI

### Glossary of terms

<b>Acute services</b>	Mental health services for people in crisis who may need urgent diagnosis, care, and treatment.
<b>Adult</b>	Person aged over 19 and under 65 years old.
<b>Best practice</b>	Treatment and support practices which are based on evidence of effectiveness and merit use throughout the sector.
<b>Carer</b>	People who support service users when they are unwell.
<b>Child</b>	Person aged 0-14.
<b>Clinical Training Agency (CTA)</b>	A division of the HFA which is responsible for funding advanced health professional training in New Zealand.
<b>Community Mental Health Team (CMHT)</b>	Team comprising a mix of different health professionals and support workers which provides assessment, treatment and support for people with mental illness.
<b>Consumer</b>	A person who experiences or has experienced mental illness, and who uses or has used mental health services. Also refers to service user, survivor, patient, resident, client, and turoro (Maori person who engages with mental health service). <i>See also tangata whaiora.</i>
<b>Consumer movement</b>	Consumers organising for self-help purposes, to advocate for more responsive services, and to increase acceptance by the wider community – according to the principle of self-determination.
<b>CQI</b>	Continuous Quality Improvement. A system for ensuring that the management methods, practices, and overall culture of an organisation bring about continuous improvement to the services it offers.
<b>CTA</b>	Clinical Training Agency.
<b>CYPFS</b>	Children, Young Persons and Their Families Service, a division of the Department of Social Welfare. It provides child protection and child abuse services.
<b>Discharge planning</b>	Process of assessment and preparation with the service user for their exit from a service or transfer to another service.

<b>Family</b>	Relatives, whanau, partners, friends, or others nominated by a person with mental illness.
<b>FTE</b>	Full-time equivalent staff.
<b>Hapu</b>	Sub-tribe.
<b>Hauora</b>	Health.
<b>Health Funding Authority (HFA)</b>	A national agency established by the Health and Disability Services Order 1997. It is responsible for funding services according to the needs of the population, in line with Government strategic directions for public health, personal health, and disability support services.
<b>Health Research Council</b>	Crown entity responsible for funding of health research on behalf of the Government.
<b>HFA</b>	Health Funding Authority.
<b>Hospital and Health Service (HHS)</b>	A new term for Crown Health Enterprises (CHEs); Crown owned entities that provide health and disability support services.
<b>Iwi</b>	The people of the local area (tribe).
<b>Kaumatua</b>	Elder; wise and experienced older members of the whanau.
<b>Kaupapa Maori services</b>	Maori centred services which are offered within a Maoricultural context.
<b>Key worker</b>	The mental health worker who has responsibility to maintain contact with the service user, and who links with other services and community supports for them.
<b>Mental Health Research and Development Strategy</b>	A project funded by the HFA and administered by the Health Research Council which aims to use research and development to identify ways that will improve the planning, purchasing and delivery of mental health services in New Zealand.
<b>Mental health services</b>	Organisations whose primary function is the provision of care, treatment, and support and education for recovery to people with mental illness, or mental health problems.
<b>Mental health support worker</b>	Non-clinicians who work with people with mental illness.

<b>Ministry of Health (MOH)</b>	The Government agency whose functions are to: provide strategic policy advice and ministerial services to the Minister of Health; monitor HFA performance; and administer legislation and regulations.
<b>Multi-disciplinary team</b>	Group of mental health staff who co-operate to provide a range of treatments and supports for the service user.
<b>National Mental Health Standards</b>	A set of standards developed by the Ministry of Health for use by mental health service providers to improve quality of services and ensure consistency for people who need to use them. [The Standards are listed in Appendix III.]
<b>National Mental Health Strategy</b>	An overall strategy for mental health covering the Government's goals, principles, and objectives for mental health services. It is set out in two key documents: <i>Looking Forward: Strategic Directions for Mental Health Services</i> published in June 1994; and <i>Moving Forward: The National Mental Health Plan for More and Better Services</i> published in June 1997.
<b>Needs assessment</b>	A process where the service provider and the person with a mental illness identify needs and goals for recovery, and the services, supports, and resources required to meet them.
<b>Needs group</b>	A group in the population who are potential consumers of the mental health service. These groups may be defined in terms of geographical locality, social characteristics, or service needs.
<b>NZ Community Funding Agency</b>	A unit of the Department of Social Welfare responsible for the delivery of funding and support for community-based social and welfare service providers.
<b>Older person or Older adult</b>	Person aged 65 and over.
<b>Outreach</b>	Provision of mental health services in the wider community, usually to individuals or groups with high support needs.
<b>Pacific people</b>	People from Pacific Islands countries (or ethnic background) resident in New Zealand.
<b>Pilot</b>	A preliminary, often small-scale attempt to deliver a new, untried kind of service or project to test if the approach should be used more widely.

<b>Primary health care service</b>	Services for individuals and families which consumers have direct access to. They are the first point of contact with health services, and are also responsible for services for people with milder mental illness e.g. G.Ps.
<b>Public Health Service</b>	Services intended to prevent illness, and to protect and promote the health of the public.
<b>Rangatahi</b>	Youth.
<b>Recovery</b>	Living well in the presence or absence of mental illness and the losses that can be associated with it.
<b>Secondary health care services</b>	More specialist services that people access when their needs are unable to be met by primary care services.
<b>Service provider</b>	Organisation or individual who provides direct treatment or support service to the individual and their family.
<b>Taha hinengaro</b>	Mental and emotional health.
<b>Taha tinana</b>	Physical health.
<b>Taha wairua</b>	Spiritual health.
<b>Taha whanau</b>	Family health.
<b>Tamariki</b>	Children.
<b>Tangata whaiora</b>	People seeking wellness, or recovery of self.
<b>Tangata whenua</b>	People of the land or region; hosts; the indigenous people of New Zealand (Maori).
<b>Te Puni Kokiri</b>	Ministry of Maori Development.
<b>Te reo Maori</b>	Maori language.
<b>Te Tiriti o Waitangi</b>	The Treaty of Waitangi.
<b>Tikanga Maori</b>	Maori knowledge and practices.
<b>Tino rangatiratanga</b>	Self-determination.
<b>Treatment</b>	Specific physical or psychological assistance provided by a health professional to reduce (mental) illness, and assist recovery.
<b>Turoro</b>	Maori person who engages with a mental health service.
<b>Whakapapa</b>	Genealogy.
<b>Whanau</b>	Extended family.

<b>Whare Tapa Wha</b>	Maori concepts of health and well-being. It has four dimensions: taha wairua (spiritual health) taha hinengaro (mental and emotional health) taha tinana (physical health) taha whanau (family health).
<b>Work and Income NZ</b>	A new agency merging the New Zealand Employment Service, Income Support, and the Community Employment Group.
<b>Youth</b>	Person aged 15 to 19.

## Appendix VII

### Contributors to this revised Blueprint

Mental Health Commission Advisory Committee

Mental Health Commission Maori Expert Panel

Mental Health Commission Pacific Peoples Advisory Committee

Dr Erihana Ryan, Commissioner, Maori Health Commission

Dr Sue Hallwright, Consultant

Dr Janice Wilson and staff, Ministry of Health

Te Puni Kokiri, Ministry of Maori Development

Health Funding Authority

Marion Clark, Clark Consulting Limited

Mary O'Hagan, Consumer Consultant

Nigel Kee, Clinical Training Agency

The Mental Health Commission wishes to acknowledge the valuable submissions on the *1997 Blueprint Working Document* made by many individuals, services and organisations, including the original work by Derek Wright and Chris Harris. In particular, we thank all those kaupapa Maori services we visited who freely shared with the Commission their models of healing for the people in their care.

In addition, the Mental Health Commission wishes to thank all those services it consulted about the benchmark figures. These included the following expert panel members: Professor Peter Ellis, Dr Bruce Adlam, Professor Gavin Andrews, Christine Elliot, Dr Sue Hallwright, Materoa Mar, Professor Graeme Mellsop, Dr Doug Sellman, Dr Elizabeth Wells, Dr Janice Wilson, Derek Wright, and Professor Mason Durie.

