

Better Mental Wellbeing for All

Mental Health & Addictions Strategic Action Plan
2013 - 2018

‘making every contact count’





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FOREWORD

It is both timely and appropriate that this Counties Manukau Mental Health and Addictions Strategic Action Plan has been developed. Since the previous Counties Manukau Mental Health and Addictions Action plan was written and implemented (2006-2010) there have been a number of significant changes within the sector at both local and national levels. There has been a change in the leadership of the country to that of a National Government (from 2008) which is now in its second term, this has had an influence on the way funding and planning for services at a national level are led.

The Mental Health Commission was set up in response to the 1996 Mason Inquiry into Mental Health Services and has had a huge influence on the direction of the sector being responsible for the development and publication of Blueprint and Blueprint II – documents which have guided the deinstitutionalisation of Mental Health and Addiction services in New Zealand. The Commission has now been disestablished and the role devolved out to the Office of the Health and Disability Commissioner marking a significant change for the Mental and Addictions sector. At the local level there have also been changes at multiple levels across the sector including a change in leadership at the DHB.

There has been a real shift in the way we think about planning health services for our people. We have to be much more business savvy in the way we approach our planning, and so too in how we evaluate current services and look to continue to be innovative in new services. Accountability to those receiving services as well as those holding the budget is equally important. As this plan demonstrates we need to have a balanced approach to ensure we continue to build on the significant gains we have made over the years but do not miss out on new and innovative ways of providing better, sooner and more readily accessible services. The quandary is the how and where do we allocate our resources most effectively to maximise the benefits to our people.

In order to achieve our vision of “Better Mental Well Being For All” we need to set realistic but challenging goals for ourselves to achieve. We need to plan responsibly so that our resources will last over the life of the plan and will set a positive foundation from which further plans may be laid. This plan illustrates the collaborative nature of our current sector and a willingness to engage with other sectors for the betterment of our communities. It draws on key National plans and projects occurring in our Counties Manukau communities to ensure we are considerate of the work that has already begun.

Counties Manukau has a rich and diverse population, I would like to acknowledge the input from stakeholders to date in the coming together and development of this plan to determine and prioritise what our common goals are and how we will achieve them. We must now embark on the next phase of our plan feeling positive yet challenged about what lies ahead.

Ali’imuamua Sandra Alofivae

Counties Manukau District Health Board member

HE PUAWAITANGA MOTE HAUORA HINENGARO

Our vision is that the communities of Counties Manukau will support mental health and wellbeing and be able to get support when they need it, quickly and easily, in their local community.



Title: *Waimana – Strong Waters*

Artist: *Thomas Pere*

Medium: *Stone (Carving)*

This piece is named after my Dad who lost his eye as a young boy. His Iwi decent is Te Arawa, Nga Puhi, Tainui Raukawa, Moriori, Tarara. He was born in Rotorua, worked as a shearer and loved the outdoors. The heart represents my Mother, his wife. The koru represents his Maori and bi-lingual ancestry.

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MIHI

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EXECUTIVE SUMMARY

This Strategic Action Plan defines the actions that we will take to achieve our strategic goals for Mental Health and Addictions services in Counties Manukau over the next 5 years (2013-2018).

Our vision is that the communities of Counties Manukau will support mental health and wellbeing and be able to get support when they need it, quickly and easily, in their local community. This plan will help us get there.

We have considered the unique needs of our very diverse Counties Manukau population, and the benefits gained by implementing these objectives and actions here in Counties. We have looked to our past; where we've come from and what we've achieved, we've looked at the present; our current services and activities to understand where we're at and, through this plan; we look to the future and where we plan to be in 5 years' time.

This is a Strategic **Action** Plan because it is about more than strategy - it's about action, it's about doing and it's about changing. It's about working smarter not harder and sharing our resources to improve the wellbeing of our communities. Throughout the document the term 'we' has been used as this plan is inclusive of the whole sector, those who work with us and the communities we serve as we all need to work together to be able to achieve our goals.

To get us to where we need to go, we have identified our key priorities and goals as follows:

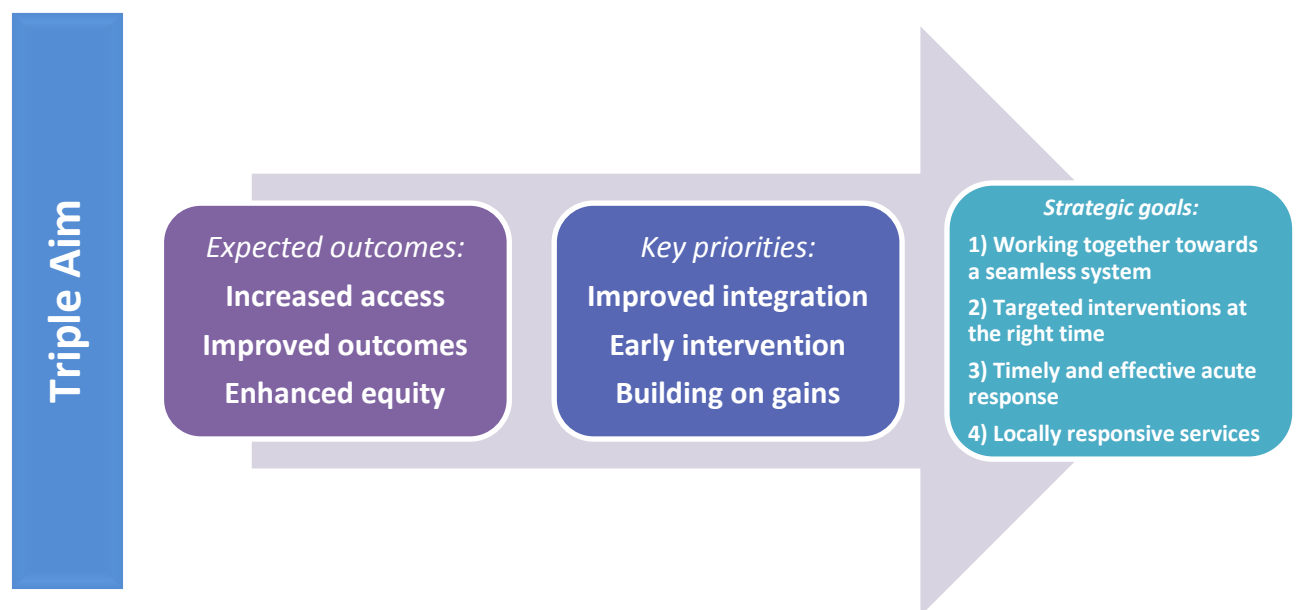


Figure 1: Relationship between expected outcomes, key priorities and goals.

We will improve integration across our system and ensure better coordination and navigation through services. We will intervene early by providing targeted interventions to our mothers, babies, children and youth and will ensure that services are working together. We will provide a timely and effective acute service to those who need it and we will ensure that our services are responsive to the needs of our local communities.

We have a number of actions that we need to complete to help us achieve this and we will monitor and measure our success against the Triple Aim framework. The Triple Aim outlines the direction

our organisation is intending to follow, with broad guidance as to the implications for services or action.

Our actions will ensure we achieve the Triple Aim objectives:

1. Improved health and equity for all populations;
2. Best value for public health system resources;
3. Improved quality, safety and experience of care.

The success of this plan depends on all of us working together, across our sector, the wider healthcare system, across a range of other sectors and the wider community. We will measure our success in a number of ways and we will seek feedback from all stakeholders. The plan sets clear priorities, objectives and actions, ensuring the provision of seamless, targeted and effective mental health and addiction services to people resident in Counties Manukau.

The Mental Health and Addictions Strategic Plan 2013-18 incorporates both national and local strategic direction. Significant stakeholder consultation has occurred in order to develop a plan that is specific to Counties Manukau with the aim of ensuring **'Better Mental Wellbeing for All'**. Our objectives are responsive to the unique needs of our population and our associated actions will define and shape the future of mental health and addictions service provision and associated improvements during the next five years.

INTRODUCTION

The Mental Health and Addictions sector has changed significantly over the last decade and it will continue to grow and develop. In the current financially constrained environment, we are being challenged to use our current resources more effectively to extend Mental Health and Addictions services to cater for more people as well as continuing to build on the gains that we have made in terms of improving outcomes for people with low prevalence conditions and/or high needs.

Creative and innovative approaches are called for that allow more flexible and responsive methods and build on key initiatives. These approaches will require innovative and flexible funding arrangements to support them, and monitoring of outcomes to evaluate them.

A key theme of this plan is integration across the wider health sector to ensure we are working together to improve access, improve outcomes for both high and low prevalence groups and enhance equity of health outcomes. Improved integration at a local regional and national level will enable the health sector to deliver more connected services as well as being able to interface better with other sectors to improve outcomes.

WHAT IS MENTAL HEALTH?

'Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.' (WHO, 2013)



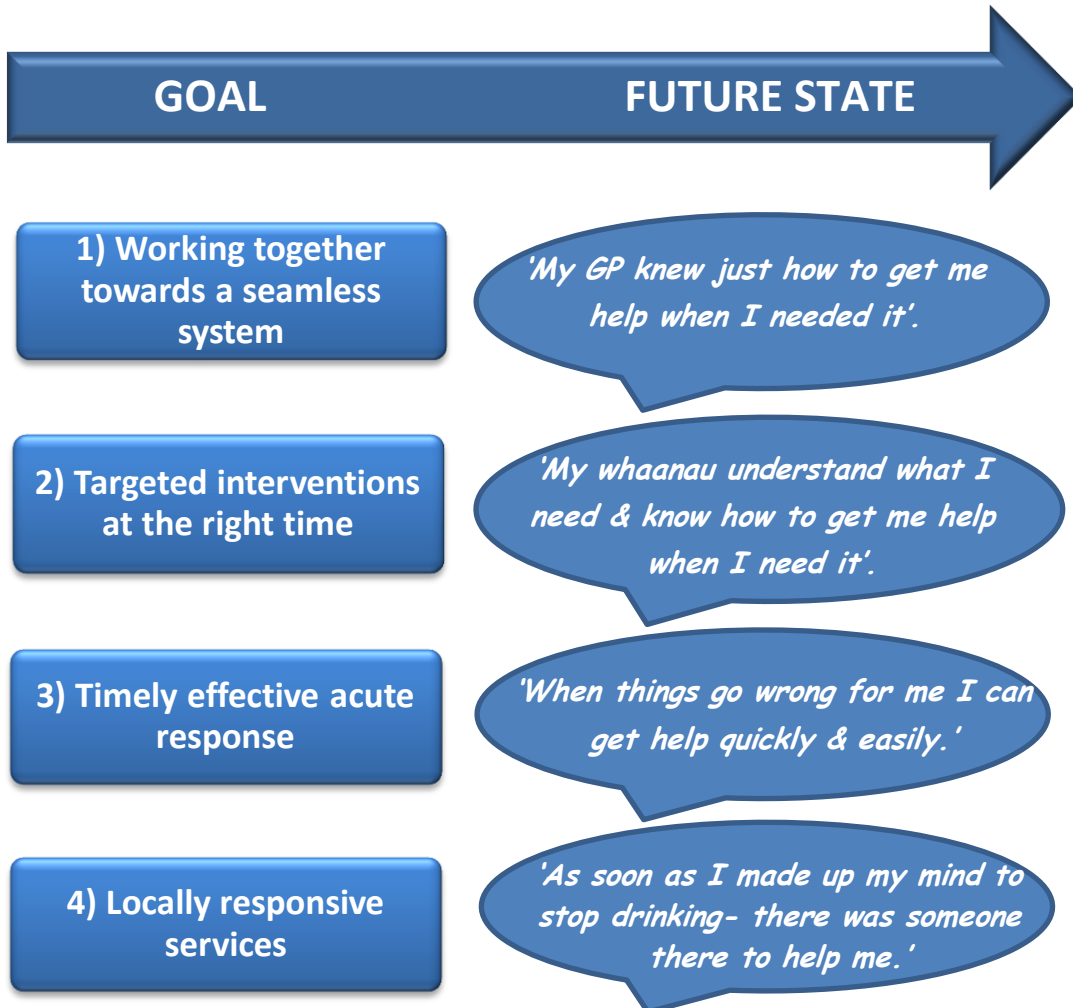
Title: Four Letters of Emotion

Artist: Anonymous

My main influences for this piece came from the clients under our mental health services, both inspired and moved by the work submitted for the Matariki Inside Out Exhibition 2013 – the simple 4 letter words reveal how, although we are all different and individual in our own way, we are all connected through our emotions – hope, pain, calm, hurt and love – is simply, to be human.

VISION

The communities of Counties Manukau will support mental health and wellbeing and be able to get support when they need it, quickly and easily, in their local community.



GUIDING PRINCIPLES

The following guiding principles from Rising to the Challenge (MoH, 2012) will guide the way in which we work with people who experience mental health and addictions issues here in Counties Manukau.

We will:

- actively challenge stigma and discrimination wherever they are encountered;
- value communities as essential resources to support family and whaanau wellbeing and the effective delivery of services;
- expect recovery and work in a way that will support it and that will build future resilience;
- engender hope by demonstrating a belief in the talents and strengths of service users;
- form authentic partnerships with service users at all levels and phases of service delivery;
- promote the participation and leadership of service users at all levels;
- personalise services to the particular needs of the service user and their family and whaanau;
- strive to uphold the human rights of service users and their families and whaanau;
- respect diversity and demonstrate cultural competence;
- encourage and support positive participation by families and whaanau;
- when working with Māori, take a whaanau ora approach;
- work collaboratively, transcending service boundaries and boundaries between government sectors.

Building on these principles, we will work with the communities of Counties Manukau to increase understanding and awareness of mental health and addiction and enable better access to information that supports wellbeing, resilience and recovery.

SETTING THE CONTEXT

INTERNATIONAL CONTEXT

Mental illness accounts for 15% of the total burden of disease in the developed world, with depression set to become the second leading cause of disability in the world (similar to ischemic heart disease and chronic obstructive pulmonary disease) by 2020 (WHO 2013). Alcohol is the world's third largest risk factor for disease burden and accounts for 9% of deaths in the 15-29 age group (WHO, 2013) In New Zealand, at any one time an estimated 20% of the population has a mental health and/or addiction issue and 3% are severely affected.

The World Health Organisation (WHO) has released a mental health action plan which was discussed at the 66th session of the World Health Assembly in Geneva from 20 to 28 May 2013. Key objectives from the plan are to:

1. Strengthen effective leadership and governance for mental health;
2. Provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
3. Implement strategies for promotion and prevention in mental health;
4. Strengthen information systems, evidence and research for mental health.

These key objectives align closely with the key themes in both of the national documents that were released in 2012 in New Zealand and are summarised in the following pages. Internationally there has been a real focus on efficiency in relation to health care spend.

The latest release of The World Health Report (2010) was aptly named "[Health systems financing: the path to universal coverage](#)". The recent global financial crises has had a profound effect on our system, there is a continued focus on value for money and increasing efficiencies both within health and inter-sectorally to better meet the needs of those we serve. WHO estimates that from 20% to 40% of all health spending is currently wasted through inefficiency" (World Health report, 2010). In the current economic climate investment levels are unlikely to significantly increase at levels seen in the past 10 years, so we need to be smarter with our resources particularly with our growing population in Counties Manukau.

NEW ZEALAND CONTEXT

Key National Documents

In 2012, three key documents were released to continue to guide and direct Mental Health & Addictions services at a national level. These are the Blueprint II: How things need to be with the companion document Blueprint II: Making change happen (MHC, 2012) and Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017 (MoH, 2012). Rising to the Challenge outlines government policy and prioritised actions for the Health Sector over a 5 year period whereas Blueprint II has a wider focus spanning not only health but social services and signalling wider social responsibility over a 10 year period (Figure 2). While many of the goals within Blueprint II will be met through implementation of the Rising to the Challenge plan, there is scope for a further Service Development Plan to be developed in order to build on the gains made over the 5 years up to 2017.

| Blueprint II How things need to be & Making change happen <i>(Mental Health Commission, Jun 2012)</i> | Rising to the Challenge Mental Health & Addiction Service Development Plan <i>(Ministry of Health, Dec 2012)</i> |
|--|--|
|  |  |
| Aspirational sector-informed documents | Government policy document |
| Using resources more effectively | Using resources more effectively |
| Timespan: 10 years | Timespan: 5 years |
| Strong emphasis Life course approach - earlier intervention Increasing access, stepped care: primary-specialist integration Extend use of ring-fence beyond those with highest needs | Strong emphasis Earlier intervention Increasing access, stepped care: primary-specialist integration Increased accountability of ring-fence spending |

Figure 2: Comparison of the key messages from Blueprint II and Rising to the Challenge.

National Government Priorities

The New Zealand government has a range of initiatives, priorities and key projects relating to the area of Mental Health and Addictions. These include:

- Prime Minister's Youth Mental Health Project. This is a package of 22 initiatives aimed at improving the mental health and well-being of young people aged 12-19 years with, or at risk of developing, mild to moderate mental health issues and will be implemented over a period of 4 years (2012-2016);
- [Preventing and Minimising Gambling Harm six-year strategic plan 2010/11–2015/16](#), which sets out a high-level framework to guide the structure, delivery and direction of Ministry-funded problem gambling services and activities. It also outlines strategic alliances with other key stakeholders and organisations with an interest in preventing and minimising gambling harm;
- In recognition of the fact that New Zealand has one of the highest rates of suicide in developed countries, the New Zealand Government have implemented an all ages approach to suicide prevention through the [New Zealand Suicide Prevention Strategy 2006-2016](#) which is overseen by a Ministerial Committee; and there is also the associated New Zealand Suicide Prevention Action Plan 2013 – 2016;

- The [National Depression Initiative \(NDI\)](#) - provides a framework to reduce the impact of depression on the lives of New Zealanders by aiding early recognition, appropriate treatment, and recovery;
- [National Drug Policy 2007-2012](#) is the guiding document for policy and practices aimed at preventing and reducing drug-related harm in the community.

National Projects

To implement the key priorities there are a number of national projects:

- The development of services for young people in direct reference to the **Prime Minister's Youth Mental Health Project** and associated initiatives;
- Implementation of **New Zealand Suicide Prevention Action Plan 2013-2016**;
- Implementation and support of initiatives within the **Children's Action Plan** where appropriate to mental health and addictions services;
- Implementation of **Drivers of Crime** project initiatives across the 3 of the 4 priority areas:
 1. Improving maternity and early parenting support;
 2. Addressing conduct and behaviour problems in childhood;
 3. Reducing harm from alcohol and improve treatment.

NORTHERN REGION

CM Health (Counties Manukau Health) is involved in the development and implementation of the third **Northern Region Health Plan 2013/2014**, which is driven by the four Northern Region District Health Boards (DHBs) and their primary care partners. This plan has a 3 year time span with the intention is to deliver one whole of system regional health plan and to improve the health outcomes and reduce disparities for the 1.7 million people who live in the Northern Region. Throughout the plan Ministerial expectations around greater service integration, particularly with primary care and growing regionalisation are embedded.

The region has identified three themes which are interwoven through the plan:

1. Health gains for Maaori;
2. Better integration across services;
3. Enabling our patients to be more involved in their care.

The three strategic goals from the Northern Regional Health Plan have not changed from the previous 3 year plan and are as follows:

1. First Do No Harm;
2. Life and Years;
3. The Informed Patient.

Mental Health and Addictions was introduced as a new area of focus for the Life & Years Goal in 2012 and Counties Manukau Annual Plans encompass the strategic directions set by the Regional Health Plan.

Specific targets for Mental Health and Addictions Services for the 2013/2014 Northern Region Health Plan are:

- 100 more young people to be seen in Youth Forensic services;
- 1.0% of the youth population will access specialist AOD services;

- Increasing the percentage of mentally unwell prisoner admissions to Forensic inpatient services;
- Baselines for the throughput of adult forensic inpatient services and the capacity of general adult services to meet high and/or complex needs;
- Regionally consistent plans for perinatal and infant mental health services for mothers with babies and/or infants who are at risk;
- Regional approaches to workforce development issues.

These targets will be met through the implementation of the regional work programme including key projects focussed on Perinatal and Maternal mental health service development and review of Northern DHBs Services for People with High and/or Complex Needs.

COUNTIES MANUKAU – A LOCAL APPROACH

Counties Manukau Health is responsible for the funding of health and disability services and for the provision of hospital and related services for the people of Counties Manukau. Working with the funding allocated by Government, Counties Manukau Health is responsible for:

- Collaborating with other DHBs, service providers, the community and other stakeholders to plan the strategic direction for health and disability services in the northern region and promote the integration of health services;
- Funding the provision of most health and disability services provided in Counties Manukau through service contracts with health and disability providers and non-governmental organisations;
- Providing hospital and specialist community based services for the population of Counties Manukau and some access to specialist or highly complex services for people referred from other DHBs;
- Promoting, protecting and improving the health of the Counties Manukau population through the provision of health promotion, health education and evidence based public health initiatives.

SHARED VISION

To work in partnership with its communities to improve the health status of all, with particular emphasis on Maaori and Pacific peoples and other communities with health disparities.

- We will do this by leading the development of an improved system of healthcare that is more accessible and better integrated;
- We will dedicate ourselves to serving our patients and communities by ensuring the delivery of both quality focussed and cost effective healthcare, at the right place, right time and right setting;
- Counties Manukau Health will be a leader in the delivery of successful secondary and tertiary healthcare, and supporting primary and community care.

SHARED VALUES

| | |
|---------------------------|---|
| Care & Respect | Treating people with respect and dignity; valuing individual and cultural differences and diversity. |
| Teamwork | Achieving success by working together and valuing individual and cultural differences and diversity. |
| Professionalism | Acting with integrity and embracing the highest ethical standards. |
| Innovation | Constantly seeking and striving for new ideas and solutions. |
| Responsibility | Using and developing our capabilities to achieve outstanding results and taking accountability for our individual and collective actions. |
| Partnership | Working alongside and encouraging others in health and related sectors to ensure a common focus on, and strategies for achieving health gain and independence for our population. |

TRIPLE AIM

CM Health aims to be the best healthcare system in Australasia by 2015 and one of the ways we will achieve this is through the Triple Aim approach. The objectives of Triple Aim encourage us to take an integrated approach to align improvement across the whole system by focusing on: population health (including addressing inequities), cost per capita and patient experience. These objectives of the health sector provide the basis for our prioritisation process, ensuring that CM Health delivers safe and high quality services which provide value for money and the best health outcomes for the population.

OUR POPULATION

Counties Manukau is a rich and diverse district that is home to an estimated 512,000 people from a wide variety of different cultural backgrounds. There are a high proportion of Māori (16%), Pacific peoples (23%) and Asian (22%) living in our district and our population continues to increase; it is expected to grow by 25% by 2020. Our increasing population brings increasing demands on health services and this is further impacted on by the significant proportion of people living in socio-economic deprivation (34%) and subsequent reliance on the publically funded health system. Through the Achieving a Balance framework, CM Health continues to develop smarter and more effective ways to deliver healthcare and ensure better health outcomes for our population in a challenging environment.

LOOKING BACK

Looking back over the last 10 years, there have been several national documents that have led to significant transformation of the Mental Health and Addictions sector in New Zealand. The most prominent of these are development of New Zealand's National Mental Health Strategy, *Looking Forward* (Ministry of Health 1994); and the Mental Health Commission's *Blueprint for Mental Health Services in New Zealand: How things need to be* (Mental Health Commission 1998). The focus of these two guiding documents was to shift from an institutional base to a culture of recovery and more community centred approach, and to drive the provision of access to services for the 3% of people most seriously affected by mental illness and addiction issues (Mental Health Commission, 1998). There was also a significant increase in investment into the sector which promoted innovative thinking and the opportunity to develop specialist services to better cater to the needs of the population.

Over the past decade, CM Health has led a range of initiatives to improve the mental health of the Counties Manukau population, reduce the harm caused by alcohol and other drugs and to continue to meet the demand for services. Throughout this period we have formed strong collaborative partnerships between Planning & Funding, the DHB Provider services and the network of NGO providers that deliver service to our community.

We have seen a range of positive impacts including:

- Improved outcomes for people with mental health and addiction issues in Counties Manukau;
- Investment in service improvement and innovation, including services not provided elsewhere in New Zealand;
- Development of the Peer Support workforce and increased involvement of peers (those with lived experience) in service delivery;

- Effective and strong partnerships between DHB clinical services and NGO providers;
- Development of a range of school-based programmes aimed at young people whose lives are affected by alcohol and other drugs.

We are continuing to strengthen and develop our collaborative partnerships in the community as we configure services by locality and work towards ensuring seamless integration between primary and secondary services.

WHERE ARE WE NOW? Understanding Our Current Sector

We have a wide range of services in Counties Manukau including innovative services that are not provided in any other part of the country. We offer a range of support options across the continuum from inpatient through to community based supports. With all the range of services we offer, connections are everything which is why collaboration and coordination are woven into every part of this plan.

Over the last decade, we have invested in collaboration and we are working across our system to create synergy. Synergy describes the increased value and energy created by the system as a whole; by the coming together of the parts and the interconnected relationships between them. Collaborative partnerships create synergy and allow us to use our resources more effectively to enhance the journey of those accessing our services and promote better outcomes.

CM Health Mental Health and Addictions supports the following collaborations:

- CHAMP (Counties Manukau Mental Health & Addictions Partnership- collaborative network);
- Te Arawhiriwhiri (Kaupapa Maaori Provider Collaborative);
- AOD Provider Collaborative;
- Mental Health Consumer Network;
- AOD Consumer Network.

There are a number of key pieces of work that have enhanced and deepened our understanding of the journey through our system and these have informed the development of our priorities, objectives and actions. It is through looking at provider performance data, working with providers to understand service delivery and listening to feedback from those who experience our services that we are able to understand and resolve issues that arise.

Key Projects

There are a number of key projects and work streams that have been prioritised or are already underway. These are reflected in our Strategic Action plan and we will ensure CM Mental Health and Addictions actively contribute to ensure clear channels of communication and duplication is minimised or eliminated.

Key projects, documents and reviews that contribute to our overall understanding of the journey, pathways and processes that make up our system:

- Development of locality clinical partnerships
- Partners in Care: Revisiting Visiting
- Framework for Change
- The Dementia Pathway
- Seclusion and Restraint Project
- Acute Community Options Project
- Sustainable Housing Project
- The Residential Rehabilitation project
- Realignment project- Mobile Community Support
- Service reviews and evaluations
- Mental Health Medical Taskforce
- Triage/Access to Service Project
- CHAMP Consumer/Whanau Hui
- National KPI Project
- Local Benchmarking Forums
- Youth CLS review
- Northern DHBs Perinatal and Infant MH project
- Community Acute Support Options review
- Acute MH Services for Youth review
- Respite review
- Acute System Evaluation Framework.

These pieces of work have helped us to develop a deeper understanding of our system and recommendations considered as part of setting the objectives. Some of these are not yet complete and will continue to inform our planning processes as we move forward to action our plan. We are committed to continuous quality improvement and are always on a discovery journey to deepen our understanding of how people experience our services, what the issues are and where there are gaps in service.

Counties Manukau Health has compiled a **Five Year Service Plan for Mental Health** being led by the Mental Health Provider Arm 2013/14 to 2017/18. This plan was developed focussing on the Rising to the Challenge: Service Development Plan (MoH, 2012) and has taken into consideration recent reviews, projects, recommendations and discussions that took place during the development phases of this plan to ensure the content is relevant and connected. The Provider Arm has set 4 Big Dot Goals to achieve over the life of this plan:

1. 30% reduction in inpatient readmissions and community re-referrals in 3 years;
2. 25% reduction in Counties Manukau Suicide Rate;
3. 50% of community FTE working alongside primary care in 5 years;
4. 75% assessments demonstrate cultural capability within 3 years.

Service Utilisation

Since 1998, CMDHB has been aiming for the target of ensuring access to the top 3% of the population who are most severely affected by mental illness and/or addiction as set by the Blueprint for Mental Health Services in NZ (MHC, 1998).

A reduction in acute mental health episodes is an indication of people having access to appropriate support and thus receiving the right care at the right time. Mental health service access rates is a proxy measure for determining the impact of CM Health mental health services delivery on improving the quality of life for members of our population who are suffering from mental illness or issues with alcohol or drug addiction.

There has been a substantial amount of work done since 2006 to increase mental health access for those with severe mental illness. CM Health has invested in a number of community based support options including community support, respite and acute alternatives. The expanded focus for the next one to five years relates to those with moderate to severe illness, with a need to look at system wide models of care that further enhance the role of primary care and community based services.

MH&A access rates for 2011-2012 (Figure 15) show that while we have exceeded our 3% target rate overall, there are still key population groups that require further attention e.g. child and youth.

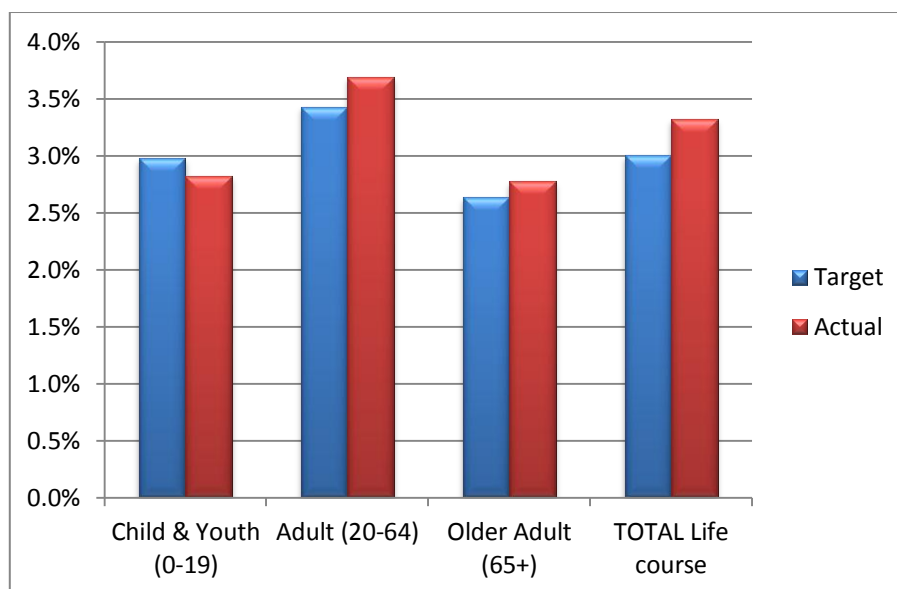


Figure 3: Access rates for Counties Manukau Mental Health & Addiction services across the age groups for all ethnicities 2011-2012

Preliminary data on CM Health service use shows that 31% of current diagnosed clients have a diagnosis of schizophrenia, and this group accounts for approximately 68% of all expenditure on mental health services for adults who have received a diagnosis. Of the people whose diagnosis has been recorded, people with a diagnosis of schizophrenia account for 64% of all adult mental health acute inpatient use and 86% of all support service use. Use of inpatient services by this group is highest for young adults, while use of support services progressively increases with age. International evidence has shown that people diagnosed with a psychotic disorder have a 20-25 year shorter lifespan than the wider population and they commonly experience marked health disparities. For this reason, it is essential that we continue to build on gains for this group of clients and continue to improve services to enable recovery.

The Mental Health and Addictions Budget

Planning and Funding arms of DHBs are predominantly responsible for the contracting of mental health and addiction services, however the Ministry of Health does retain some residual funding responsibilities for national programmes, and with more integrated service delivery PHO's are also emerging as important funding bodies for mental health and addictions services.

Crown Funding Agreements require DHBs to operate within the Operational Policy Framework (OPF) for DHBs, which contains a set of requirements approved by the Minister of Health or Cabinet. Important provisions in the OPF about mental health include:

- DHBs are required to give effect to the mental health ring fence provisions in their planning documents
- DHBs are required to use the Nationwide Service Framework (NSF), including:
 - Service specifications published on the NSF Library website;
 - Established business rules, such as wash-ups, inter-district protocols and risk management;
 - Existing monitoring processes;
 - Sector Services (formerly known as HealthPAC);
 - Common Counting Group and Costing Group Standards.

The national service specifications use a predominantly input-based approach to purchasing mental health services, with most community-based service purchased on the basis of FTEs and most residential and inpatient services purchased on the basis of available or used 'beds' (MHC, 2010).

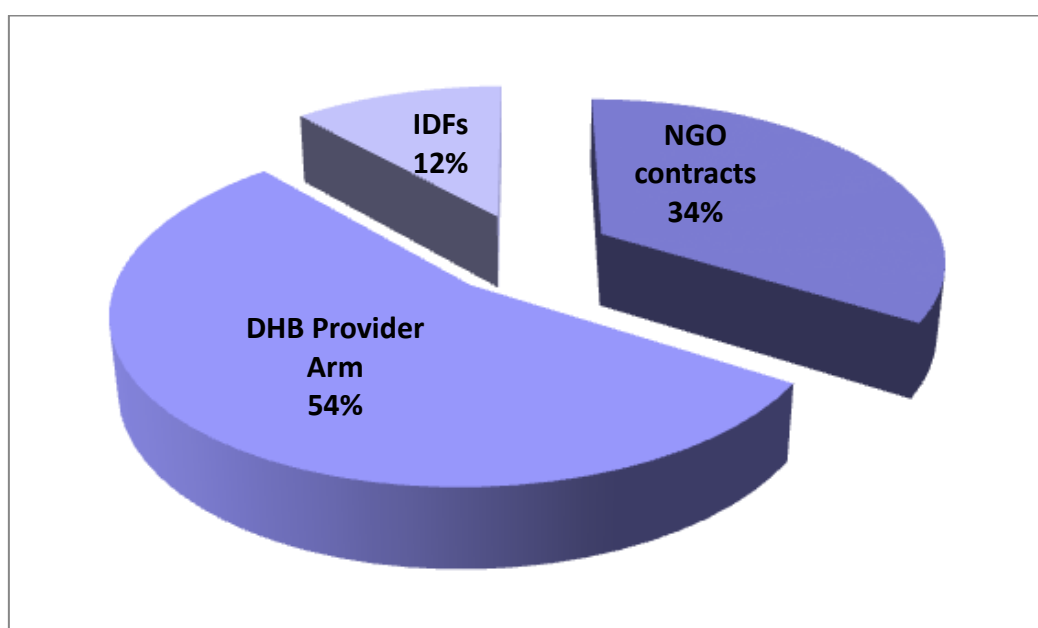


Figure 4: The ring-fenced Mental Health & Addictions budget as currently allocated.

The ring-fenced budget for the provision of Mental Health and Addictions services for Counties Manukau (2012-2013) was \$137 million (this does not include Primary Mental Health). This money is spent on the provision of service across the life course and across the full continuum of service. In addition to the services provided by Counties Manukau DHB, we hold 56 contracts for service with 27 NGO service providers. We also spend money on Inter-district flows (IDFs) which is money we pay to other DHBs for the services they provide to our population. Over a third of our IDFs are spent on regional AOD services. With the estimated annual cost of alcohol harm in New Zealand ranging from \$4-6 billion, investment in this area is crucial.

Services

Counties Manukau Health prides itself in working in partnership with its community and by doing so we create better service choices for our people. We have formed strong collaborative partnerships between Planning & Funding, the DHB Provider services and the network of NGO providers (including Peer led) that deliver a range of services to our community.

We fund and provide a wide range of services as follows:

- Community based support services account for a third of the total budget, comprising 54 contracts with 26 NGOs for a wide variety of service types including:
 - Acute Community Options including Peer-led Acute Alternative, Sub-acute and Crisis Respite (Adult, Youth & Maternal)
 - Community Living Services (Adult & Youth)
 - Community Support Services (Adult)
 - Peer Support Services (Adult)
 - Housing and Recovery Support Services (Adult)
 - Intensive Support Rehabilitation (ISR) Services (Adult)
 - Co-existing Disorders Residential Programme (Adult)
 - AOD Respite & Treatment (Adult)
 - AOD Education Programmes Delivered in Schools (Youth)
 - Parenting Support Programmes
 - Kaupapa Maaori Iwi Support Services (Adult and Youth)
 - Workforce Development
 - Vocational Support Services (Adult)
 - Family/Whaanau Support Services
 - AOD Residential Programmes (Adult)
 - Cultural Support Services (Adult)
 - Housing Coordination Service (Adult)
- There are also regional services provided by NGOs for both Addiction and Mental Health including:
 - Residential and community AOD programmes
 - Youth residential service
 - Refugee service
 - Eating Disorders service
- DHB Mental Health Services account for just over half the budget and provide services for:
 - Perinatal (Maternal and Infant) Mental Health services
 - Whirinaki- Child and Youth Mental Health services including:
 - Hekakano (Maaori Child & Youth)
 - Vaka Toa (Pacific Child & Youth)
 - Four Adult Community Mental Health Centres (The Cottage, Te Rawhiti, Manukau, Awhinitia) and Manukau police watch-house
 - General hospital liaison team
 - Intensive Community Treatment (ICT) team
 - Te Puna Waiora (Maaori) and Faleola (Pacific) Mental Health Teams (community based)
 - Home based and mobile response teams
 - Acute adult inpatient- Tiaho Mai (52 beds on the Middlemore site)
 - Mental Health Services for Older People (including 15 beds on the Middlemore site);

- Regional inpatient rehabilitation beds - Tamaki Oranga (10 local and 10 regional beds);
- Regional Dual Disability Services provided by Counties Manukau;
- Regional services provided by other DHBs, e.g. Child and Family Unit (Auckland DHB), Forensic Services (Waitemata DHB), Youth Forensic (Auckland DHB), Community Alcohol & Drug Services (CADS, Waitemata DHB), Tupu –Pacific Alcohol & Drug Services (Waitemata DHB), Te Atea Marino – Maaori Alcohol & Drug Services (Waitemata DHB).

We have a culture of innovation that encourages us to find new and more effective ways of meeting the needs of our people. The Consumer voice is strong in Counties Manukau and one way that we have been able to achieve these innovations is through the development of Peer support services and cultivation of the Peer Specialist workforce.

MOVING FORWARD

Better Mental Wellbeing for All is the overarching aim of our Strategic Action Plan 2013 – 2018. We have taken a balanced approach to our planning and covered the whole spectrum of mental health and addictions services. We have considered how to make the best use of our limited financial resources to achieve the most significant health gains for the people of Counties Manukau. We also need to consider not only short term gains but also long term gains right across the life course and the changing demographic of our communities. We need to ensure that we continue to support our current strategies to maintain and build on the gains that we have already made, while constantly looking to how we may make improvements in other areas. Changes that are made need to be sustainable and integrated into our system of care.

It is imperative that our planning encompasses a collaborative and integrative approach both within and across our sector and beyond to ensure we take a considered approach through our investment strategies and not duplicating, replicating or being counteractive to other initiatives. We are part of a complex and inter-related system and our planning decisions need to be based upon a balanced and thorough decision making process.

From the strategic planning process we have been able to integrate objectives of national focus with local need and aligned our local plan with the national goals of Rising to the Challenge (MoH, 2012). To get us to where we need to go, we have identified four strategic goals and these are shown in Figure 5 on the following page. This diagram shows an overview of the plan, outlining our goals and identifying the specific resources or ‘enablers’ that underpin all of our actions and are essential to successfully implement our plan.



Figure 5: Visual Strategic Action Plan 2013 – 2018

Goal 1: Working together towards a seamless system

Current state- what does it look like now?

CM Health provides mental health and addiction services across a wide continuum and offer a range of support options from inpatient through to community based supports. We are working across our sector to create flexible and responsive services that are able to flex with the needs of people to support them when they need it and step back when they don't so they can get on with living their lives.

This wide range of service also offers challenges particularly when it comes to coordination and navigation through these services to ensure people are able find their way through the maze of services on offer. With all the different types and level of services, coordination and navigation needs to be a central component of our system.

Actions- what are we going to do?

We need to improve integration across our system and work collaboratively to create pathways defining how we will work together to reduce fragmentation and duplication, share information and improve the experience and outcomes for clients. This will mean ensuring our workforce is informed and skilled at working across a more integrated health system.

Closer integration across our sector and will create a more seamless experience for people who need access to Mental Health and/or Addiction services. By connecting and improving services for those with low prevalence and/or high needs we will be able to improve outcomes for this group and decrease reliance on specialist services. This will enable us to use our resources to increase access for those with high prevalence and/or low needs and help to enable recovery at an early point in the course of their illness.

The Counties Manukau Health System Integration Programme aims to increase integration and deliver more services in a primary care setting. Delivering specialist Mental Health and Addictions services alongside primary care will lead to a more seamless experience of service and increase access. Information sharing will be an important part of working more closely together and IT systems need to be able to support this. Shared systems will make it easier for services to connect, take a more holistic view and work together to develop collaborative care plans.

Closer integration, coordination and navigation right across our system will ensure that people can get the right service for them, at the time they need it. Locality-aligned, inter-disciplinary teams can support pathways through services and work cohesively to ensure the best match of service. Mental health and AOD needs change along the recovery journey and services need to be able to respond and flex as needs change.

Inter-disciplinary teams are teams of people who are working together to meet the current needs of each person. The make-up of these teams will change depending on what's needed at any given time but the core components are:

- Community Mental Health clinical care and/or Specialist clinical care
- AOD Specialist care
- General Practice
- Navigation
- Coordination and knowledge of local services
- Peer Support (may also fulfil the navigator role)
- Support for day to day living
- Housing coordination and tenancy support (with local knowledge)
- Employment support
- Social work
- Family/whānau support
- Cultural support.

Depending on current needs, the team will also include service providers:

- Mobile Community Support services
- Community AOD services
- Residential AOD services
- Housing and Recovery Support services
- Acute Community services (Respite, sub-acute and Acute alternative)
- Inpatient
- Other support services e.g. home help
- Other sector involvement e.g. Justice, Education, Social Development; dependent on needs.

Together, these teams of mental health and/or AOD professionals will take a strength-based and holistic approach and work with clients and their family/whaanau to share their knowledge and expertise to develop collaborative care plans. The locality base will ensure services are delivered closer to where people live and use community resources as part of their recovery journey.

| ACTIONS Years 1-2 | ACTIONS Years 3-5 | KEY STAKEHOLDERS |
|---|---|--|
| OBJECTIVE 1.1 | | |
| Locally based coordination and delivery of existing services and improved efficiency across services | | |
| Create locality-based navigation roles for those with low prevalence and/or high needs who have multiple agency involvement | Bring navigation, coordination, housing, employment, peer support, family/whaanau support and cultural support together as a locality based team | NGO, DHB, Primary Care, Planning & Funding, Employment & Housing agencies, MSD |
| Develop streamlined referral pathways to specialist services | Enable this team to work within each locality area to pull together Inter-disciplinary teams that work holistically and collaboratively and navigate people through services; including the acute continuum | |
| Extend coordination function to cover all support services and use consistent needs assessment process to inform most appropriate service match | | |
| Increase housing and tenancy support services | Develop flexible funding models that are more personalised and client-directed (not restricted by age or changing level of need) | |
| Increase employment support | | |
| OBJECTIVE 1.2 | | |
| Improved integration between primary care and specialist care (both DHB and NGO) | | |
| Map current pathways through services and establish agreed shared pathways to enable easy access | Agreed pathways implemented and regularly reviewed to ensure access | Clinicians, Primary Care providers, DHB provider arm, Locality GM's, NGO sector, IT providers, Consumer Networks |
| Create and implement integrated triage processes to appropriate service delivery for people with high prevalence conditions | Build IT infrastructure to support integration and shared care planning between primary and specialist services | |
| Increase Mental Health and Addictions services delivered in local primary care settings | | |

| OBJECTIVE 1.3 Increased capability and capacity of the primary care and specialist workforce to work collaboratively to implement the pathways | | |
|--|--|---|
| Contribute to the development of a workforce development plan | Implement workforce plan and monitor effectiveness | DHB, PHO, NGO's, Health Workforce NZ, Te Pou, CHAMP, Te Arawhiriwhiri, MSD, Peer services |
| Support mental health credentialing for practice nurses | Implement training modules through primary care | |
| Develop Mental Health and Addiction training modules | | |
| OBJECTIVE 1.4 Better access to information that supports wellbeing, resilience and recovery | | |
| Employ a range of techniques to extend reach of information including further development of consult-liaison function, multi-media technology for e-therapy, access to online resources, existing community networks | Taking a locality-based approach, work with communities and local community leaders to increase awareness of protective factors and resilience | Community Agencies, Locality Managers, NGO's, DHB & Maternal services, web support services, Parenting & Family/Whaanau services, Consumer Networks |
| Develop web-based information services to ensure the provision of information that is accessible to our communities and age and culturally appropriate | | |
| Support the implementation of the New Zealand Suicide Prevention Action Plan | | |
| Extend the Mental Health First Aid Programme and ensure sustainability of the programme | | |
| Extend the delivery of Wellness Recovery Action Planning (WRAP) programmes to promote wellness planning and support people to self-manage | | |

Future state- what difference will it make?

| Working together towards a seamless system | |
|---|---|
| EXPECTED OUTCOMES: TRIPLE AIM | POTENTIAL INDICATORS* |
| 1. People live healthier, longer, more productive, disease free lives <ul style="list-style-type: none"> Improved physical health for people with low prevalence conditions/high needs Increased access to information that supports wellbeing, builds resilience and promotes recovery Enhanced community engagement, housing options and social inclusion | <ul style="list-style-type: none"> % of people with low prevalence conditions enrolled with a PHO and seen by a GP in the past 12 months Access rates (specialist services) for brief assessment and referral back to GP (broken down by age group) Availability of information (current: 'Look at You' DVD, Mellow Parenting programmes, CCM patient booklet, peer support programmes, Mental Health First Aid)- measured through audit Employment rates, education rates and housing access rates |

| | |
|---|---|
| | <p><u>MoH measures:</u></p> <ul style="list-style-type: none"> Percentage of current relapse prevention plans in place for MH clients <ul style="list-style-type: none"> 2013-14 target is 95% across all age groups for Maaori and non-Maaori. |
| <p>2. People are at the centre of our health system with earlier access to quality health services</p> <ul style="list-style-type: none"> Improved experience of care for both high and low prevalence conditions Improved experience of integrated and connected health service Improved access to effective mental health care for people with high prevalence conditions | <ul style="list-style-type: none"> Number of community FTE working alongside Primary Care (goal of 50% in 5 years¹) Feedback from clients, family/whaanau and community <p><u>MoH measures:</u></p> <ul style="list-style-type: none"> Access rates to specialist MH & AOD services <ul style="list-style-type: none"> 2013-14 targets are 4.45% (0-19 yrs Maaori), 3.07% (0-19 yrs total), 7.75% (20-64 yrs Maaori), 3.07% (20-64 yrs total), 2.8% (65+ yrs total). |
| <p>3. Health system clinical and financial sustainability</p> <ul style="list-style-type: none"> Resources are used more effectively Services are more efficient and effective Increased capacity and capability of the workforce | <ul style="list-style-type: none"> Contact time and number of contacts Pathways in place and being followed – measured through auditing Inpatient admissions and community re-referrals (goal of 30% reduction in 3 years¹) Staff feedback <p><u>MoH measures:</u></p> <ul style="list-style-type: none"> Wait times for non-urgent MH specialist services (DHB) <ul style="list-style-type: none"> 2013-14 targets are 75% (0-19yrs), 80% (20-64 yrs), 80% (65+ yrs), 80% (total) to be seen in at least 3 weeks 2013-14 targets are 95% (all age groups) to be seen in at least 8 weeks. Wait times for non-urgent Addictions (AOD) services <ul style="list-style-type: none"> 2013-14 targets are the same as those noted above for MH services. |

*These are noted as potential indicators to provide a starting point for further discussion as part of the development of an Outcomes framework and associated measures (see pg 43). Expectations and further targets will be defined through annual plans as we work towards our goals over the next five years.

What does this mean for me?

‘I know how to get help when I need it, to get better and to stay well’

‘I know where to go to ask what’s available and even if they can’t answer all my questions, they’ll find out- they have local knowledge’

‘My navigator knows me and what will work best for me right now- there are so many options’

¹ ‘Big Dot’ goal of Five Year Service Plan for Mental Health (CM Health Provider Arm)

Goal 2: Targeted interventions at the right time

Current state- what does it look like now?

Counties Manukau Health provide a wide range of health services to mother, babies, children and youth including mental health and addiction services that cater specifically for these groups. We have a youthful population with 24% of our population aged 14 or under and 14% of NZ's children live here.

Evidence shows that by providing interventions earlier in people's lives there are greater opportunities for positive health outcomes including reducing the need for more intense interventions later on in life. In terms of access to mental health and addictions services, our access rates are improving but we need to keep working on it if we are to ensure interventions are accessed earlier. Ensuring easy access for mothers, children and youth to effective mental health and/or addiction services is a priority for Counties Manukau and is an area we know we can continue to improve.

Maternal and Infant

Women are particularly vulnerable during pregnancy and following childbirth and the impact of mental illness and substance misuse at this time can be particularly profound as it is not only the woman who is affected but also her baby, family and the community (Foreman, 1998; Stewart, Robertson, Dennis, Grace, & Wallington, 2003).

There is compelling evidence that shows early adverse environments can have lifelong effects on the emergence of conduct disorder, substance abuse, and physical and mental health problems (MoH, 2011). Alcohol and substance misuse during pregnancy can also have detrimental effects on the unborn child and is estimated to occur in 1% of live births (Foetal Alcohol Network NZ, 2013).

There are a range of maternal and infant mental health services available in Counties Manukau including culturally specific teams and community-based respite options. Recent local and regional reviews have highlighted the need to further extend the range of services including acute options and address the challenges of navigating through the complex web of maternal and child services (both within health and across sectors).

Young people

There have been significant improvements in some areas of youth health and wellbeing over the last few years however there remain areas of concern that are highlighted in the recent national health and wellbeing survey of secondary school students (Clark, Fleming, Bullen, Denny, Crengle, Dyson, Fortune, Lucassen, Peiris-John, Robinson, Rossen, Sheridan, Teevale, Utter, 2013). The report identifies some significant problems that young people in New Zealand face including bullying, significant depressive symptoms and lack of access to family doctors (Clark et al., 2013).

Mental health issues and/or substance misuse often first appear in adolescence however responding to these issues early can be a challenge for a range of reasons including a lack of understanding and reluctance to seek help. Families, whānau, schools and local communities are often in a position to be able to intervene but may lack the knowledge and tools to know what to do.

Suicide is the second most common cause of death for the 15-24 year old age group, with high hospitalisation rate for suicide attempts, and those living in more socially deprived areas having higher rate of suicide than others (NZ Suicide Prevention Strategy, 2006). In Counties Manukau, there are just over 64,000 12-19 year olds; of these 21% are Māori and 30% are Pacific, 37% of this group live in socio-economically deprived areas.

There are a wide range of services available in Counties Manukau that cater specifically for youth including culturally specific teams that young people can access if they choose. Primary care and

specialist services (including NGO) are delivered in a range of settings however number of services can lead to fragmentation and coordination challenges.

To improve access to specialist services and allow the opportunity to intervene early, there are a number of challenges to address in relation to building stronger connections with primary care.

The following challenges need to be addressed:

- Isolation and limited scope of some school-based nurses
- Improving access to primary care for young people not connected to school
- Primary care access for older young people who have left school (18-24 years)
- Improving access to specialist mental health and addiction services.

Actions- what are we going to do?

Maternal and Infant

For our mothers², babies and children, increasing connectedness with maternal and child services through clarification of pathways and exploring shared triage processes will assist in improving access to specialised services in a more timely and effective manner. This will include using culturally appropriate models such as *whaanau ora* and *fanau ola* to ensure we are also supporting families and maximising potential benefits to children. We need to work collaboratively with a multitude of agencies to provide better services and support for children in care, establishing pathways and sharing information to aid in this.

National documents and guidelines such as the Children's Action Plan (NZ Government, 2012) and Healthy Beginnings (MoH, 2012) will inform the way we develop services and actions will be progressed through linking in and supporting these plans at the local, regional and national level.

The Counties Manukau Health "First 2000 Days" project focuses on improved integration of services to connect the myriad of services mothers and babies interact with when planning their families, pregnancy and for the first 2000 days of a baby's life. By investing in early intervention it is hoped that there are better population health outcomes in the long term. Implementation of this project will include input from Mental Health and Addictions services, and will have important implications for services.

Young People

Counties Manukau Health are taking a strategic approach to the planning of Youth Mental Health and Addiction services as part of a wider Youth Strategy, which will include meeting the objectives of the Prime Minister's Youth Mental Health project. Our aim is to intervene early to prevent the development of mental health issues and improve access to specialised treatment when required through working collaboratively with our primary care partners and wider community- wherever our youth are.

We will work in collaboration to better meet the needs of our youth and work across sectors to develop clear inter-agency pathways. This means working more closely with other agencies and sectors, particularly education and justice to intervene earlier for those most at risk of developing mental health and addictions issues.

We need to increase the range of services available, improve how we communicate, and provide services from different locations, not just schools and primary care but wherever our youth are. Co-existing mental health and substance use problems are a significant concern for youth and we need to ensure that 'any door is the right door' so that everyone working with young people have the

² To be consistent with Healthy Beginnings (MoH, 2012) the term mother is used for the simplicity as mothers are most commonly in the role of primary caregiver for their infants. However, fathers, grandparents, adoptive parents, foster parents and others may also undertake this role and may access services if eligible.

skills and knowledge to facilitate access to the most appropriate services. This means supporting and developing the workforce to better respond and relate to our youth.

Overseen by the Youth Expert Advisory Group we have initiated a project that will inform a service development plan for youth mental health and addiction services in Counties Manukau. The outcome of this project will be a new model of care that will:

- Include a model of primary youth health that incorporates school-based health delivery and includes effective primary mental health and addictions care;
- Improve referral pathways between primary care, mental health and addictions services and the Centre for Youth Health;
- Is consistent with the Counties Manukau Health System Integration Programme and the development of Locality Clinical Partnerships.

| ACTIONS Years 1-2 | ACTIONS Years 3-5 | KEY STAKEHOLDERS |
|--|--|--|
| OBJECTIVE 2.1 Better mental health and wellbeing for young people | | |
| <p>Develop model of care that encompasses primary youth health services and will meet the objectives of the Prime Minister's Youth Mental Health project</p> <p>Map current pathways through services and establish agreed shared pathways to increase access to specialist mental health and addiction services through interagency collaboration</p> <p>Create a service development plan in consultation with local providers, taking into consideration the unique needs of youth e.g. cultural, service accessibility, gender, age and developmental stage</p> <p>Expand delivery of school based alcohol and drug programmes into alternative education settings</p> <p>Explore and implement innovative ways to enable better access to information about Mental health and addiction issues including suicide prevention</p> | <p>Bring youth services together as part of locality approach</p> <p>Agreed pathways implemented and regularly reviewed to ensure access</p> <p>Implement service development plan</p> | <p>Primary Care, NGO providers, DHB services, schools & other education providers, Youth service providers and relevant government departments: MOE, Justice</p> |
| OBJECTIVE 2.2 Increase capability and capacity of the youth health workforce | | |
| <p>Contribute to the development of a competency framework that encompasses primary, secondary and NGO workforce</p> <p>Increase local youth forensic capability (MH & AOD) as part of the development of the regional Youth Forensic service</p> | <p>Implement competency framework and develop initiatives that increase youth employed in the workforce</p> | <p>DHB, PHO, NGO's, Health Workforce NZ, Te Pou, CHAMP, Te Arawhiriwhiri, schools & other education providers, Youth service providers and relevant government departments: MOE, Justice</p> |

| OBJECTIVE 2.3 | | |
|--|--|---|
| Improve integration between health services for mothers, infants and children | | |
| <p>Map current inter-sectoral pathways (primary care, specialist, schools, CYFs) and establish agreed pathways to ensure access to appropriate care</p> <p>Contribute to Whaanau Ora initiatives</p> <p>Establish process for collaborative wellness planning and support for maternal services</p> <p>Further develop the continuum of Maternal, Perinatal and Infant Mental Health and Addictions specialist services at a regional level</p> <p>Create and implement integrated triage processes to appropriate health services for mothers, infants and children including clear definitions of wait times for non-urgent referrals and establish baseline</p> <p>Develop COPMIA (Children of Parents with Mental Illness and Addictions) services across localities</p> | <p>Agreed pathways implemented and regularly reviewed to ensure access to appropriate care is enabled</p> <p>Implement processes to enable collaborative wellness planning and support for maternal services</p> <p>Contribute to the development of an integrated and coordinated response to meeting the needs of children in care</p> | <p>CM Health Maternal Mental Health, Maternity Services, Kidz First, Primary Care providers, NGO, Regional Maternal & Parenting services, Whaanau Ora providers, Pacific service providers, GM Maaori & Pacific health & NGO providers, Locality managers, other relevant government sectors: MOE, CYFS</p> |
| OBJECTIVE 2.4 | | |
| Increased capability and capacity of the maternal, perinatal and child health workforce | | |
| <p>Contribute to the development of a workforce development plan, building on regional recommendations</p> <p>Contribute to the development of a competency framework for Maternal, Perinatal & Infant Mental Health</p> | <p>Implement workforce plan and monitor effectiveness</p> <p>Implement competency framework</p> | <p>CM Health Maternal Mental Health, Maternity Services, Kidz First, Primary Care providers, NGO, Regional Maternal & Parenting services, Whaanau Ora providers, Pacific service providers, GM Maaori & Pacific health & NGO providers, Locality managers, other relevant government sectors: MOE, CYFS</p> |

Future state- what difference will it make?

| Targeted interventions at the right time | |
|---|--|
| EXPECTED OUTCOMES: TRIPLE AIM | POTENTIAL INDICATORS* |
| 1. People live healthier, longer, more productive, disease free lives <ul style="list-style-type: none"> Better mental health and wellbeing for young people Earlier intervention for youth with emerging health issues Improved parental support and attachment Earlier intervention in the life cycle Increased access to information that supports wellbeing and builds resilience | <ul style="list-style-type: none"> Access rates (specialist services) for brief assessment and referral back to GP (broken down by age group) Self-harm and suspected suicide data Suicide rate (goal of 25% reduction³) Availability of information (current: 'Look at You' DVD, Mellow Parenting programmes, CCM patient booklet, peer support programmes, Mental Health First Aid)- measured through audit <p>MoH measures:</p> <ul style="list-style-type: none"> Percentage of current relapse prevention plans in place for MH clients <ul style="list-style-type: none"> 2013-14 target is 95% for 0-19 yrs for Maaori and non-Maaori. |
| 2. People are at the centre of our health system with earlier access to quality health services <ul style="list-style-type: none"> Improved experience of care for mothers and babies Improved experience for youth of youth-centred services Increased access to services for youth and mothers and babies | <ul style="list-style-type: none"> Pathways in place and being followed – measured through auditing Consumer and family/whaanau feedback Feedback from other sectors e.g. Education, Justice <p>MoH measures:</p> <ul style="list-style-type: none"> Access rates to specialist MH & AOD services <ul style="list-style-type: none"> 2013-14 targets are 4.45% (0-19 yrs Maaori), 3.07% (0-19 yrs total). |
| 3. Health system clinical and financial sustainability <ul style="list-style-type: none"> Services are more efficient and effective Increased capacity and capability of workforce | <ul style="list-style-type: none"> Client contact time and number of contacts- CAMHS and AOD services Staff feedback <p>MoH measures:</p> <ul style="list-style-type: none"> Wait times for non-urgent MH specialist services (DHB) <ul style="list-style-type: none"> 2013-14 targets are 75% (0-19yrs) to be seen in at least 3 weeks 2013-14 targets are 95% (0-19 yrs) to be seen in at least 8 weeks. Wait times for Youth AOD services (non-urgent) <ul style="list-style-type: none"> 2013-14 targets are the same as those noted above for MH services. |

*These are noted as potential indicators to provide a starting point for further discussion as part of the development of an Outcomes framework and associated measures (see pg 43). Expectations and further targets will be defined through annual plans as we work towards our goals over the next five years.

³ 'Big Dot' goal of Five Year Service Plan for Mental Health (CM Health Provider Arm)

What does this mean for me?

'I was able to get specialist mental health support quickly and easily after having my baby'

'I was able to access information on-line about how to help my friend with her drug use after hearing about it at school'

'The youth services really seem to make a difference – our son loves going there and he seems much happier. He didn't used to want to talk to anyone about what was going on for him.'

'Thank heavens there is some support now for kids whose parents are having problems.'

Goal 3: Timely, effective acute response

Current state- what does it look like now?

Adult Mental Health services have been experiencing challenges in meeting the demand for acute inpatient and community services due to a range of factors including increases in demographic growth and a shortage in the medical workforce. On-going high demand has a negative impact on client access, continuity of care, consistency in service provision, client outcomes and staff morale.

Local solutions have been put in place over the last few years to better manage increasing demand including acute community options such as peer-led acute alternatives and respite. Additionally, a contingency plan for medical staffing has been put in place to address some of the immediate and high priority issues. While the development of a range of acute community options has strengthened the acute continuum, we continue to experience pressure on beds at Tiaho Mai (inpatient acute mental health service) and on-going high occupancy rates. With adult (20-64 years) population growth predicted at an average of 1.5% per annum from 2013 to 2026 the pressure on our acute services is expected to increase.

Actions- what are we going to do?

Long term, systemic solutions are needed to address issues across the acute adult services continuum, ensure better client outcomes and keep pace with the changing needs of our population.

We need to continue to develop the range of community-based acute options as part of the acute continuum. Whenever safe management in the community is an option, we need to ensure there is access to a service that can meet this need. When acute inpatient care is needed, we need to make sure people can access this quickly and easily and are able to return to their local community as soon as appropriate.

The Framework for Change is an improvement programme led by Counties Manukau Mental Health (Provider Arm) to support and enable systemic improvements across the acute adult service continuum. This will be achieved commencing with building on the learning from current and past initiatives, reconfiguring acute adult services and the engagement of staff and clients to embed implementation.

The Framework for Change proposes the following key changes to service delivery for adults:

- Single point of access;
- Centralised triage and assessment;
- Increased community acute care.

The Framework for Change is the first step in bringing about systemic, sustainable improvements in the delivery of care for adults with acute mental health care needs. It will be the platform for future change and will evolve over time to reflect salient issues across the acute adult services continuum.

| ACTIONS Years 1-2 | ACTIONS Years 3-5 | KEY STAKEHOLDERS |
|--|--|---|
| OBJECTIVE 3.1 Accessible and effective acute response | | |
| <p>Develop a systemic assertive action plan to better manage acute demand through a range of approaches including rapid response early on in relapse, intensive supports and addressing housing & social issues</p> <p>Establish agreed clear pathways to a range of community-based acute options (including AOD respite) across localities</p> <p>Work with a range of community based services to optimise utilisation of existing community based resources and enhance services to prevent or shorten acute inpatient admission</p> | <p>Establish multidisciplinary teams to deliver within services and clinical practice is consistent across localities while being responsive to locality services</p> <p>Further develop and enhance AOD respite and treatment options</p> | <p>NGO, DHB, Primary Care, Planning & Funding, Employment & Housing agencies, MSD</p> |
| OBJECTIVE 3.2 Redesign and implement the two service delivery components within the Framework for Change programme | | |
| <p>Increase access by developing pathways into the services for urgent and non-urgent assessment and treatment, including access for advice by GPs and other providers</p> <p>Extend acute treatment to include community-based options including in the home</p> | <p>Agreed pathways implemented and regularly reviewed to ensure ease of access and improved client experience</p> | <p>NGO, DHB, Primary Care, Planning & Funding</p> |
| OBJECTIVE 3.3 Replace inpatient facility and increase inpatient capacity | | |
| <p>Develop and gain approval for a business case to rebuild and redesign Tiaho Mai, allowing for increased continuity of care between ICU and open wards</p> <p>Develop and test a short-stay unit to manage people who present with mental health issues who could benefit from enhanced assessment and treatment initiation over a short period thereby avoiding an acute inpatient admission</p> | <p>Deliver on approved business case to redesign and rebuild Tiaho Mai ensuring we are able to effectively and safely meet the needs of our local youth and maternal population</p> | <p>NGO, DHB, Primary Care, Planning & Funding, Employment & Housing agencies, MSD</p> |

Future state- what difference will it make?

| Timely, effective acute response | |
|--|---|
| EXPECTED OUTCOMES: TRIPLE AIM | POTENTIAL INDICATORS* |
| 1. People live healthier, longer, more productive, disease free lives <ul style="list-style-type: none"> Enhanced recovery for people with both high and low prevalence conditions Enhanced community engagement, housing options and social inclusion Earlier intervention in the course of an emerging mental health issue | <ul style="list-style-type: none"> Inpatient readmissions and community re-referrals (goal of 30% reduction in 3 years⁴) Average length of stay of inpatient and acute and residential options Occupancy of inpatient, acute and residential options Employment rates, education rates and housing access rates <p>MoH measures:</p> <ul style="list-style-type: none"> Percentage of current relapse prevention plans in place for MH clients <ul style="list-style-type: none"> 2013-14 target is 95% across all age groups for Maaori and non-Maaori. |
| 2. People are at the centre of our health system with earlier access to quality health services <ul style="list-style-type: none"> Improved experience of care Increased access to services that enable recovery | <ul style="list-style-type: none"> Admissions to acute community options Consumer and family/whaanau feedback Seclusion and restraint rates <p>MoH measures:</p> <ul style="list-style-type: none"> Access rates to specialist MH & AOD services 2013-14 targets are 4.45% (0-19 yrs Maaori), 3.07% (0-19 yrs total), 7.75% (20-64 yrs Maaori), 3.07% (20-64 yrs total), 2.8% (65+ yrs total). |
| 3. Health system clinical and financial sustainability <ul style="list-style-type: none"> Services are used more effectively Services are more efficient and effective Increased capacity and capability of workforce | <ul style="list-style-type: none"> Contact time and number of contacts Pathways in place and being followed – measured through auditing Staff feedback |

*These are noted as potential indicators to provide a starting point for further discussion as part of the development of an Outcomes framework and associated measures (see page 43). Expectations and further targets will be defined through annual plans as we work towards our goals over the next five years.

What does this mean for me?

‘When I get to the point that things are breaking down, I know I’ll get the care I need’

‘My son wrote down what he wants me to do when he gets unwell so I can help him choose the things that will help.’

‘I feel safe and supported and I don’t need to go to hospital unless I really need it’

⁴‘Big Dot’ goal of Five Year Service Plan for Mental Health (CM Health Provider Arm)

Goal 4: Locally responsive services

Current state- what does it look like now?

There are particular features of the rich and diverse population of Counties Manukau that impact on health outcomes for our people and if we are to achieve better mental wellbeing for all, we need to focus our attention on some specific areas. The previous ten years of service development focused on the needs of the people in our population with low prevalence conditions and/or high needs, representing the top 3% of the population most severely affected by mental health and addiction issues. Focus on this group remains a priority as more effective services will allow freeing up of resource that can then be applied to address inequities. Health outcomes are not consistent across our local population and there are some identified service gaps and population groups that warrant a more targeted approach.

Inconsistencies of Mental Health & Addictions health outcomes

There are a high proportion of Maaori (16%) and Pacific peoples (23%) living in our district. Maaori have higher overall rates of mental health disorders, have higher rates of co-morbidity and suicide rates amongst Maaori are 2.5 times higher than non-Maaori (Te Rau Hinengaro, MoH 2006; MoH 2010).

Counties Manukau has developed a continuum of mental health and addiction services to better meet the needs of Maaori including the provision of Kaupapa Maaori services and supporting the development of Kaupapa Maaori organisations. Despite these developments, Maaori are still over-represented in terms of severity and tend to present to services at a later stage in the development of their mental health and/or addiction issues.

Pacific peoples, while less than Maaori, were found to carry a higher burden of mental illness than the general population and access rates to services were low compared to need, particularly for Pacific children and adolescents. Pacific mental health and addictions services have enabled Counties Manukau to respond to the needs of our Pacific population but further development is needed to ensure increased access and early intervention, particularly as a large proportion of our Pacific population are youth.

Counties Manukau is home to a large Asian population (21%) and there is growing evidence of a lack of consistency of health outcomes for this group. Emphasis will need to be given to culturally appropriate service delivery for this group and while there is no publicly available plan in place there are several reports and activity focused service development plans in place for Asian Mental Health and Addiction Services.

The incidence of mental health and addiction issues is higher for our refugee populations and they are 10 times more likely to experience post-traumatic stress disorder compared with the general population (Kirmayer et al 2011, cited in Rising to the Challenge, MoH, 2012). Counties Manukau is home to the largest resettlement centre in New Zealand and some of these refugees will settle in our community.

Living with a disability can have a detrimental impact on mental health and the prevalence of mental health disorders is higher among people with intellectual disability than the general population (Borthwick-Duffy 1994, cited in Rising to the Challenge, MoH, 2012). Counties Manukau has a dedicated Dual Disability team who provide clinical care across the region to those who have both intellectual disability and mental health issues. Access to community services to support this group can be challenging due to different funding streams and too often access can be delayed or disrupted due to these challenges. Workforce expertise is also an issue for this group as staff are usually trained in either disability or mental health and need to adapt their approach to this population.

34% of the Counties Manukau population live in socio-economically deprived areas, the impact on mental wellbeing is significant and the need to access mental health or addiction services is 2.7

times more likely (MoH, 2013). Factors such as low household income and living in an area of deprivation are associated with an increased prevalence of mental illness, prolonged length of episodes of illness, and increased issues of access and effective use of mental health services. Harmful consumption of alcohol and other drugs contributes to health and social inequalities and is also among one of the foremost underlying causes of violence (including domestic violence) and crime.

Older Adults

In Counties Manukau the population aged 65+ is projected to increase substantially over the next five years at an average rate of 5.2% per year. The fastest growth in the over 65 age group will be in those people identifying as Asian, followed by Maaori and Pacific whose populations are expected to double by 2026.

The current range of Mental Health and Addiction services provided to the 65 and over age group is limited compared to other age groups and will need to be increased if we are to meet future demand.

Alcohol and Other Drugs (AOD) services

The Alcohol and Other Drugs Service Plan (2009-2014) outlined the specific actions we needed to take to improve the wellbeing of local people, families/whaanau and communities whose lives were being harmed, or may become harmed in some way by alcohol and/or other drug use.

Delivering on the key goals and objectives have led to the development of the AOD sector in Counties Manukau and we now have a range of services that are provided both locally and regionally including community-based, residential, peer support, AOD respite, co-existing (community and residential) and school-based education programmes.

Actions- what are we going to do?

Consistency of Mental Health & Addictions health outcomes

With Maaori and Pacific at the helm, we need to develop effective approaches that can make a real difference to addressing health inequalities. This means supporting culturally appropriate models such as Whaanau Ora and Fanau Ola to ensure we are taking a holistic approach, supporting whaanau and fanau and working collaboratively across health and across sectors.

We will support the work of Te Arawhiriwhiri (Kaupapa Maaori provider collaborative) to deliver strategies and we will work with our Pacific providers to develop better service for Pacific peoples.

We also need to gain a better understanding of the needs of Asian, refugees, people with disabilities and other groups to develop targeted initiatives that can make a real difference in terms of health outcomes. This will include workforce development, service development and working collaboratively to ensure that access to service is enabled and any blocks are identified and worked through.

Older Adults

To meet current and future demand we need to increase our range of services for Older Adults. The pressure for services is growing; we need to find sustainable ways in which to meet this need including provision of community options, and working with Health of Older Persons to provide more responsive services. This includes sharing of processes such as triage and closer working relationship including potential co-location of services. Developing a workforce to cater to this growing population is also required.

Ensuring those with dementia get the care they need is a priority for Counties Manukau and the implementation of the Dementia Care pathway will ensure assertive and ongoing care for people

and their families throughout their illness. The pathway is a collaboration between Health of Older Persons (HOP) Service and Mental Health Services for Older People (MHSOP) and will be implemented over the next five years.

Alcohol and Other Drugs (AOD) services

The Alcohol and Other Drug Services Plan 2009-2014 has guided the development of locally responsive AOD services and we have achieved most of the goals set out in this plan. We now need to develop a new plan that builds on these gains and continues to develop AOD services that are responsive to our local communities.

Our plan will consider the needs of those with co-existing mental health and AOD to ensure our services are working together to ensure that 'any door is the right door'. This means supporting and developing the workforce to ensure they have the skills and knowledge to facilitate access to the most appropriate services. The plan will encompass adult and youth services and link in with specific youth objectives identified in Goal 2.

We will continue to work in partnership with the Counties Manukau AOD Collaborative group who are leading a number of projects in line with the current AOD Services Plan 2009-2014 including: vocational support, aftercare, web development, KPI project, addressing stigma, service mapping, ADOM, Pacific residential treatment, workforce development, cultural competency organisational stocktake, & vocational support for young people.

| ACTIONS Years 1-2 | ACTIONS Years 3-5 | KEY STAKEHOLDERS |
|--|--|--|
| OBJECTIVE 4.1 | | |
| More effective approaches to improve outcomes for Maaori and Pacific peoples | | |
| <p>Work in partnership with Te Arawhiriwhiri to develop initiatives to ensure services embrace tikanga and provide culturally appropriate service to tangata whaiora</p> <p>Develop integrated approaches for Maaori and their whaanau through applying the Whaanau Ora approach as part of locality service developments, building whaanau resilience and capability</p> <p>With a focus on families with complex needs, develop integrated approaches for Pacific and their fanau through applying the Fanau Ola approach as part of locality service development, building fanau resilience and capability</p> <p>Through clear and connected pathways, ensure ready access to a variety of appropriate cultural supports</p> | <p>Implement integrated approaches for Maaori and their whaanau through applying the Whaanau Ora approach as part of locality service developments, building whaanau resilience and capability</p> <p>Extend focus to include all Pacific families and implement integrated approaches for Pacific and their fanau through applying the Fanau Ola approach as part of locality service development, building fanau resilience and capability</p> | <p>NGO, DHB, Maaori Health, Pacific Health, Te Arawhiriwhiri, Consumer & Peer services</p> |

| OBJECTIVE 4.2 | | |
|--|--|---|
| More effective approaches to improve consistency of outcomes | | |
| Develop initiatives to better meet the needs of those groups that experience disparities in health outcomes e.g. Asian, Refugees, Lesbian, Gay, Bisexual, Transgender (LGBT), people with disabilities and other groups. | Implement targeted initiatives to address health disparities | NGO, DHB, Maaori Health, Pacific Health, Te Arawhiriwhiri, Taikura |
| Develop clear and connected pathways to ensure appropriate service delivery for people with disabilities and/or head injury | | Trust and other disability services, Refugee & Migration Services, CM HEALTH Asian Service Development, Consumer Networks and Peer Services |
| OBJECTIVE 4.3 | | |
| Develop a culturally competent and capable workforce | | |
| Implement targeted recruitment strategies to better reflect cultural makeup of Counties Manukau population | Develop cultural competency training package specific to Older Adult services | DHB, NGO's, Health Workforce NZ, MSD, Peer services, Maaori Health, Pacific Health, Te Arawhiriwhiri, Taikura |
| Develop cultural competency component as part of wider framework | Phased implementation of the cultural capability plan | Trust and other disability services, Refugee & Migration Services, CM Health Asian Service Development, and Consumer Networks |
| Develop cultural capability plan to build the cultural capability of the CM Health Provider Arm services | | |
| Ensure 80% of all Mental Health and Addictions staff have attended Cultural & linguistic diversity (CALD) training | | |
| OBJECTIVE 4.4 | | |
| Integrated health services for older people | | |
| Create clear pathways & triage processes (for HOP & MHSOP) including collaborative planning between the two services | Develop flexible funding models that are more personalised and client-directed (not restricted by age or changing level of need) | HOP, MHSOP, NGO providers, Consumer Networks and Peer services |
| OBJECTIVE 4.5 | | |
| More community options for older people | | |
| Develop the continuum of care for older people with a range of mental health and addictions needs including acute community-based options | | MHSOP, HSOP, NGO's, CM Health Planning & Funding |
| Develop and deliver services in a way that is supportive of cultural values and beliefs. | | |

| OBJECTIVE 4.6 More locally responsive Alcohol and Other drugs (AOD) services | | |
|---|---|--|
| Further extend the range of local AOD services and develop and implement an AOD Service Development Plan that builds on the gains of the previous plan (2009-2014) | Develop locally responsive services in accordance with plan | DHB, Planning & Funding, NGO, AOD Networks, Consumer Networks, AOD Provider Collaborative, Justice |
| Build capacity to meet the needs of those with co-existing problems through closer integration between mental health and AOD service delivery and targeted workforce development to ensure co-existing competency | | |

Future state- what difference will it make?

| Locally responsive services | |
|---|--|
| EXPECTED OUTCOMES: TRIPLE AIM | POTENTIAL INDICATORS* |
| 1. People live healthier, longer, more productive, disease free lives <ul style="list-style-type: none"> Consistency of mental health and addictions outcomes for all Increased cultural effectiveness Enhanced recovery for Older Adults, Maaori, Pacific and other groups Enhanced recovery for those with co-existing problems | <ul style="list-style-type: none"> Dementia care pathway implemented Use of CCM Depression for over 65 Demonstrated cultural capability through assessments (goal of demonstration in 75% of assessments in three years⁵) Average length of stay for relevant services <p>MoH measures:</p> <ul style="list-style-type: none"> Percentage of current relapse prevention plans in place for MH clients <ul style="list-style-type: none"> 2013-14 target is 95% across all age groups for Maaori and non-Maaori. |
| 2. People are at the centre of our health system with earlier access to quality health services <ul style="list-style-type: none"> Improved experience of care Increased access to services for Older Adults, Maaori, Pacific and other groups Increased access to local AOD services | <ul style="list-style-type: none"> Consumer and family/whaanau feedback Access rates to specialist MH and AOD services across different population groups: <ul style="list-style-type: none"> Maaori Pacific Asian (differentiated Asian groups) LGBT Refugees People with disabilities Older Adults Other groups Seclusion and restraint rates across different population groups <p>MoH measures:</p> <ul style="list-style-type: none"> Access rates to specialist MH & AOD services <ul style="list-style-type: none"> 2013-14 targets are 4.45% (0-19 yrs Maaori), 3.07% (0-19 yrs total), 7.75% (20-64 yrs Maaori), 3.07% (20-64 yrs total), 2.8% (65+ yrs total). |

⁵ 'Big Dot' goal of Five Year Service Plan for Mental Health (CM Health Provider Arm)

| | |
|--|---|
| <p>3. Health system clinical and financial sustainability</p> <ul style="list-style-type: none"> • Services are more efficient and effective • Increased capacity and capability of workforce | <ul style="list-style-type: none"> • Pathways in place and being followed – measured through auditing • Wait times for specialist AOD services from those in justice system (including forensic services) • Staff feedback <p><u>MoH measures:</u></p> <ul style="list-style-type: none"> • Wait times for non-urgent MH specialist services (DHB) <ul style="list-style-type: none"> ○ 2013-14 targets are 75% (0-19yrs), 80% (20-64 yrs), 80% (65+ yrs), 80% (total) to be seen in at least 3 weeks ○ 2013-14 targets are 95% (all age groups) to be seen in at least 8 weeks. • Wait times for non-urgent Addictions (AOD) services <ul style="list-style-type: none"> ○ 2013-14 targets are the same as those noted above for MH services. |
|--|---|

*These are noted as potential indicators to provide a starting point for further discussion as part of the development of an Outcomes framework and associated measures (see pg 43). Expectations and further targets will be defined through annual plans as we work towards our goals over the next five years.

What does this mean for me?

'I was able to access support for my father that was respectful of his wishes, enabled him to maximise his independence whilst receiving specialist support for a short period'

'I knew I really needed to stop drinking and as soon as I made up my mind to stop, there was someone there to help me'

'They really get me and my whaanau and how we come as a package deal'

RESOURCES/ENABLERS

To effectively achieve our goals, there are four elements that underpin all of our objectives and actions.

1. Actively Use Our Resources More Effectively

Expected Result: *Increase value for money in ring-fenced, publicly funded mental health and addictions services*

While there has been significant growth of funding in previous years we are now in a time of fiscal restraint. A continued emphasis on efficiency and value for money is required to provide sustainable mental health and addictions services for our district. In today's economic and financial environment new funding will be limited and is likely to be tightly directed towards specific services; hence we will need to work smarter with what we have. Rising to the Challenge (MoH, 2012) points to a need for greater accountability in terms of our healthcare spend.

All providers of mental health and addictions services need to be able to demonstrate outcomes and the difference made to those who are using the services. With increased accountability, our task is to ensure the data and tools we use are able to measure outcomes and performance as well as being able to inform service improvement. Benchmarking is a powerful method that allows comparison across our sector and can inform how we work together to set and meet the targets that help us measure our success.

Ensuring that our systems and services are more connected and integrated will enable us to use our resources more efficiently and in turn, further extend our capacity.

2. Develop and Grow a Sustainable Workforce

Expected Result: *A mental health and addictions workforce with the capabilities and motivation to implement the plan.*

Our workforce is our most valuable resource in terms of service delivery. In order to develop and grow a sustainable workforce we need to work collaboratively to enhance our knowledge base and extend our capabilities in primary and secondary care.

Our aim is for our workforce to reflect the diversity of our population and targeted campaigns are required to recruit, retain and educate our workforce to start to move towards this vision.

Significant work has occurred at national level in terms of the workforce through Te Pou – 'Let's Get Real' campaign and Health Workforce NZ whose role it is to provide leadership, co-ordination and oversight of planning and development of the workforce across the country's health and disability sector (<http://www.healthworkforce.govt.nz/our-work>).

The health workforce group provides the following recommendations:

- making better use of the existing health workforce, from untrained workers to highly specialist, by developing new roles and extending existing roles to make best use of the skills of all members of the health care team;
- a focus on prevention, rehabilitation and self-care to underpin a shift of resources from hospital to community;
- better use of the potential of IT, including telemedicine;

- development of regional clinical networks to make best of resources and ensure provision of services to all communities.

There are a number of local and regional workforce development plans in place for the different sections of the health workforce and we will support the implementation of these rather than developing additional plans; **Te Remu Tohu: A Framework for Youth Health Workforce Development 2009** is one such example.

Included in existing plans are our priority actions including:

- Directed recruitment & retention strategies to address workforce challenges e.g. medical, nursing, AOD;
- Extending initiatives to support further development of the peer workforce;
- Fostering a culture of excellence across our workforce that supports strength-based, holistic and inclusive approaches that enable recovery.

Development of the peer workforce and peer led services provides a significant opportunity to build capacity within our workforce. Counties Manukau are committed to strengthening the consumer voice and there are further projects planned to support the sustainability of this future workforce. There are several actions woven into our plan that will help us strengthen our workforce to ensure we can deliver on our objectives.

3. Using Information & Technology to Inform Outcomes

Expected Result: *Information and technology enables integration and collaborative care planning and supports the measurement of outcome data.*

It is imperative that we make use of the data available to us to ensure that what we are doing is effective. By utilising data we can become better informed about what parts of our systems are working well and enable us to identify improvements that can be made. Embracing developments and innovations in information and technology will assist with earlier detection of service provision gaps and support evidence based decision making. Collection and utilisation of health outcome data between services and sector groups will assist us to see how we can work better together and maximise gains in health outcomes.

We will need to ensure that the data we capture has the ability to measure our targeted activities, provide useful baseline data and allow us to benchmark across services to identify opportunities to improve.

Investment in technology has allowed us to gather information to guide and inform our work, enabling increased efficiencies, stronger analysis and support in our decision making processes. The use of PRIMHD (Programme for the Integration of Mental Health Data) is one example. There are several benchmarking forums that have been rolled out across the sector utilising the data from these systems to inform service improvements and encourage collaboration. It will be important to consider how these forums may be further developed and connected across our sector to improve integration across the Mental Health and Addiction sector and beyond.

The establishment of a measurement working group as part of the implementation of this plan will help us ensure we can make the best use of the information available to us.

4. Enhancing Cultural Capacity & Capability

Expected Result: *Services are delivered in a culturally appropriate way and the workforce is culturally competent.*

There is recognition at a national level that defined population groups within New Zealand experience significant health inequalities, based on their socio-economic position and ethnic identity. Maaori are over represented in the moderate and severe dimension of experiences of mental illness. Access rates for Pacific people are lower with services reporting difficulty with engagement.

Within Counties Manukau there are already a number of advisory groups and networks that have been established in order to enhance our cultural responsiveness and improve outcomes for specific population groups. Ensuring that these groups are well connected, and that the right people and organisations sit at these forums is paramount. By collaborating and consulting effectively we can better ensure that we will be able to better meet the needs of our people. Developing cultural capacity and capability through workforce development initiatives is an on-going priority. We need to develop a shared understanding of 'cultural competency' and support initiatives to increase cultural competency and capability. Working collaboratively with other stakeholders and embedding the principles of Whaanau Ora and Fanau Ola will assist us to ensure consistency of mental health and addiction outcomes.

The actions we will take to enhance cultural capacity and capability are woven into several of the objectives of our plan.

MEASURING OUR SUCCESS

The success of this plan will be dependent upon the way in which we can engage mental health and addictions services to work together to deliver on the activities within the plan. Many of the goals identified rely upon more than one service or sector working collaboratively to achieve greater results and system wide efficiencies. By supporting each other to reach common goals we can continue to work towards realisation of our overall vision of 'The communities of Counties Manukau will support each other's mental health and wellbeing and will be able to get support when they need it, quickly and easily, in their local community'.

National Reporting

Activities within this plan align well with the goals and priorities outlined in the Rising to the Challenge Service Development Plan (MoH, 2012). Through this alignment we are ensuring that we are meeting national reporting requirements and have the ability to measure our success through nationalised benchmarking data.

Outcomes Framework

We will monitor and measure our success against the Triple Aim framework identifying the following high level outcomes:

1. People live healthier, longer, more productive, disease free lives;
2. People are at the centre of our health system with earlier access to quality health services;
3. Health system clinical and financial sustainability.

Using this framework we will develop a shared understanding of expected client outcomes & measures.

This means working together to develop and implement an outcomes framework with associated measures and funding mechanisms to support it. Development of such a framework will give clearer information on how effective services are in meeting the needs of the Counties Manukau population through utilising a number of meaningful measurements including social indicators of housing, employment and education.

Blueprint II *Making change happen* (MHC, 2012) provides an initial framework that will assist in defining our strengths and opportunities in each activity area of the Blueprint II vision. Furthermore there is a broad monitoring framework that will assist in tracking progress and achievements; reference to the KPI project is also made. The information within this document will guide some of the development of our localised outcomes framework and ensure we are meeting national monitoring and evaluation expectations.

Additionally there are outcomes frameworks in place for some of the interagency plans that this plan feeds into, one example of this is the development of an outcomes framework for the New Zealand Suicide Prevention Action Plan. It will be important to integrate these measures into our own outcomes framework so that we are aiming to achieve relevant goals and we gain efficiencies in our data collection and reporting mechanisms.

Measurement

For each of our goals, there are a number of potential indicators listed that may help us measure our success. Some of these are already available and some of these will need to be further developed. The lists provide us with a starting point and further discussion is needed to determine if these will provide the information we need and to weigh up the cost of collection versus usefulness. There may be other indicators that will provide a more accurate picture. The indicators are largely quantitative (we can count them) but there are also qualitative measures listed as these will help us gain an understanding of how people experience our services and what difference they make. Qualitative data can also help us explain what the numbers are showing us and allow us to gain a much deeper and fuller understanding of our services.

As part of measuring our progress against the plan, we will set up a measurement working group to determine how to gather the information we need to measure progress including establishing a process for tracking progress over time. This group will be made up of those who have knowledge of measurement as well as those essential to accessing the data required. Through this group we will ensure the availability of high quality information to inform performance improvement.

Implementing the Plan

The audience and users of this plan encompasses the broader Counties Manukau Mental Health and Addictions sector including Non-Government Organisations (NGOs) and the wider health and social sector.

It is intended that this plan will provide a strategic guide as to how we as a district intend on developing our services over the next five years. A number of high level measures and expected outcomes have been included as part of this Strategic Action Plan.

As this plan has been developed in collaboration with stakeholders it is inclusive of key activities occurring amongst our partners within the community and hospital settings, and should be aligned to the strategic priorities of our partners.

Monitoring the Plan

The Counties Manukau Mental Health and Addictions Advisory Committee (CM-MHAAC) will be responsible for on-going monitoring and guidance of how the plan is implemented over the next 5 years. This committee is comprised of representatives from the Counties Manukau Mental Health and Addictions sector (refer Terms of Reference, appendix III).

Throughout the plan there are a number of specific actions which may be delegated out to other organisations who will report back in through CM-MHAAC and/or the Counties Manukau Planning and Funding team, whichever is most appropriate. There are also projects included here whose responsibility sits outside of Mental Health & Addictions such as those run by central Government departments and different services or departments within Counties Manukau Health. It will be important to actively seek updates on progress and outcomes of these to ensure we are utilising the learnings of others to enhance our mental health and addictions service developments. This is integral to the role of the CM-MHAAC and will be incorporated into the monthly meeting content.

GLOSSARY

| | |
|-----------|--|
| ADOM | Alcohol & Drug Outcome Measure |
| AOD | Alcohol & Other Drugs |
| CADS | Community Alcohol & Drug Services |
| CALD | Cultural & Linguistic Diversity |
| CAMHS | Child & Adolescent Mental Health Services |
| CCM | Chronic Care Management |
| CHAMP | Counties Manukau Mental Health & Addictions Partnership |
| CLS | Community Living Service |
| CM | Counties Manukau |
| CM Health | Counties Manukau Health |
| CMDHB | Counties Manukau District Health Board |
| CM-MHAAC | Counties Manukau Mental Health & Addictions Advisory Committee |
| COPMIA | Children of Parents with Mental Illness & Addictions |
| CYF | Child Youth & Family |
| DHB | District Health Board |
| FTE | Full Time Equivalent |
| GP | General Practitioner |
| HOP | Health of Older People |
| ICT | Intensive Community Treatment |
| IDF | Inter-district Flow |
| ISR | Intensive Support Rehabilitation |
| KPI | Key Performance Indicator |
| LGBT | Lesbian, Gay, Bisexual, Transgender |
| MH | Mental Health |
| MHC | Mental Health Commission |
| MHSOP | Mental Health Services for Older People |
| MOE | Ministry of Education |
| MoH | Ministry of Health |
| MSD | Ministry of Social Development |
| NDI | National Depression Initiative |
| NGO | Non-Government Organisation |
| NSF | National Service Framework |
| OPF | Operational Policy Framework |
| PHO | Primary Health Organisation |
| PRIMHD | Programme for the Integration of Mental Health Data |
| PSA | Public Service Association |
| WHO | World Health Organisation |

APPENDICES

Appendix I: Developing the Plan

In November 2012, a planning process commenced to develop a Strategic Action Plan for the Counties Manukau community in relation to Mental Health and Addictions. The objective being to develop a plan that outlines our 5 year priorities and actions, ensures delivery of the goals of the Rising to the Challenge- Service Development Plan (MoH, 2012) and contributes to the achievement of the organisational goals of Counties Manukau Health.

There are a number of key influences that impact on Counties Manukau and informed our planning process as represented in Figure 6 below.

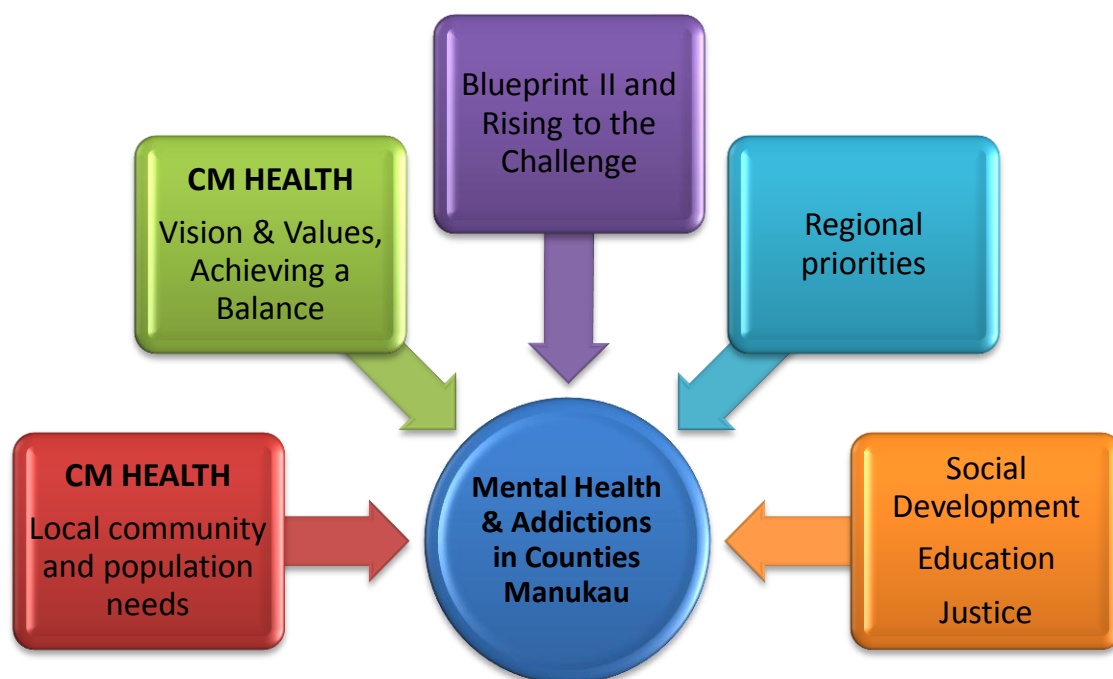


Figure 6: Key influences on the Mental Health & Addictions sector in Counties Manukau.

In developing this plan we brought together a range of stakeholders to imagine how our sector could look in 5 years' time if we were delivering excellent service and meeting the needs of our population. We were challenged to describe what this would look like and what this would mean for people who need our services. We discussed what we had, what we need and what we need to grow and develop. We shared our hopes, our aspirations as well as our issues and frustrations. Then we discussed what we will do to get us to where we need to be.

This plan brings all these ideas together and aligns them to the key national strategies as outlined in the Blueprint II (MHC, 2012) and Rising to the Challenge: The Mental Health and Addiction Service Development Plan (MoH, 2012) and ensures the relevance of these national documents to the local context of Counties Manukau. It also aligns to our local strategies for Counties Manukau Health and ensures contribution to the achievement of our organisational goals.

The Mental Health & Addictions Advisory Committee has been guiding the development of this plan and consumer leadership has been a key component with representation from the Mental Health Consumer and AOD Consumer Networks as part of the leadership group.

We had strong representation from across the sector (Appendix I) including primary care, secondary services, NGOs, consumers, family/whaanau and PSA representation. We also had a focused workshop session in partnership with Te Arawhiriwhiri to ensure the needs of Maaori are met over the next 5 years and we continue to work towards more equitable health outcomes for Maaori.

From our first workshop, key priority areas were developed and follow up focused workshops were held early March.

Through the focused workshops we were able to identify our objectives for each age and stage. We took a life course approach to facilitate more detailed discussion for each of the following:

- a) Maternal, Perinatal and Child
- b) Adolescent, Youth and Young Adults (up to 25 years)
- c) Adult
- d) Older Adults

Through these discussions key themes emerged which have subsequently been developed further to form this Strategic Action Plan. It has been widely distributed out to the broader sector for feedback through advisory networks, collaborative forums, and through written communication channels and subsequently updated.

This plan was prepared by Sonya Russell and Anna O'Connor for Counties Manukau Health.

| Counties Manukau – Mental Health & Addictions Advisory Committee (CM-MHAAC) Membership | |
|---|---|
| Sonya Russell | Senior Portfolio Manager- Mental Health & Addictions (CMH) |
| Tess Ahern | General Manager Mental Health (CMH) |
| Peter Watson | Clinical Director Mental Health (CMH) PM Youth Mental Health- Youth Expert Advisory Group (YEAG) representative |
| Raewyn Allan | Te Arawhiriwhiri representative |
| Theodora Despotaki | CHAMP Representative |
| Abi Bond | Portfolio Manager- Mental Health & Addictions (CMH) |
| Anne Bateman | Portfolio Manager- Mental Health & Addictions (CMH) |
| Kitty Ko | Asian representative Primary Mental Health Clinical Governance representative |
| Linda Poynton | AOD Collaborative Network representative |
| Tatjana Karaman | Family/Whanau Network representative |
| Whitiora Cooper | Mana Whenua |
| Susanna Galea | CADS Representative |
| Brody Runga | AOD Consumer Network representative & Mental Health Consumer Network representative |
| Roine Lealaiauloto | Pacific Provider Network representative |
| Jonathan Frith | Consumer Representative |
| Vacant | Mental Health Services for Older People representative |

Appendix II: Stakeholders who contributed their expertise, ideas and perspectives to the development of this strategic action plan

Initial Workshop

| Representative of and/or perspective provided |
|--|
| Planning and Funding – Portfolio Manager Mental Health & Addictions CMDHB |
| Union and workforce perspective |
| AOD Consumer Network |
| Mental Health Consumer Network |
| Primary Care Clinical perspective |
| Deputy Chair of CHAMP & Professional Leader Peer Support CMDHB |
| Primary Care & Localities perspective |
| Consumer perspective |
| Youth Services perspective |
| Maori Advisor for Mental Health |
| Asian Network |
| Alcohol & Drug Provider Network |
| Director of Area Mental Health Services |
| Director of Strategic Development CMDHB |
| Master Planner/Strategic Advisor CMDHB |
| Mental Health for Older People |
| Pacific Advisor |
| Clinical Director Mental Health CMDHB |
| Child, Youth and Adolescence and Maternal perspective |
| Pacific Provider Network |
| Planning & Funding – Senior Portfolio Manager Mental Health & Addictions CMDHB |
| Family/Whaanau perspective |
| CMDHB Strategic Advisor |
| Family/Whaanau Network |
| General Manager Mental Health CMDHB |
| Primary Care Planning & Funding CMDHB |

Focussed Workshop: Adult

| Representative of and/or perspective provided |
|---|
| CM Health Planning and Funding |
| CM Health Mental Health Provider Arm Leadership |
| Recovery Innovations |
| Framework NGO |
| CM Health Peer Support Specialist |
| Primary Care perspective |
| NDSA – MH&A |
| Consumer perspective |
| WDHB- CADS |
| Odyssey House |
| CM Health – Cottage Crisis Nurse |
| CM Health ICT Mental Health |
| CM Health Faleola Services |
| CM Health Project Management |
| GP Liaison |
| Connect Supporting Recovery |
| ProCare |
| Family/ Whaanau perspective |
| CM Health Primary Care Planning and Funding |

Focussed Workshop: Older Adults

| Representative of and/or perspective provided |
|---|
| NDSA |
| Odyssey House |
| CM Health – Mental Health Services for Older People |
| CM Health Mental Health Provider Arm Leadership |
| CM Health Primary Care Planning and Funding |

Focussed Workshop: Maternal, Perinatal and Child

| Representative of and/or perspective provided |
|---|
| CM Health Planning and Funding |
| CM Health ICAF |
| CM Health Maternal Mental Health |
| Child, youth and adolescence and maternal perspective |
| ProCare |
| NDSA – Mental Health & Addictions |

Focussed Workshop: Adolescent, Youth and Young Adults (up to 25 years)

| Representative of and/or perspective provided |
|--|
| CM Health Peer Support |
| Pathways NGO |
| GP Liaisons |
| Youthline |
| ProCare |
| Waitemata DHB CADS Altered High Youth Service |
| Family/Whaanau perspective |
| Family/Whaanau Network |
| CM Health Primary Care Planning and Funding |

Additional Stakeholders Consulted

| Representative of and/or perspective provided |
|---|
| Te Ara Whiriwhiri - Kaupapa Maaori Provider Perspective |
| Sue Hallwright - Strategic Advisor (CM Health) |

Thank you to all who contributed to the development of this plan. Your thoughts, views, perspectives, knowledge and experience are very much appreciated.



COUNTIES MANUKAU MENTAL HEALTH & ADDICTIONS ADVISORY COMMITTEE

TERMS OF REFERENCE

PURPOSE

To provide advice, expertise and guidance to Counties Manukau Mental Health and Addictions on strategic priorities, key actions and best use of resources to allow the DHB to support community wellbeing and improve the mental health of its communities.

Key functions:

- **Communication:** Sharing information, advice, expertise and guidance about key priority areas for the sector with the DHB and key stakeholder groups across the sector
- **Strategic Planning:** Participation in planning processes together with funders, providers and other relevant organisations to ensure alignment with key local, regional and national directions including Blueprint II (MH Commission, 2012) and 'Rising to the Challenge' Service Development Plan (MoH, 2012) and contribute to the strategic objectives of Counties Manukau Health in alignment with our commitment to the Triple Aim of: keeping people well; improving patient experience and affordability.
- **Evaluation:** Reviewing strategic outcomes in relation to key priority areas as above.
- **Advocacy:** Advocating for the mental health and addictions sector and for Counties Manukau, and providing advice to relevant organisations and agencies (in regard to matters on which there is consensus).

MEMBERSHIP

The Mental Health Advisory Committee members are as follows:

- General Manager Mental Health (CMH)*
- Clinical Director Mental Health (CMH)*
- Senior Portfolio Manager- Mental Health & Addictions (CMH)*
- Portfolio Managers- Mental Health & Addictions (CMH)*
- Regional Manager Community Alcohol & Drug Services (CADS) (WDHB)*
- Mana Whenua
- CHAMP representative
- AOD Consumer Network representative
- Mental Health Consumer Network representative
- Family/Whanau Network representative
- AOD Collaborative Network representative
- Te Arawhiriwhiri representative

- Pacific Provider Network representative
- Asian representative Primary Mental Health Clinical Governance representative
- PM Youth Mental Health- Youth Expert Advisory Group (YEAG) representative
- Mental Health Services for Older People representative
- Relevant invitees, speakers, etc are invited on an as-needed basis.

Membership Nominations and Term

Committee members who are members as a result of their employment and position (indicated with * in the list above) do not require nomination and do not have term limits.

All other members are nominated by the group that they represent. When vacancies arise, that group/network will be asked to nominate a replacement member.

The key criteria for membership of the CM-MHA Committee are:

- 1) Involvement with networks to support an applicant's expertise
- 2) Activities to keep informed
- 3) Commitment of time to work in the CM-MHA Committee.

For nominated members, the usual term for is two years up to a maximum of two consecutive terms. At the end of a second term, a Committee member must stand down for a period of one year from the completion date of their second term, except if a replacement cannot be found within 3 months in which case the previous representative can be re-nominated provided that person is willing to participate for a further 2 years.

Expectations of Committee Members:

All members of the CM-MHA Committee will be expected to:

1. Prepare for meetings by reading any materials sent out prior to the meeting; prioritise attendance to meetings and notify the Chair (or delegate) when circumstances prevent them from attending meetings;
2. Notify the Chair and stand down from the Committee if they leave the Network/ group or position they represent;
3. Be actively involved in the network or group they represent, and willing to represent that group at the Committee;
4. Be the conduit for information-sharing between any network or group they represent and the Committee, and ensure that information-sharing on behalf of the network or group represented relates to network-mandated issues only;
5. Demonstrate commitment to improving outcomes for people with mental health or addictions issues and a willingness to prioritise this purpose over and above personal interests ;
6. Work with others on the Committee to find common ground and solutions;
7. Reflect collectively agreed outcomes of discussions outside of the Committee and retain confidentiality as appropriate;
8. Display integrity and professionalism;
9. Respond in a timely way to requests on decisions to be made between meetings;
10. Declare any conflicts of interest prior to commencing as a Committee member or at the time they arise.

STRUCTURE

Chair:

The Committee has an elected community co-chair and a DHB funder co-chair.

Meetings:

- Meetings will occur monthly on the last Thursday of each month
- Meetings will be facilitated by the Chairperson (co-chairs will alternate) or their delegate
- Meetings will have an agenda which will be distributed prior to the meeting
- Minutes of the meeting shall be approved by the Chair and circulated to members within 5 working days of the meeting
- Minutes will be distributed via an agreed mailing list to members
- Coordination and administration support for the meetings including minute taking will be managed by the Executive Assistant to the Mental Health & Addictions team.

Quorum:

Decision-making will require more than 50% attendance of current membership of which at least half must be community representatives. In making decisions, the CM-MHA Committee will work to achieve consensus. Where this does not prove possible, a majority vote will apply. Where the votes for and against are equal, the Chair shall have the deciding vote (and may cast a second vote). It is the responsibility of absent members to review meeting actions to be able to contribute to decision making.

Attendance:

The work of the Committee requires a solid, in-depth knowledge of the Committee's functioning and prior activities and efficient working of the Committee which will be impeded by recurrent changes in membership. For this reason, absent Committee members are not permitted to deputise (select alternative attendees). There is an expectation that members attend 75% of meetings and absent members are responsible for briefing the Committee on any items they would have raised, and familiarising themselves with Committee minutes following missed meetings.

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NOTES



Title: **Whakapapa Te Ra**

Artist: Vik Fitzpatrick

Medium: Acrylic

This piece is an abstract landscape depicting the Whakapapa (Family) with the koru (spiral) in the bottom left corner, protected by the pohutakawa tree, symbolic of ancestry, and guided by te Ra (the sun) at the top right corner of the canvas. The orange and red rocks in the foreground are to symbolise the current challenges which we face in society today, and the imagery in the hills and waves depict the ethereal perspective of the future.

*'making
every contact
count'*



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