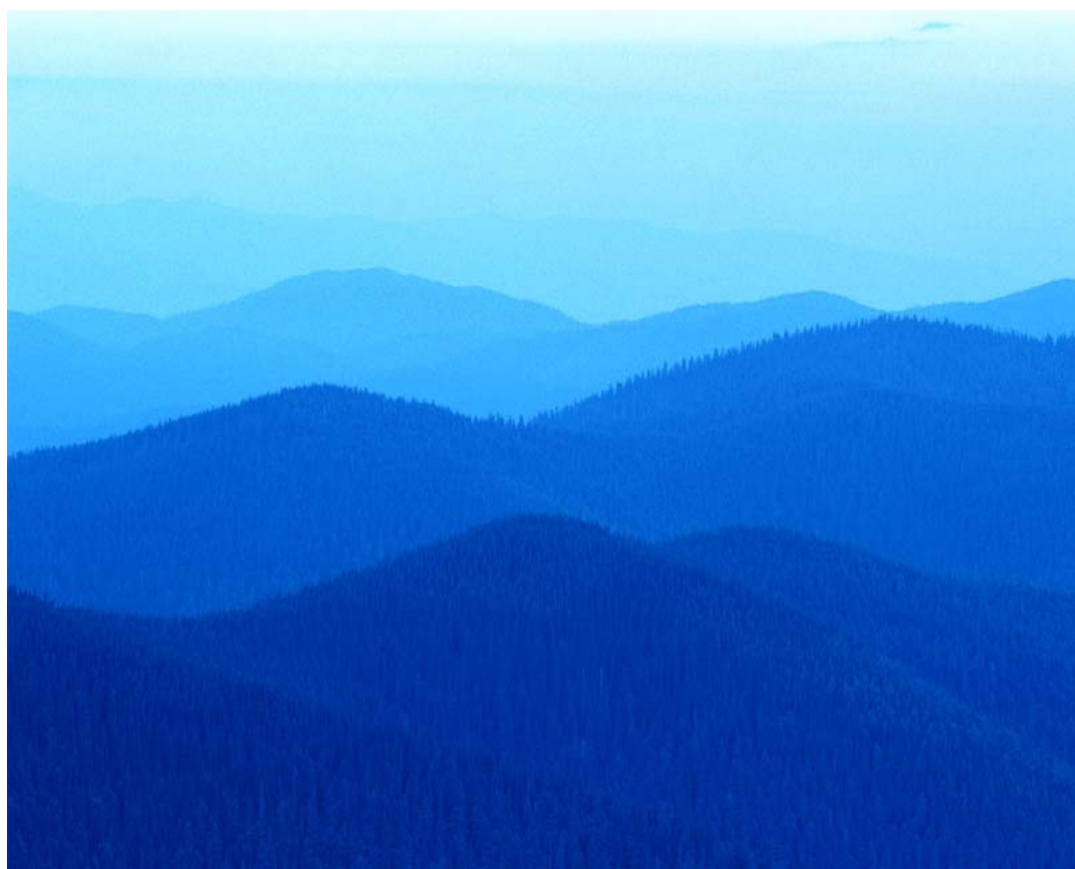




Mental Health & Addictions Funding Plan

Full feedback from stakeholders

December 2009



Stakeholder Feedback Re MH&A Funding Plan Service Gaps Nov 2009			
	Respondent Group	Service Gap	Detail
1	Rural Health Advisory Group - Grant O'Brien	Rural Crisis Response	However the recent MH&A Review Report is the Blueprint for development of this service for the next few years. The report while largely DHB service has an impact on the whole sector. Any other plan in my view needs to be supportive of this programme of work
2	Prof John Werry/Boudine Williams - Hauraki C&Y Cluster	Primary MH	Hauraki - no service for children, adolescents, infants
		Secondary MH staffing	Hauraki - no service for children, adolescents, infants. There is about half to 5/8 shortfall compared to EBOP & Tairāwhiti
		Cumulative services	Experience here and elsewhere CYFS, GSE, RTLBs, schools, NGOs in Hauraki
		Crisis respite	Suicidal adolescents in Hauraki identified through my experience here. I keep saying the same things over & over but I see no sign that anyone is listening.
3	AgeWise	ARC education on calming & restraint	Access to clinical expertise to provide education sessions on calming & restraint to ARC contracted sector. While the sector recognises they are responsible for providing this information, the DHB is realistically the main source of clinical expertise to deliver it.
		Inappropriate placement in ARC facilities	Access to services & accommodation for people 65y+ with chronic mental health conditions who are inappropriately placed in aged care
		A&D	Access to age-specific drug & alcohol services for older people
		24hr access	24 hour access to primary care and other services
4	Matamata Piako CHF - Morrinsville community House	Depression, stress, anxiety, grief	Adult men & women, all socio-ec groups, children esp 8-15y. Clients self-refer or through GP, schools, CYF, HBC. 7 adults referred in one week, 2 children in one week, unable to pay & did not meet criteria for available funding.

		A&D	A&D services in Morrinsville have improved with Pai Ake Solutions. However time spent in meetings, admin, evaluations & assessments erode client time. Youth 13-17, adults 18+. Self referred all ages, 14 referrals in 2 weeks.
		Sexual abuse counselling	Women 16y +. ACC changes are impacting on counselling for sexual abuse causing stress & further trauma. No alternative funding. Shortage of professionals qualified to meet new criteria. Self-referred or through GPs (& ACC subject to acceptance following initial assessment).
5	Matamata Piako CHF - ex member Pohlen Board	Counselling	Funded counselling esp male counsellors - urgent counselling for >25 years - identified by Matamata GP
		A&D services for 13/14 year olds	Abuse/misuse of alcohol/drugs, self harm, grief issues for 13-14 year olds (college age) - identified by Matamata College Guidance counsellor
		Counselling for 11-13 year olds	Anger & boys self harming, poor self image, inability to relate socially, lack of positive parenting - identified by Matamata Intermediate principle
6	Tokoroa CHF Chair	Crisis services & services for self harmers	Review of how people who are intoxicated threatening self harm are dealt with. Patients who have been sent to Police cells from Hospital for safety for themselves and others, while waiting. Length of time that is spent waiting for crisis team. Identified by Tokoroa Community Constable.
		Short term /long term residential care for adult mental health clients	Community House or place for people to stay, who can't immediately return to live in their own home. Ideally with a respite care bed. More flexible respite care. Ideally a place with facilities for day care. More community support for patient and family in a home based situation. Identified by CHF members.
		Primary care/co-ordination	Better utilisation of what is already in place. More liaison between GPs mental health and NGOs. More support to patient and family. To ensure that no one falls through the cracks. Maybe the appointing of a Community Co-ordinator to set up and to work in a non clinical situation in home and community. Community Educator role would ideally be a temporary person to work with agencies and community to ensure that all the services that are available are being used in the best possible way. All ages.
7	Centre 401	Physical Support to access GP's, PHO activities, social groups, exercise etc.	People who are not eligible to gain support from ACMH or Pathways. Yet return to hospital regularly and have done for years and years. The health of this group of people has deteriorated over the years of institutionalisation and treatment. Support is needed to gain back the physical and social health lost during periods of acute unwellness

8 Pathways & women's Wellness

Support to gain healthy accommodation	People who are not eligible to gain support from ACMH or Pathways. These people have no references often have come from a homeless situation, have no furniture, very low income and need to live away from drugs and alcohol. More residential care for people that are around in the community that don't have life skills
Recovery training	Regeneration and review of recovery education by individuals with experience of mental illness Recovery Education that is offered in Hamilton is now over 10 years old. New information and experience of recovery has emerged and recovery education needs to reflect this. This endeavour needs support. People with experience of Mental Illness
Clinical services	Clinical services treat and refer, please ensure that the NGOs these people are referred to are adequately resourced to accomplish the intent of the referrals. People referred from Clinical services to community services. Education around exiting the hospitals. More staff and more beds – they tend to push people into the community too early. A more permanent relationship with my doctor – they only seem to stay for 6 months before leaving
Respite Accommodation	More respite available. People wanting to prevent hospitalisation Help getting accommodation sorted, if that happens to be supported accommodation then education on exiting there, then you need something to do ie work,- changing from being a beneficiary to being a worker which produces all sorts of problems, need help with holding down a job becomes important that means dealing with emotional problems, dealing with other workers and developing skills around dealing with that. More 1 and 2 level accommodation
Counselling	Put funding into counsellors to help with marriage, anger management, drug and alcohol and how to overcome bad situations that happen in life.
Kaupapa Maori Employment	More funding for Kaupapa Maori services More positions in the mental health sector to be available to those of us who have the training and skill but there are no jobs. Support to get education for mental health patients to be able to become employable
General	Lunch once a week. More places like Centre 401 for people who have come out of the system and are trying to move on
Maternal Mental Health Respite Services	Mothers with babies. Midland Strategic Plan WWL

	Stand-alone adult mental health respite services	Not sure if you want to put this in. I'm just suggesting it as it's not currently funded from P&F – and as a result isn't really sustainable. Proven efficacy in other DHB localities. PHL
	Intensive home based support services	Endorsed by LAG. Ministerial review group. Proven efficacy in other DHB localities. PHL. – moving services closer to home
	Acute alternatives to inpatient admission, based in the community	Moving services closer to home. Potential outcome of further government reviews Proven efficacy in other DHB localities PHL
9	Rostrevor House Mental Health Services Review. Specialist/specific services for families of children/young people diagnosed ADHD/ADD	We understand that there are 70 recommendations and support a transparent process that prioritises and actions the proposed changes. Located in Hamilton City - identified through feedback from families with children/young people and city wide services
10	Rostrevor House Family Advisor	For the Waikato DHB. There is no family advisor sitting in an advisory position to the board in the same respect as the Maori and consumer advice roles. Thereby dismissing 2.6.1/2.6.2 of the Health & Disability Standards

Iwi Māori Council

Background:

Feedback on the Mental Health and Addictions Funding Plan addresses the inclusion of reducing inequalities analyses, culturally effective service provision, and the use of clinical FTEs. It is suggested that the planning process include available comparative ethnicity data to support Māori health gains when purchasing services. In addition, planning could be enhanced by critically analysing the purchase of clinical FTEs in line with 'lean thinking' principles.

Current Process:

Currently, the Mental Health and Addictions Funding Plan uses a Population Based Funding (PBF) comparison which includes comparing the Waikato District Health Board (DHB) against expenditure data at national, and Midland DHB levels. Comparisons are also drawn between Waikato DHB and larger centres. National and DHB comparisons are coupled with Blueprint¹ recommended purchasing to produce a benchmarking 'yardstick' for key areas of current Mental Health and Addictions.

The current process is both standardised and rational and supports measured decision making on the purchase of core services.

Issues with the Current Process:

The Blueprint

Evidence of Benchmarking Effectiveness

At least one critique of blueprint recommendations has been found through recent work undertaken by Te Puna Oranga (Māori Health Service) in support of youth residential drug and alcohol treatment. This critique relates to the recommended decrease in spending on residential drug and alcohol facilities.

A study investigating the alcohol and drug treatment population profile between 1998 and 2004 found that significant changes have occurred as a result of restructuring following the release of the Mental Health Commission's Mental Health Blueprint (1998). Adamson, Sellman, and Deering et al (2006)ⁱⁱ measured a significant shift during this period in the settings in which drug and alcohol clients were seen. There has been a decline in Non – Government Organisation (NGO) residential facilities and a comparative increase in community based DHB services.

The impacts of reducing residential treatment appear to be both positive and arguably negative. The positive contribution to a shift in treatment setting is linked to the philosophy that has both driven and grown out of recognising deficits associated to residential 'care'. There has been a shift from long term 'care' and 'treatment' to therapeutic intervention. It is important to note that residential facilities of today largely adopt and operate based on therapy, habilitation and recovery as opposed to 'care' and 'treatment'.

Negative impacts discussed by Adamson et al include that any marked preference for one treatment mode over another can result in a 'one size fits all' therapy policy. Given the trends in service use that their study reports, it would be detrimental to ignore need for a mix of services. Some of these trends include:

- 1 Māori engage less with therapy after the initial contact

- 2 Those with complex presentations need more intensive treatment than community based outpatient services can offer
- 3 A higher retention rate of Māori in kaupapa Māori services

Clearly, the recommendations within the Blueprint cannot be uniformly adopted without some screening related to outcomes since 1998 and the current health environment.

Recommendation: Each of the key benchmark areas is screened to identify any evidence that suggests a need to review Blueprint recommendations.

Innovation and Culturally Effective Service Provision

A key message embedded in the Blueprint relates to innovation in the planning and delivery of services.

The Blueprint states that:

Innovative service delivery is extremely important for mental health services in order to meet the needs of the people who use them, in the best possible way. An environment should be fostered in which people working in the mental health sector are encouraged to continually look at new and better ways of delivering services (pVII)

While the current benchmarking exercise handles the calculation of facilities and FTE resources well, the entire process will be enhanced by exploring ideas on innovation. These ideas could easily be sourced from the high number of Mental Health and Addictions proposals that were submitted for prioritisation funding. Proposals are expected to be supported by evidence of efficacy and need and therefore remain as a potential source of service development direction.

The Blueprint also includes a significant focus on Māori mental health, and meeting the needs of Māori. At one level, meeting the needs of Māori can be quantified by targets such as those set out in *Moving Forward: The national mental health plan for more and better services (Ministry of Health, 1997)*, including, for example, that by July 2005, the Māori mental health workforce (including clinicians) will have increased by 50% from the baseline in 1997/98. At another level, meeting Māori mental health needs is linked closely to innovation. For example, the Blueprint states that:

From a Māori perspective, mental well health is not just the absence of illness; more effective work must be undertaken to address those issues which directly impact upon mental wellness such as housing, unemployment, and cultural isolation. They require a constructive, co-ordinated approach in order to achieve positive changes in Māori mental health status. (p55)

Recommendation: Iwi Māori Council provide planning expertise, from a local perspective, related to areas of Māori mental health need identified in the Blueprint.

Reducing Inequalities

Planning

Increasing the size of services is sometimes essential to ensure that service users get what they need. Size increases can support a reducing inequalities approach by contributing towards the goal of making sure that service users are getting the right care at the right time from the right people. If, however, the size of services is

primarily considered, with comparatively less attention paid to how services are delivered, the chances of achieving enhanced outcomes are diminished.

Even when planning includes attention to convenient measures of service effectiveness, some key issues that impact on services users can be missed. For example, *access* to services is often measured as *utilisation* of services. The New Zealand Health Strategy however describes access in a way that appreciates the complex issues involved, especially for priority populations. The strategy describes access as *'timely and equitable access for all New Zealanders to a comprehensive range of health and disability services...'*. Both the effectiveness and timeliness of access to health services are essential in ensuring equity of outcomes. Differential experiences of access, across the entire continuum of care, especially for populations such as Māori, are likely to compound poor health outcomes.

Recommendation: Service provision indicators of potential inequalities are developed in partnership with Iwi Māori Council and Te Puna Oranga (Māori Health Service). The service indicators are utilised in the planning process to determine how purchasing can have the greatest impact on identified inequalities.

Monitoring

There are a number of ways in which the reduction of inequalities can be measured. Often, reports on health status use rate comparisons (i.e. 100 per 100 000) to show differences between populations rates of illness. Rate differences are also used over time to show any reductions (or increases) in the prevalence of illness. While rate data are valuable in illustrating prevalence of illness, these data may be less effective at measuring relative inequalities.ⁱⁱⁱ

Table 1 shows how expanding the use of available data can more accurately measure inequalities as opposed to measuring a decrease in disease prevalence. While Māori prevalence rates per 100 000 are clearly being reduced, the rate difference between groups is not reducing. The ratio difference (relative inequality) is actually increasing.

Table 1: Reduction of disease prevalence and the increase of inequalities

	MEASUREMENT 1 (2009) PER 100 000	MEASUREMENT 2 (2010) PER 100 000	MEASUREMENT 3 (2011) PER 100 000
Maori	200 per 100 000	150 per 100000	125 per 100 000
Non Maori	100 per 100 000	50 per 100 000	25 per 100 000
Rate difference	100 (200-100)	100 (150 – 50)	100 (125 - 25)
Ratio difference	2:0 (200/100)	3:0 (150/50)	5:0 (125/25)

Recommendation: Reducing inequalities analyses are extended beyond using rate difference data (reduction in prevalence) to include ratio difference data that accurately measures relative inequalities.

Lean thinking – Clinical FTEs

The variance summary completed for the Mental Health and Addictions Funding Plan shows a significant focus on clinical FTEs and the possible increase in clinical FTE purchase. Recent shifts in thinking related to the 'lean thinking' approach have urged health organisations to consider the effectiveness of investing in *more* of the existing resources within health.

A recent journal article describes the shortfalls of assuming that increased investment in existing systems will lead to better outcomes.^{iv} The authors state that,

Mental Health practitioners have been making assertions for many years. Things along the lines of: "We need more beds/consultants/junior doctors/resources/nurses/social workers." Or: "My patients like things the way they have always been; they like to see the doctor".

And

We tend to 'batch' procedures – such as decisions on discharge taken only at the weekly review – to try to be more efficient, but end up being less so. How frustrating for patients to receive a 15 minute outpatient appointment with a consultant psychiatrist and be sent on their way when they are well, only to be told when they are unwell and need to see a psychiatrist that there are no appointments for three months? This is the problem with batching.

While no lean thinking exercise should hinge on the critique offered in a journal article, what this critique does provide is the impetus to search for evidence on how current practice is flawed. The benefits of looking for current flaws include that investments and purchasing won't simply contribute to making an ineffective system larger as opposed to more effective.

Health Waikato Mental Health and Addictions services have some documentation that could assist in identifying opportunities for changes in practice. One of the most significant and most recent documents is the evaluation of Adult Mental Health services: *A time for change (2009)*.

Recommendation: Evidence of effectiveness and opportunities for change are explored before purchasing to increase resources is finalised.

ⁱ Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand; How things need to be*. Mental Health Commission, New Zealand: Wellington.

ⁱⁱ Adamson SJ, Sellman JD, de Zwart K. National Telephone Survey of the Alcohol and Drug Workforce. In: Adamson SJ (Ed). *New Zealand Treatment Research Monograph, Alcohol, Drugs and Addiction*. Research Proceedings from the Cutting Edge Conference, September 2004. URL: <http://www.addiction.org.nz/>

ⁱⁱⁱ Moser, K., Frost, C., & Leon, D. (2007). Comparing health inequalities across time and place – rate ratios and rate differences lead to different conclusions: analysis of cross – sectional data from 22 countries 1991 – 2001. *International Journal of Epidemiology*. 2007; 1-7 doi: 10.1093/ije/dym176.

^{iv} Humphries, S., Newby, D., & Vize, C. (2008). Lean thinking: getting your house in order. *Health Service Journal*. <http://www.hsj.co.uk/lean-thinking-get-your-house-in-order/1793151.article>. retrieved 8/12/09, 12.22 pm.