



# Mental Health Development in Counties Manukau, NZ

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# Overview of Presentation

- Context
  - Healthcare funding and provision in New Zealand
  - Mental health in New Zealand
  - Counties Manukau District Health Board
- Mental Health Development Team
  - Rationale
  - Activities
  - Critical success factors

## Context - healthcare funding in NZ

- Predominantly Government funding from
  - Income tax
  - Compulsory accident insurance (inc. sexual abuse)
- User co-pay for primary care
- Some private insurance
  - 20% for all services
  - very little for mental healthcare

# Context - healthcare funding in NZ

## ■ Government

- Pays providers of DD services, public health providers
- Pays District Health Boards (DHBs) to fund other services (like HMOs)
- Uses Population Based Funding Formula to calculate each DHB's funding

## ■ DHBs

- Responsible for health of population
- Make decisions regarding mix of services/programs
- Fund primary healthcare, inpatient and specialist services, support services (mental health and older people), child dental services

# Context - healthcare provision in NZ

- DHBs deliver majority of inpatient services and specialist services
- Primary Healthcare Organisations deliver primary care
- Non-Government Organisations deliver most support services
- MH Services
  - often funded on capacity not fee for service
  - 60 - 70% of funding goes to DHB providers (treatment services)
  - 20 – 30% of funding goes to NGOs (support services)
  - Minimal Government funded private providers (for profits)

## Context - Mental Health in NZ – the history

- Decreased institutional care, minimal community care '70s-'80s
- Numerous inquiries nationally
- National Mental Health Strategy *Looking Forward* 1993
- Mental Health Commission established 1996, "*Blueprint*", 1997
- "Blueprint" Benchmarking reveals Northern and Midland regions poorly resourced relative to other NZ areas
- Rapid and substantial funding growth in mental health funding

## Context – History of mental healthcare in northern New Zealand

- 1971: 270 inpatient beds per 100,000 - institutions
- 1991: 43 inpatient beds per 100,000 – institutions
- 1995: 31 inpatient beds per 100,000 (60% of spend)
- Current: 29 inpatient beds per 100,000 (27% of spend)

## Context – History of mental healthcare in northern New Zealand – impact of funding growth

- Huge increase in NGO services
- Wide range of service provision and of providers
- Fragmentation
- DHB specialist mental health service staff vacancies
- Increasingly inexperienced workforce

## Context – Counties Manukau DHB – population served

- 435,000 people
- Both urban and rural
- High deprivation
- Multiple ethnicities (18% Maori, 20% Pacific Island, 11% Asian)
- Youthful population

## Context – Counties Manukau DHB – inpatient beds 2005

	CMDHB beds (Per 100,000)
Acute	11.1
Subacute/rehab	3.6
Older people	3.3
Child and youth	1.0
Forensic	6.0
<b>Total inpatient</b>	<b>25.0</b>

## Context – Counties Manukau DHB – services and funding

- Fasted service growth in NZ (\$15.7M growth in 3 years)
- Value of services \$82M (2005)
  - 28% NGO
  - 52% CMDHB
  - 20% other DHB (Forensic, Alcohol and Other Drug Services)
- Current access 0.7% of population per month
- Option of separate services for Maori, Pacific people
- Challenges:
  - fragmentation
  - expanding at required rate
  - shaking off institutional past

# Mental Health Development Team - rationale

## CMDHB mental health in 02/03:

- Acute beds overflowing
- Staff constantly responding to crises
- DHB staff morale low, industrial action
- Lack of housing and supports

## In spite of:

- Five extra acute beds
- Substantial additional funding over several years

# Mental Health Development Team - rationale

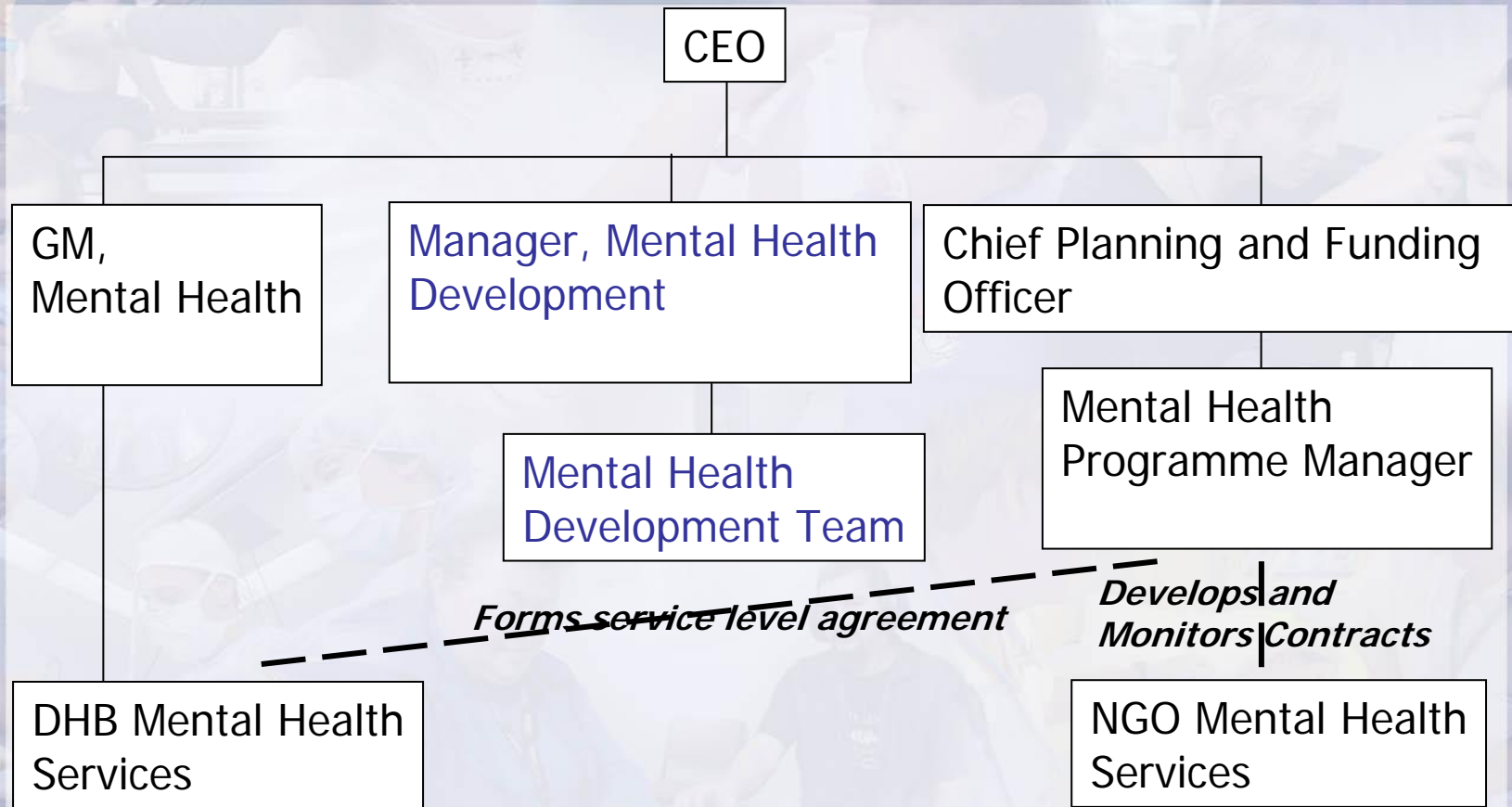
- 2002 Review of Auckland's Mental Health Services by the Mental Health Commission:
  - identifies major problems
  - recommends
    - greater regional collaboration
    - greater stakeholder involvement in planning services
    - preferential increase in funding for northern region:
- Results in accelerated funding growth!

# Mental Health Development Team - rationale

## CMDHB Response:

- Mental Health is a priority
- Substantial change required
  - if we do more of what we have always done, we will get more of what we have always had
- Dedicated resource needed to support change
- Resource should support existing leaders to achieve change
- Funding for change from intentional Blueprint underspend

# Mental Health Development Team



# Mental Health Development Team

- Mix of employees and contractors
- Average 4 FTE including manager
  - Highly skilled, self-directed
  - Philosophically aligned (recovery orientation, social inclusion)
  - Capacity to design and manage complex projects
  - Evaluation capability (at least one team member)
- Each manages multiple projects
- Increasing emphasis on educational and capacity building approaches

# Mental Health Development Team - activities

- Mental health development review to identify issues
- Collaborative prioritization of projects
- Identification of talented project managers
- Collaborative design of projects with the sector
- Identification of key opinion leaders
- Collaborative implementation of projects

## Mental Health Development Team – activities – review findings

- fragmentation/poor alignment
  - DHB/NGO
  - DHB/Primary care
  - Inpatient/community
  - Regional/local
- workforce capacity issues
- Limited acute/crisis responsiveness
- lack of flexibility/personalisation of services
- social isolation for service users

## Reducing Fragmentation – all projects

- DHB/NGO Collaborative Group
- CM-Mental Health and Addictions Network
- Primary Care integration initiatives
- Consultative forum with unions
- Wide stakeholder involvement in all mental health development projects (including staff)
- NGO-DHB partnerships for Personalised Community Living Services
- Cross-sectoral partnerships around housing, employment

## CM-Mental Health and Addiction Network Committee

- DHB Funder, General Manager, Clinical Director, Manager Mental Health Development, CPHAC member
- Manawhenua, MAPO, Maori providers
- Pacific provider
- NGO, Primary Care
- Child and Youth, Older Adult
- Migrant communities
- Asian
- Consumers (5) - three pending – D&A, youth, older people

## Workforce Development – all projects

- All projects include a workforce development component
- Provider Arm focusing on rapidly building clinical workforce. Particularly challenging is increasing:
  - Child and Youth workforce
  - Maori clinical workforce
  - Pacific clinical workforce
- Development of consumer workforce has commenced

# Summary of key MHDT projects

- System-wide thinking and design
- Adult Core Service Project
- Personal Solutions (Community Living Services)
- Peer Support Specialists (emerging)
- Recovery Education (emerging)
- Housing Partnership
- Employment Partnership
- Workforce Development (through all)
- Evaluation (all)

## Other MHDT projects

- Chronic Care Management of Depression
- Maori Mental Health
- Pacific Mental Health
- Alternatives to Admission (“living room” concept)

# Challenges

- Regional and national consistency
- Project workforce:
  - Skilled project management
  - Philosophical alignment
  - Mental health knowledge
- Alignment of all leaders
- Implementation capacity and commitment

## Mental Health Development Team – critical success factors

- Board and CEO commitment
- Alignment of philosophy, strong leadership
  - Clinical Director
  - General Manager
  - Planner and Funder
  - MHD Manager
- Sector engagement (including service staff)
  - Identifying the priority challenges and projects to address them
  - Designing and implementing the solutions
- Commitment to “system”, support to relinquish patch protection
- Project management capacity

## Mental Health Development Team – critical success factors

Projects that emphasise:

- Social inclusion and community capacity building
- Partnerships with service users
- Integration, collaboration between providers and settings
  - Primary/secondary, community/inpatient, DHB/NGO

Future emphasis will include:

- Consumer capacity building through
  - Peer involvement (peer support specialists)
  - Recovery education (adjuncts to treatment/therapy)