

# MR GAFW

11 August 2011

Kathryn Platz

Development of a new Blueprint for sustainable investment in Mental health and Addiction Services

## Presentation Overview

- **Role of the MHC**
  - Purpose
  - Core functions
- **MHC work program 2011-12**
  - Blueprint 2
  - Monitoring and Advocacy
  - Consumer and family networks
- **What happens to MHC after June 2012?**
- **Current Work Program**
  - National Indicators Report
  - Prevention project

## Our Vision

The best mental health & wellbeing for all

Statement of Intent 2011-2012

The vision reflects the Commission's concern with the quality of life of all people living in New Zealand.

Nearly half of the population will meet the criteria for a mental disorder at some time in their lives\*.

\*Oakley Browne, M.A., Wells, J.E. & Scott, K.M. (Eds.). (2006). *Te rau hinengaro: The New Zealand mental health survey*. Wellington: Ministry of Health.

## Our Core Functions

- Monitor services
- Provide advocacy and advice to the mental health sector
- Support innovation

### Mental Health Commission (MHC) outcomes framework 2011-2015

Please note in order to keep these diagrams simple, all of the interrelations among and between outputs and outcomes have not been depicted.

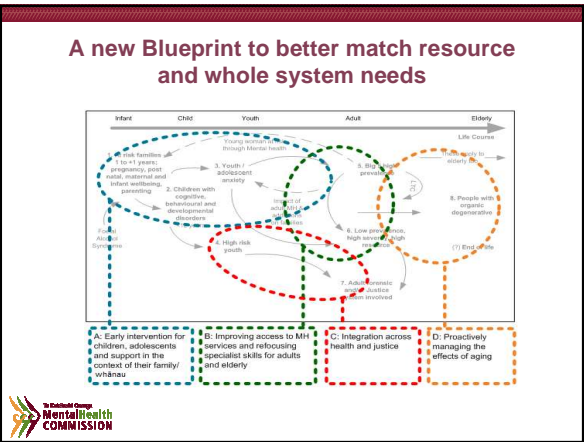
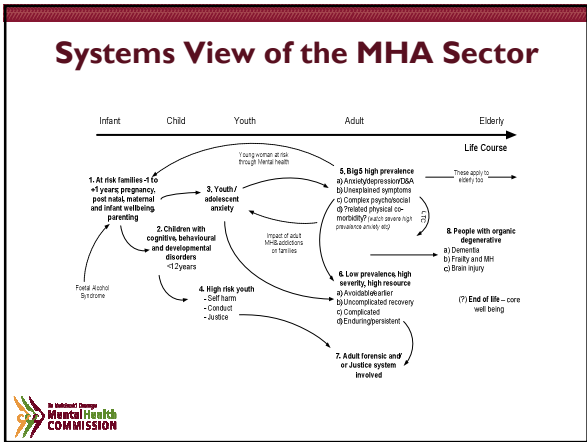
## MHC SOI 2011 Key Outputs

### Advocacy

1. Expert advice and input into MOH Service Development Plan
2. Blueprint II Year 1 – sector engagement & develop service models
3. Consumer and Family involvement in services supported
4. Support development of sustainable representative national consumer and family entity

### Monitoring

1. DSVs – Currently under review
2. Population indicators of mental distress, addiction and social Inclusion
3. Provision of direct feedback to support service improvement
4. Exchange of information with consumers and family organisations to monitor effectiveness of services



## Core Mental Health Funding

**The Mental Health Ringfence**

The Mental Health Ringfence is a specified quantum of revenue within each DHB to be used only on Mental Health services.

The quantum is based on the previous years revenue plus a number of annual adjusters for population changes, inflation and new initiatives.

The intent is to grow the ringfence each year to increase the investment in mental health and breach the Blueprint Funding Targets

**The Blueprint Funding Target**

The Blueprint for Mental Health Services from 1998 included a resourcing guide to support the model of care outlined and reinforce the direction of travel. For example, it suggests there needs to be about 41 equivalent beds and 101 community mental health nurses per 100,000 population.

A Blueprint Funding Target is generated for each DHB by applying these resource guidelines to each DHB's population multiplied by current prices.

The intent is to grow the ringfence for each DHB to reach the Blueprint Funding Target. In 2009/10 DHB actual spend in Mental Health was about 80% of the Mental Health Target. This ranged from 65% of target in South Canterbury to 128% on the West Coast.

**Mental Health Share of DHBs Population Based Funding (PBF)**

Annual funding received by DHBs is calculated using the Population Based Funding Formula. The formula is made up of a number of components. For example personal care, disability, primary care and mental health components. There is funding flexibility across all these components. The mental health component is calculated by taking the total ringfence funding across all DHBs, 2. weighting that funding by the average utilisation of mental health services across the country, 3. Allocating the total ringfence funding using each DHB's population and the national weighted averages.

The Mental Health share of PBF does not use any of the resource metrics outlined in the Blueprint which makes up the Blueprint Funding Target.

2009/10 spend was 90% of the Blueprint funding target

Blueprint funding target

Mental Health Commission. 2010. *Mental Health and Alcohol and Drug Services: Performance Monitoring and Improvement Report 2009/10*

Mental Health Commission. 1998. *A Blueprint for Mental Health Services in New Zealand*.

## Ring Fence Funding and its Challenges

**A Revenue Plus model**

Each year a Mental Health 'ring fence' is negotiated with each DHB guided by the Blueprint Funding Target and resource guides:

- The ring fence is a revenue plus model made up of the previous years revenue PLUS:
  - A provision for demographic growth
  - A provision for cost pressures (e.g. inflation)
  - Any surplus from the previous year
  - Any new Blueprint funding available

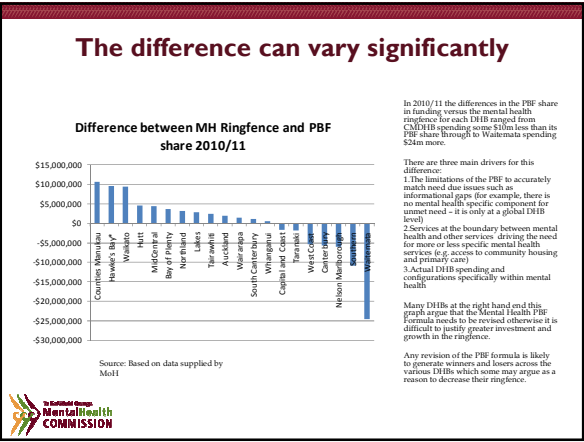
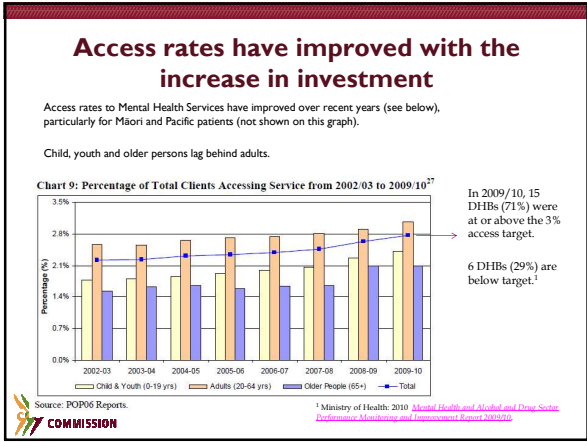
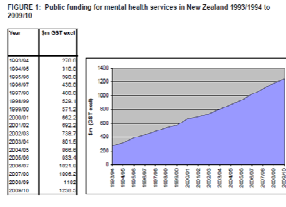
**To help drive up investment**

A key objective of the ring fence is to drive up investment to a sector which has traditionally been underfunded.

It has been successful in helping drive significant increases in Mental Health funding over the last decade by more than doubling from \$529m in 1998/99 through to 1.29bn in 2009/10.

This growth has been during a period of significant expansion in health sector funding. The challenge should be:

- whether continued expansion is feasible in the tightening fiscal climate and less expansionary DHB funding, and
- with these likely constraints, how to maximise the outcomes from the funding available and achieve some level of equity across the country (see next two pages).



### Scope of New Blueprint

### Questions to be answered

The first challenge is what is a useful overall shape for a new Blueprint?

The straw man does help to define the sort of questions the new Blueprint process needs to address.

A structure and process will need to have the skills, resources and time to work through these questions and others.

The types of questions to be answered will determine the capability mix required in the new Blueprint project teams.

1. Sustainable investment pathway	<p><b>Questions</b></p> <ul style="list-style-type: none"> <li>- future investment pathway for core MHC spend?</li> <li>- definition of ringfence?</li> <li>- opportunities for new resourcing methods in cross agency zone?</li> <li>- transition from input based funding to new accountability mechanisms? links between MHA resourcing and RPPF?</li> <li>- how to include additions funding?</li> </ul>
2. National direction for MHA evolution	<p><b>Questions</b></p> <ul style="list-style-type: none"> <li>- what is best way to define MHA system?</li> <li>- what are the response and access goals across different parts of system?</li> <li>- what is linkage between MOH SDP and this national frame?</li> <li>- how best to describe future service environment in a clear, simple and meaningful way?</li> <li>- what is best way to describe future state in numbers?</li> <li>- how do we bring together evidence-base, consumer perspectives and inequalities?</li> </ul>
3. Annual service and investment review	<p><b>Questions</b></p> <ul style="list-style-type: none"> <li>- can the decision support process described work as a core to guide performance assessment and service development?</li> <li>- what is the scope, specifications and function of the tool - in detail?</li> <li>- how exactly could this annual review be linked into DHB funding contracts?</li> <li>- do we have the necessary KPIs?</li> <li>- what skills support for DHBs is required?</li> </ul>
4. Local leadership and accountability	<p><b>Questions</b></p> <ul style="list-style-type: none"> <li>- what contract performance measures should replace the current input-based measures?</li> <li>- do we need ministers health targets for MHA to focus CEOs and Boards on MHA outcomes?</li> <li>- how does the new BP development fit with the HWNZ demonstration sites for new models of care?</li> </ul>

Page 13

### Blueprint 2 Concept Diagram

Goal - to achieve clarity and agreed mechanisms for resourcing, national direction, process for service development and performance assessment and DHB permissions and accountability for flexible local delivery.

1. Sustainable investment pathway	MHA resourcing pathway defined. Dedicated MHA spend ringfence retained at level of core MHA spend. MHA investment outside ringfence encouraged in terms of improved general health outcomes. Improve access to cross agency resources for integrated consumer support. Funding ringfence rules relaxed around boundaries and inputs.
2. National direction for MHA evolution	<p>For each area across continuum define goals for access and response across services and provide evidence-based guidance for mix/balance of services. Set KPIs and resourcing guidance for core MHA resourcing.</p> <p style="text-align: center;"><b>Continuum of MHA wellness, distress and impact on function</b></p> <p style="text-align: center;">Well -&gt; Mild -&gt; Moderate -&gt; Severe</p>
3. Annual service and investment review	<p>Each DHB is supported to undertake formal annual review using rationally considered service planning decision support tools. Assess performance and analyse future service and investment options for best outcomes. Evidence-based. Advice on change priorities. Supports performance tracking.</p> <p style="text-align: right;">High performing and effective interventions and approaches are systematically shared across system and inform next iteration of high level goals.</p>
4. Local leadership and accountability	<p style="text-align: center;">DHB funding, planning and provider outcomes</p> <p>Each DHB and other MHA organisations engage in incremental change that links top down goals, bottom up review and learning from their neighbours.</p>

Page 14

### New Blueprint development structure

Leading on from the high-level joined-up governance, the proposed structure for the new Blueprint development is simple.

1. Clear project sponsorship and leadership from the Mental Health Commissioner(s).
2. Support from a sector expert reference group (suggest look at building out from HWNZ expert group to retain continuity around future focused infrastructure).
3. A project team with an appropriate capability set, which will need to include internal MHC and external skills.
4. A set of structured action workstreams to do the work of the new Blueprint development (see next page).
5. Skills and infrastructure to support the communications process to engage with consumers, the wider MHA sector and other stakeholders.

Page 15

### New Blueprint process and timing

The process for developing the new Blueprint can be defined across three stages and three key workstreams.

The stages include:

1. High level new Blueprint concept (August, 2011)
2. Full draft document (December, 2011)
3. Final details, tools, policy, resourcing estimates etc (May, 2012)

The workstreams include:

1. Focus on framing what we are aiming for (future state continuum, goals etc) in appropriate way (building from MOH SDP)
2. Focus on how we will get there (tools, review, best buys etc) linking with HWNZ demonstration sites. Aim to test new tools with HWNZ sites.
3. Special focus cross agency workstream exploring approved resourcing approaches for Mental Health, Justice, TPK, Housing etc).

Page 16

### Alignment across the three national strategic processes

Overview of alignment across Ministry of Health, Mental Health Commission and Health Workforce NZ strategic processes for Mental Health and Addiction during 2011/12

Page 17

### What happens to MHC after June 2012?

- Proposed early disestablishment 30 June 2012
- Transfer core functions to HDC
- Establish Mental Health Commissioner in HDC
- Decisions yet to be made.....

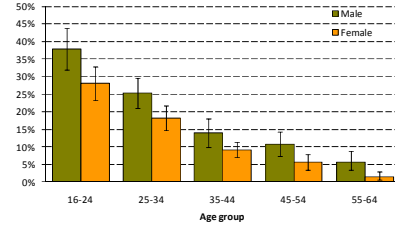
Page 18

## National Indicators

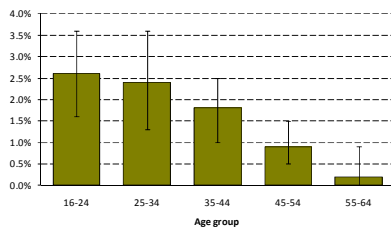
- Provides a broad view of mental health and addiction in New Zealand
- Establishes a baseline for monitoring over time
- 15 indicators covering 3 domains:
  - mental health of population;
  - service delivery;
  - social inclusion based on international frameworks
- International peer reviewed process
- Collating data from various surveys including inaugural 2008 General Social Survey
- The Commission's objective is for the reports to be useful to planners and funders – will seek feedback



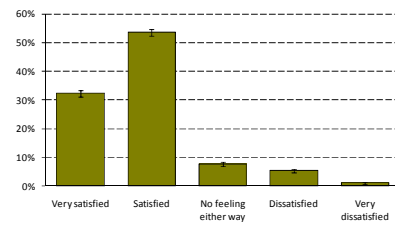
## Experienced harmful effects due to alcohol or drug use in the last 12 months 2007/08



## Service delivery: Wanted help to reduce alcohol or drug use in the last 12 months but had not received it, 2007/08



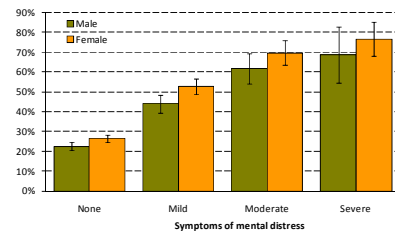
## Mental Health of Population: Proportion of people satisfied with their life overall, 2008



## Employment status by symptoms of mental distress, 2008



## Social Inclusion: Felt isolated from others in the last 4 weeks, 2008



## Prevention

*"A strategy which invests in promotion, prevention and early intervention not only can reduce the burden of mental ill health and inequality but also makes sound economic sense".*

No Health Without Public Mental Health: The Case for Action  
Royal College of Psychiatrists, Position statement 2010



## Prevention

- The Blueprint's target for mental illness prevention (not mental health promotion) is 10 specialist FTEs per 100,000 population
- 2008/09 data shows no funded MHA specialist prevention FTEs\* - significantly under-developed area nationally
- Brief review to examine the literature and service examples to provide advice to planners and funders
- Report will be emailed to MHA planners and funders seeking views on the value of the work

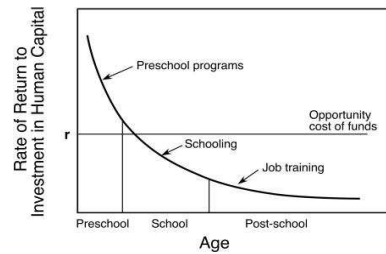
*\*arguably, this doesn't represent the whole picture – note suicide prevention FTEs; infant MHS FTEs. To some extent perinatal MHA FTEs may be preventative*



## Chief Science Advisor Prof Peter Gluckman

*"We strongly argue that prevention and intervention strategies applied early in life are more effective in altering outcomes and reap more economic returns over the life course than do prevention and interventions strategies applied later"*

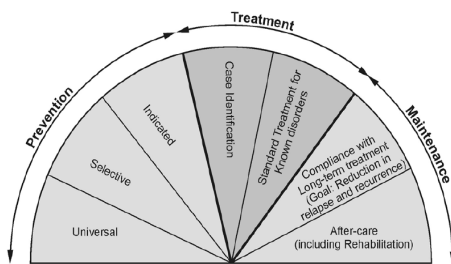
Improving the Transition: Reducing social and psychological morbidity during adolescence, 2011.



Adapted from Knudsen et al, 2006



## Spectrum of interventions



## Social environmental and economic factors that impact on mental health (adapted from WHO 2004)

Risk factors	Protective factors
<ul style="list-style-type: none"> <li>Access to drugs and alcohol</li> <li>Displacement</li> <li>Isolation and alienation</li> <li>Lack of education transport and housing</li> <li>Neighbourhood disorganisation</li> <li>Peer rejection</li> <li>Poor social circumstances</li> <li>Poor nutrition</li> <li>Poverty</li> <li>Social injustice and discrimination</li> <li>Social disadvantage</li> <li>Unemployment</li> <li>Urbanisation</li> <li>Violence and delinquency</li> <li>War</li> <li>Work stress</li> </ul>	<ul style="list-style-type: none"> <li>Empowerment</li> <li>Ethnic minorities integration</li> <li>Positive interpersonal interactions</li> <li>Social participation</li> <li>Social responsibility and tolerance</li> <li>Social services</li> <li>Social support and community networks</li> </ul>



## Individual and family related factors

Risk factors	Protective factors
Academic failure	Ability to cope with stress
Attention deficits	Ability to face adversity
Caring for chronically ill or dementia patients	Adaptability
Child abuse and neglect	Autonomy
Chronic insomnia	Early cognitive stimulation
Chronic pain	Exercise
Communication deviance	Feelings of security
Early pregnancies	Feelings of mastery and control
Elder abuse	Good parenting
Emotional immaturity and dyscontrol	Literacy
Excessive substance use	Positive attachment and early bonding
Exposure to aggression, violence and trauma	Positive parent-child interaction
Family conflict or family disorganisation	Problem solving skills
Loneliness	Pro-social behaviour
Low birth weight	Self esteem
Low social class	Skills for life
Medical illness	Social and conflict management skills
Neurochemical imbalance	Socio-emotional growth
Parental mental illness	Stress management
Parental substance abuse	Social support family of friends
Perinatal complications	
Personal loss-bereavement	
Poor skills and habits	
disabilities	
Sensory disabilities or organic handicaps	
Social incompetence	
Stressful life events	
Substance use during pregnancy	



## Life approach

S consumer pathways	Clinical Peer Community	Clinical Peer Community	Clinical Peer Community	Clinical Peer Community	Clinical Peer Community	Clinical Peer Community
At risk families pregnancy postnatal maternal mental						
Children developmental disorders						
Adult adolescent Anxiety depression						
High risk youth						
Adult high support Depression anxiety substance abuse etc						
Adult low prevalence high priority						
Adult forensic and justice						
Organic and degenerative						
Layers of support	Self help	Primary Care support	Primary package of care	Community based mental health	Specialist Mental	Inpatient acute

