Phase II Final Report & Implementation Plan

Child Adolescent and Maternal Mental Health and Addictions Continuum Project

June 2010

Prepared by Eseta Nonu-Reid & Jenny James

Mahia Mai A Whai Tara

MANAAKI ORANGA LTD
Leading Quality Health And Social Services

This report and implementation plan has been developed as part of Phase II of the Child Adolescent and Maternal Mental Health and Addictions Continuum Project. It builds on the Child Adolescent and Maternal Mental Health Continuum Report, May 2009.

‘Ehara taku toa I te toa takitahi, He toa takatini ke’

My strength does not lie in working alone. Rather my strength lies in working with others

Vision Statement

‘Ehara taku toa I te toa takitahi, He toa takatini Ke’

My strength does not lie in working alone. Rather my strength lies in working with others

Mission Statement

Kia mahi tahi ai, tatou ki te hapai ake te whanau ora o nga tamariki, rangatahi, whanau.

Working together to strengthen the health and well being of children, young people and families/whanau.

Combined Key Values / Ko Nga Uaratanga

- Quality / Tika: Minimise the risk by understanding and developing clinical and cultural boundaries
- Flexibility / Whanaungatanga: Building and maintaining relationships that can make the appropriate decisions with respect and dignity for all concerned
- Evidence based models / Mana: Employing evidenced based treatment models. Harmony and balance of the individual and the collective. Respect and trust towards each others clinical and cultural models of care.
- Duty of Care and Accountability / Ko te Putake o te kaupapa nei ko te mana whakaritea: A joint collaborative partnership that encompasses Duty of Care (clear lines of responsibilities, accountability, transparency, systems and processes and clearly defined roles).
- Workforce Development / Akona nga mea tika o runga, o raro, o roto, o waho kia noho mataara ai tatou: Empowering workforce towards individual and organisational growth, self sustainability (professional development) and quality improvement.
- Communication / Takotoranga: Building relationship between each other, across the service and with family/whanau that is recovery focused, builds resilience and weaves us together as one people.
- Clinically Competent / Tikanga, Tika and Pono: Formal processes, learnt knowledge and personal integrity.
- Respect: to practice with mana and respect.
- Advocacy: To awhi tangata Whaiora to enhance their wellbeing.

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- Mahia Mai
- Manaaki Oranga
- Te Rau Pani
- Raumano Trust
- Tu Tama Wahine
- Tui Ora Ltd

We also acknowledge the input for external sector agencies and their contribution to better understanding the continuum of care of your children, adolescents and young mothers.

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Glossary of Acronyms

Acronym	Meaning
ADHD	Attention Deficit Hyperactivity Disorder
AOD	Alcohol or Drug
CAMHS	Child & Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CYFS	Child Youth & Family Services
DHB	District Health Board
FTE	Full Time Equivalent
ICD-10	International Classification of Diseases and Related Health Problems
IDF	Inter-district Flows
MDT	Multi Disciplinary Team
MH&A	Mental Health & Addictions
MHC	Mental Health Commission
MHINC	Maternal Mental Health
MMH	Mental Health Information National Collection
NMDS	National Minimum Dataset
MOH	Ministry of Health
NGO	Non Government Organisation
SW	Social Worker
TOL	Tui Ora Limited
WFD	Workforce Development

FINAL REPORT

1. Executive Summary

This final report and implementation action plan for the Child, Adolescent and Maternal Mental Health and Addictions Project is a result of immense commitment from the mental health sector who provided expertise and guidance in developing service options that better meet the needs of our children, young people, mothers and babies and families/whanau. In a parallel process, Tui Ora Ltd established Project Kokiri which explored ways in which mental health providers can come together under one Governance structure. This work will continue throughout Phase III of the implementation of the action plan.

The initial process of the sector coming together to develop its own mission, vision and values and subsequently the work-streams development of service philosophies showed the willingness to collective work towards one service in a joint venture.

It is recommended that the Action Plan included in this be report be endorsed and implemented as the final Phase of the project. The implementation action plan includes a number of key goals, objectives and actions which over the next two years will enable more integrated, collaborative and responsive approach to delivering services to clients and their family/whanau. This will be supported and overseen by the establishment of a Clinical Governance Board for the Child, Adolescent and Maternal Mental Health and Addictions services. Clinical Governance is about changing the way people work, demonstrating that leadership, teamwork and communication is as important to high-quality care as risk management and clinical effectiveness. The shifting focus to formalised clinical governance and leadership is in line with the Ministers expectations which recognises leadership as the fundamental driver of improved patient care.

Throughout the project the importance of role of the multi-disciplinary teams was a focus. There was an identified need for better understanding about those roles, more sharing of information and knowledge and the need for enhanced support for each other as part of everyday practice. Participation within MDTs will be formalised with clear expectations for multi organisation representation and the need to reduce any duplication that exists.

A significant number of workforce development needs were identified. Given the breadth of the national Workforce Development Organisations training opportunities, we will be able to complete a comprehensive schedule for the next 18 months in conjunction with the Midland Regional Mental Health Workforce Coordinator. Action areas were also identified for workforce infrastructure development, recruitment and retention, organisational development and research and evaluation.

Three of the work streams focused on the clients' access to services and the continuum of care, Maternal Mental Health, Addictions and Client Pathway. A number of similar themes emerged including, the need for consumer, family and whanau recognition in service delivery, single point of entry, commitment to developing a collaborative MDT, inclusiveness and the standardisation of policies, procedures and documentation. A working party will be established in Phase III to review and amend documentation, with Provider Arm information being the baseline and relevant Kaupapa Maori component added.

The ongoing need to strengthen inter-sectoral relationships is supported by the expectations within Te Kokiri. As part of Phase III more work will be undertaken with potential intersectoral partners to assess the broader continuum of care where clients and their family/whanau are recipients of multi agency services.

The completion of the project report took longer than anticipated which highlights not only the extensive information collected but also the challenges of time constraints for resources when embarking on projects of this magnitude.

2. Introduction and Background

The World Health Organisation (WHO) data shows mental illness accounts for 11% of the global burden of disease, which predicatively will rise to 15% by 2020 when depression will be the most significant disease throughout the world.

Te Tahuhu – Improving Mental Health 2005-2015 identifies that specialist services for children and young people has increased with Blueprint funding, but gaps in access still remain and lag well behind those of adult services. A good quality service for children and young people acknowledges the context of the wider environment and recognises the need for all government services to work together to effectively meet those needs.

Good empirical evidence suggests that investment in early intervention and prevention programmes in child and youth mental health can be effective (Commonwealth Department of Health and Aged Care, 2000). The potential for mental health problems to have long term disabling effects on the normal development and well-being of children and young people suggest that the costs of early intervention and prevention can be easily offset by longitudinal savings from reduced treatment costs and improved occupational achievements. Te Tahuhu – Improving Mental Health 2005-2015 clearly identifies that services for at-risk mothers and infants provide opportunities for healthy development and lessen the possibility of future problems.

The Child Adolescent and Maternal Mental Health and Addictions Continuum Project assessed, reviewed and aimed to identify the key aspects of the continuum of service delivery through a client and family/whanau centred approach. This project follows on from the work undertaken by Planning and Funding and completed in May 2009, Child Adolescent and Maternal Mental Health Continuum report.

This project process has enabled the Taranaki Child Adolescent, Maternal and Addictions providers across the sector to develop an action plan for implementation which moves the sector to a more cohesive and supportive approach for all NGO/Iwi and Mainstream Providers by developing a 'one service in joint venture'

3. Alignment to National/ Regional Strategies

national

The national mental health and addictions strategy was launched by the Government in 1994 with the publication of Looking Forward: *Strategic Directions for the Mental Health Services*[1] and developed further in the National Mental Health Plan, Moving Forward: *The national mental Health Plan for More and Better Services*[2]. Shortly after, the Mental Health Commission published the *Blueprint for Mental Health Services in New Zealand: How things need to be (1998)* which became an important document in establishing service levels that guide the development of specialist mental health services. In response to a number of strategies and plans develop for (and by) the mental health and addictions sector, the Mental Health Commission produced their publication Te Hononga 2015: *Connecting for Greater Well-being* – the purpose of which they describe as presenting a unifying picture of the sector in 2015 from the perspective of the mental health commission' and which 'complements, supports and builds on both Ministry of Health documents Te Tahuhu and Te Kokiri (MHC, 2007:1).

A number of other additional health and non-health governmental documents not referred to in this report and implementation plan have a significant impact on the distribution and type of mental health and addiction services available in New Zealand and these listed in Appendix One.

Treaty of Waitangi

The principles of the Treaty of Waitangi provide the foundation for future mental health service development, planning, implementation, delivery and monitoring as outlined below:

- Partnership – working together with iwi, hapu, whanau and Maori communities to develop strategies for improving the mental health status of Maori.

[1] Looking Forward: Strategic Directions for the Mental Health Services. Ministry of health. 1994.
[2] Moving Forward: The National Mental Health and Addictions Plan for More and Better Services. Ministry of Health. 1997.

- Participating – involving Maori at all levels of the sector in planning, development and delivery of mental health services that are put in place to improve the health status of Maori.
- Protection – ensuring Maori wellbeing is protected and improved as well as safeguarding Maori cultural concepts values and practices.

Te Tahuhu –Improving Mental Health

The second national mental health plan takes a more comprehensive approach to improving mental health and addiction services. The strategy builds on the first national plan and takes a stronger emphasis by the inclusion of the health promotion and primary health care. The ten challenges outlines in Te Tahuhu are:

1. **Promotion and prevention:** Promote mental health and wellbeing and prevent mental illness and addiction.
2. **Building mental health services:** Build and broaden the range and choice of services and supports, which are funded for people who are severely affected by mental illness.
3. **Responsiveness:** Build responsive services for people who are severely affected by mental illness and/or addiction.
4. **Workforce and culture for recovery:** Build a mental health and addiction workforce – and foster a culture amongst providers – that supports recovery, is person centred, culturally capable, and delivers an ongoing commitment to assure and improve the quality of services for people.
5. **Maori mental health:** Continue to broaden the range, quality and choice of mental health and addictions services for Maori.
6. **Primary health care:** Build and strengthen the capability of the primary health care sector to promote mental health and wellbeing and to respond to the needs of the people with mental illness and addiction.
7. **Addiction:** Improve the availability of and access to quality addiction services, and strengthen the alignment between addiction services and services for people with mental illness.
8. **Funding mechanisms for recovery:** Develop and implement funding mechanisms for mental health and addiction that support recovery, advance best practice and enable collaboration.
9. **Transparency and trust:** Strengthen trust in services and accountability and information systems.
10. **Working together:** Strengthen cross-agency working together.

The Midland Region Mental Health and Addictions Strategic Plan 2009 – 2015 describes the Midland regional strategic priorities as they relate to the ten challenges that make up Te Tahuhu.

midland regional guiding principles

The following principles guide the planning and provision of mental health and addictions services in the Midland Region.

- **Service users and family whanau** are central to the mental health and addictions system and will be active partners in
- **Service users and family whanau** are central to the mental health and addictions system and will be active partners in system planning, development, and service delivery.
- **Recovery -** "Recovery happens when we regain personal power and a valued place in our communities. Sometimes we need services to support us to get there"[3].

  Certain concepts or factors are common to recovery, including hope, medication/treatment, empowerment, support, education/ knowledge, self-help, spirituality, and employment/meaningful activity. The strengths based approach [will be utilised to] enable consumers to approach their journey towards recovery using their personal strengths, supported by the strengths others can contribute to that journey.
- **Whanau Ora and Responsiveness to Maori -** Cultural identity and belonging are necessary for service user wellbeing and recovery. Whanau ora acknowledges the collective familial supports that assist in the wellness journey.
- Whanau Ora exemplifies a system responsive to Maori, with respect for Maori concepts, and inclusive of Maori service users and their whanau to achieve optimal health outcomes.
- **People in service users' support networks** - family, whanau, friends, and community - are essential to recovery. The inclusion of support networks in regional service planning, development and service delivery, helps ensure positive outcomes for service users, and recognises that support persons needs may also need to be met by the system.
- **Services are responsive** to the specific cultural and individual needs and preferences of service users, with particular attention to Maori.
- **High quality services** are outcome-focused, underpinned by continuous improvement and are based on evidence and best practice.
- **Well-connected health and social services** (housing, social services, employment, education, justice, corrections, and de-stigmatisation) promote social inclusion and support service users to achieve optimal mental health and addictions outcomes.

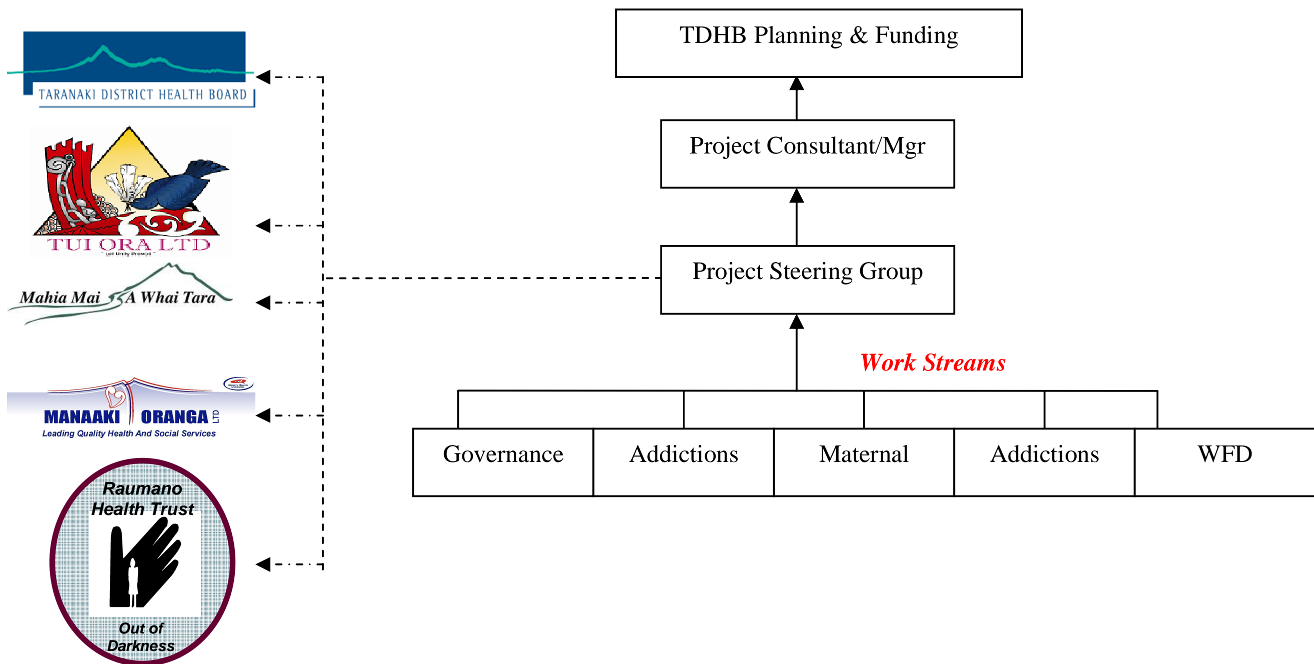
[3] Source: Our Lives in 2014, a recovery vision from people with experience of mental illness for the second mental health plan and the development of the health and social sectors.

- **Partnerships** are vital within the MH&A system, and between it and related systems, to benefit service users.

4. Project Aims, Objectives & Process

A series of meetings were held with the Kaupapa Maori Providers and Provider Arm separately and together to develop and agree a core vision, mission and a set of key values that provide the overarching direction for this project and future phases. The Project structure was established, *refer figure 1*.

Figure 1: Child Adolescent and Maternal Mental Health and Addictions Continuum Project Structure



The formation of the project steering group provided the overarching clinical and cultural governance, and strategic advice and leadership throughout the duration of the projectFive work-streams were identified:

i. Governance
ii. Client Pathway
iii. Maternal Mental Health
iv. Addictions
v. Workforce Development

It was felt that each work-stream should be led internally, however, due to work commitments the leadership of the work-streams became the responsibility of the Co-chairs. Work-streams commenced from November 2009 until April 2010 with a break from December and January.

Each work-steam developed its own terms of reference and future state positions which assisted in determining clear project deliverables. The work-streams provided a safe platform for the provider arm and NGO provider staff to come together to progress ways of working that encouraged partnerships, improved relationships and trust and to develop clinical pathways that held the client and their family whanau at the centre of the service.

In addition to the five work-streams and in parallel to the project Tui Ora Ltd affiliated providers were regularly meeting to discuss the emerging issues and to develop a system of integrated governance linking providers through a management structure that enable improved co-ordination of care. As a result of initial discussion Project Kokiri was established in March 2010.

It is important to note that the project timelines were not met, mainly due to the project Co-chairs and stakeholders work commitments.

Over 30 meetings were held and the following were key areas of focus for the work streams:

- Literature review of exemplary service and governance models.
- Scoping of impact of service delivery for areas affected by implementation
- Mapping of the current continuum and identification of gaps and duplication of service delivery.
- Process mapping for the client pathway in a new model of care that draws together the services from across primary, secondary and social care and the interaction of tertiary where appropriate, ensuring a safe and seamless transition of clients between providers of care.
- Services align to the new mental health services framework and deliver a holistic model of care that balances cultural and clinical paradigms.
- Consideration of the national workforce centre workforce development opportunities as part of enhancing service delivery, and aligning with models of care and ongoing professional workforce development.

The project process was flagship for collaborative processes, outcomes and models of care across the primary / secondary interface and across multiple work streams. Workforce planning sought to provide a platform for recruitment and retention of staff and career pathways recognise the value of leadership and succession planning across the sector.

While the project largely focused on the NGO and Provider arm mental health service continuum, as part of implementation, more work needs to be undertaken with the primary care sector, e.g. General Practice and the relationships and process linkages with other social agencies.

5. Initial Consultation Feedback

A number of one on one interviews were held with Provider Arm and NGO Kaupapa Maori service providers, external agencies and other Taranaki DHB departments. As a result a number of issues were highlighted as service gaps. Three questionnaires were also developed and disseminated to the sector. While it was agreed the results would not be published in detail, some areas have been included at high level where it was deemed that these areas have dependencies with the identified actions as part of the implementation plan.

Family/Whanau participation

Feedback indicated there were gaps in providing youth consumer and advisory forums. It also highlighted ongoing issues with support for children and young people who have parents/caregivers accessing adult addiction services. Often there is lack of family participation, at times blocking of family or not well informed and issues around confidentiality when parents/caregivers are notified of care. Concerns were raised with a lack of advocacy roles in place for youth. Often complaints that are received about the service are about lack of involving families in treatment planning and delivery. It was suggested consumer forums should be established and consideration to participants being recompensed for their time.

Transitioning clients into community and into adult services

Feedback indicated the transition of clients into adult services is often blurred due to the lack of definition of age appropriateness. Often the assessment of the clients' social age means some flexibility needs to occur when transitioning from CAMHS to adult services.

Often clients are not well transitioned back to primary care, e.g. General Practice. Sector not set up to provide ongoing education to General Practice which indicates there is demarcation between discharge processes and knowing how clients are supported back in community through primary care. Further exploration of how shared care arrangments can be developed.

Discharge planning can be difficult – often clients remain under secondary care too long. Gaps in respite services – heavily reliant on open homes. Often family support is variable / polarised. Key worker plays pivotal role in open home placements.

Stimulant medication for treatment of ADHD, adult mental health services often have a differing view of the need to continue medication.

Multidisciplinary Team (MDT) Meetings

NGO Kaupapa Maori providers used to be more actively and frequently involved in Provider Arm MDT meetings. NGO Maternal Mental Health worker attending Provider Arm MDT's on a weekly basis. NGO sector often feel isolated but maintain excellent relationships with DHB Psychiatrists. Need for improved cultural support in MDT's. Need to create and open door policy.

Interdepartmental Linkages

Challenges with ADHD referral pathways being split between Paediatrics or CAHMS services. Clients still require specialists to prescribe as costs of accessing General Practice a barrier. Referrals are received directly by Paediatrics or CAMHS service which dictates where the client will be seen. Reconnecting with primary care is not done very well. CAMHS have a dedicated ADHD nurse however it was noted it can difficult to get referral into CAMHS. Would support one stop shop for ADHD clients where services are integrated and not demarcated. Some patients prefer to come back to paediatrics as ease of contact and quicker response time. A formal assessment process is being worked on in accordance with guidelines. Linkages with CAMHS and Paediatrics continue to improve.

While the rates of referral of ADHD children are low, the demand is increasing. Paediatrics has new cases every week. Concerns over medication compliance / safety of medication and elicit use.

Concerns were raised that infant mental health problems are not being addressed. Query whether CYF's should be involved earlier for mothers on methadone and attached to a paediatric social worker.

Workforce Development

Feedback indicated there is a need for greater cultural awareness, and adopting a standard tool for rolling out across sector. Identify and provide mentoring for newly qualified nurses. There is no specific workforce development pathway for Maternal Mental Health nationwide, limited through Te Rau Matatini. Adopting the CAPA model and provide better support around early intervention models.

External Agencies and other Health Care Providers

Feedback was variable about the success and usefulness of the Strengthening Families forum. In theory the concept is great, in practice it was noted it doesn't always provide the best outcome. Query whether the right people attend the meetings.

Often Primary Care services don't have a good handle on the complex needs of children and youth and often by the time a referral is sent parents are under considerable stress. There were concerns raised over the differing referral forms received by other sector agencies. It was noted that there is a gap with Special Education Services behavioural support plans.

Families often spend long time trying to get help with children. Lack of services available for those presenting with mild to moderate mental health issues, often no major psychoses presenting but basic mental health needs not being met – issues can escalate.

Ongoing challenges for external providers and agencies when referrals don't meet the CAMHS criteria for access to services.

Improving liaison with external agencies. Demarcated funding streams and constraints within service expectations create difficulties when endeavouring to provide a seamless service. Increased referrals from Special Education for IQ tests. Multiple agencies often working with same families.

Funding issues with high and complex clients. Need a better understanding of agency criteria and gaps inter-agency service provision. Shortage of family therapy resources.

Systems and Process

Feedback strongly supported the need for one client record and the infrastructure to manage client files. Need to improve communication across the sector.

questionnaires / surveys

Workforce Development Needs Survey

The key purpose of the questionnaire was to obtain the views of the clinical and non-clinical staff on current needs across the whole of mental health services, i.e. NGO Kaupapa Maori and Provider Arm Services. Largely the overall results were positive. The analysis on the series of questions on Team Workforce Needs rated responses between 1 (low) and 5 (high). Any areas rated under a score of 3.0 were identified as potential issues that may need addressing. Of the eleven questions 2 were rated below 3.0 and included:

(1) the service needs to ensure it is able to recruit and retain staff to meet the needs of the region; and
(2) there is an enabling and supportive leadership style within the service.

Organisational Effectiveness Survey

An organisational effectiveness self diagnostic questionnaire was disseminated to all NGO Kaupapa Maori Mental Health Providers and Provider Arm Mental Health and Addiction Services. A total of 54 responses were received. The purpose was to obtain the views of the clinical and non-clinical staff on the current organisational culture. While it was agreed that results would not be published in detail the results were largely satisfactory. The numbers of respondents from the NGO sector were minimal

therefore analysis was undertaken on Provider Arm staff feedback only. The questions were rated between 1 (low) and 5 (high). The two areas that scored results under 3.0 were:

(1) Strategy and Leadership – major developments are communicated in a way that makes their impact on my work clear, and I have confidence in the leadership ability of management; and

(2) Operational Effectiveness – there is good team work and cooperation within my unit.

Survey Limitations

The Governance work-stream and Steering Group felt the following may have impacted on the accuracy of the overall results and limited the scope of the results and ability to interpret responses accordingly.

- Some questions framed to obtain a negative rather then positive response, particularly as it relates to providing comments.
- Risk that respondents may be those that may not be happy in the current work environment and those staff that have a genuine level of satisfaction with the culture may not have filled in the questionnaire.
- Agreement that a organisation effectiveness survey should be standard across the services – however the tool used should be further evaluated and amended to be fit for purpose.

Clinical Governance Readiness Survey

A clinical governance questionnaire was disseminated to the NGO Kaupapa Maori Mental Health Providers and Provider Arm Mental Health Services. The purpose was to assess the level of understanding of clinical governance across the Mental Health sector. A total of 54 responses were received. While it was agreed that detailed results would not be published the results were largely satisfactory. The numbers of respondents from the NGO sector were minimal therefore analysis was undertaken on Provider Arm staff feedback only. Respondents were asked how they rated their knowledge of clinical governance between 1 (low) and 5 (high), the average result was 2.64; suggesting knowledge base of clinical governance needs to be increased. The remaining 22 questions were rated as a Yes or No response. The following questions had a 'Yes' response rating of 50% or less.

Senior Management Commitment (1) Are you aware of the organisations clinical governance policy and procedures? (2) Appropriate resources are allocated to support clinical governance?

Clinical Governance Framework (1) Is your service delivery within the clinical governance framework? (2) The framework has been communication to all staff? (3) The framework is reviewed periodically

Clinical Governance – Operational Management (1) Operational framework for clinical governance has been developed? (2) The roles and responsibilities of staff in operational framework are clearly documented and communication within the service; (3) the service has developed a performance monitoring tool to assess its requirements against the framework?

<u>Quality & Risk and Health & Safety</u> (1) Are you aware of the Q1 Process?

<u>Survey Limitations</u>

The Governance work-stream and Steering Group felt the following may have impacted on the accuracy of the overall results and limited the scope of the results and ability to interpret responses accordingly.

- Some questions were ambiguous and may have resulted in lower scores than would have been expected.
- Agreement that a clinical governance survey should be standard across the services – however the tool used should be further evaluated and amended to be fit for purpose.

6. Demographics / Statistics

The following Statistics have are from the Report *The Determinants of Health for Children and Young People in Taranaki* by Elizabeth Craig, Gabrielle McDonald, Anne Reddington and Andrew Wicken on behalf of the New Zealand Child and Youth Epidemiology Service, November 2009. Data sources included Information on the Mental Health Information National Collection (MHINC) and reports on Provider Arm data only, ICD-10 Codes (International Classification of Diseases and Related Health Problems) and data from the National Minimum Dataset (NMDS) for inpatient admission information.

Data Source, Methods and Limitations

The MHINC is the Ministry of Health's national database covering the provision of publicly funded secondary mental health and alcohol and drug services. It includes secondary inpatient, outpatient and community care provided by hospitals and non-Government organisations NGOs. As at July 2005 most NGOs were not reporting to the system, therefore the data is limited in its provision of secondary service data only. Also the data does not include information on outpatient visits to Paediatricians, therefore if referral pathways result in the client seeing a paediatrician rather than a mental health professional this can significantly underestimate the prevalence of mental health conditions.

Where Taranaki rate per 100,000 population are significantly different to New Zealand rates this may be attributed to coding inaccuracies therefore interpretation should be undertaken with caution.

Overview

Mental Health problems become more common as young people move through adolescence. The Dunedin Multidisciplinary Health and Development Study suggesting that the prevalence of mental health problems increases from about 17.6% at age 11 through 22.0% at age 15, to 36.6% at 18 years of age, (Craig, McDonald... et al 2009). Mental Health conditions commonly diagnosed amongst this age group include anxiety disorders, depression, conduct disorders and alcohol and substance abuse

disorders. In addition, suicide rates amongst New Zealand young people remain high by international standards.

The type of mental health problem diagnosed varies by age and gender, with males tending to have higher rates of conduct disorder and alcohol and substance use and females higher rates of anxiety and depression. More limited information suggests that mental health problems vary with ethnicity, with higher rates of admission and readmission to psychiatric facilities amongst Maori males 15-19 years (Craig, McDonald... et al 2009, P211). In terms of risk factors for mental health problems, multiple disadvantages during childhood appear to place young people at higher risk of poorer mental health outcomes, Known resiliency / protective factors include intelligence and problem solving abilities; interests outside the home; a caring relationship with an adult outside the family; warm, nurturing and supportive relationships with a parent; easy temperament; positive peer relationships; and low levels of novelty seeking.

access to mental health services in children aged 0-14 years

Taranaki and New Zealand Distribution – Common Diagnoses in Children Accessing Mental Health Services

In Taranaki during 2005-2007, hyperkinetic disorders (including Attention Deficit Hyperactivity Disorder (ADHD)) and pervasive development disorders (including Autism) were the most frequent diagnoses given to children accessing mental health services (data source: Information on the Mental Health Information National Collection (MHINC) and the ICD-10 Codes (International Classification of Diseases and Related Health Problems)).

Table 1. Number of Children aged 0-14 Years Accessing Mental Health Services with Selected Diagnosis,* Taranaki vs. New Zealand 2005-2007.

Diagnosis	Taranaki			New Zealand		
	No Annual Contacts per Individuals	No. of Individuals with Diagnosis	Rate per 100,000	No Annual Contacts per Individuals	No. of Individuals with Diagnosis	Rate per 100,000
Hyperkinetic Disorders Including ADHD	8.8	252**	1,109.8	9.8	2,349	270.8
Conduct/Mixed Conduct Emotional Disorders	19.8	21	92.5	11.2	1,439	165.9
Pervasive Development Disorders (Incl. Autism)	11.2	96**	422.8	10.2	856	98.7
Learning Disorder/Development Scholastic Skills	7.1	18	79.3	8.9	475	54.8
Separation Anxiety Disorder	8.0	11	48.4	10.8	300	34.6
Reactive Attachment	14.3	35*	154.1	14.1	268	30.9

Diagnosis	Taranaki			New Zealand		
	No Annual Contacts per Individuals	No. of Individuals with Diagnosis	Rate per 100,000	No Annual Contacts per Individuals	No. of Individuals with Diagnosis	Rate per 100,000
Disorder						
Mental Retardation	6.1	21	92.5	8.6	255	29.4

*Note: DHB numbers include any resident in DHB at any time during the reference period (irrespective of where they subsequently accessed services). This approach may increase DHB rates (vs. NZ Average) in situations where mobility between DHBs is high. As an individual may have more than one mental health diagnosis, columns do not sum to 100%. * Table does not include all children with mental health diagnoses accessing service s in the region, but rather provides an overview of the most common diagnoses only. Taranaki DHB ADHD services are delivered through both Paediatric services and Child & Youth Mental Health and Addictions Services.*

access to mental health services late childhood and adolescents

Taranaki and New Zealand Distribution – Anxiety, Adjustment, Obsessive Compulsive and Eating Disorders

A number of mental health diagnoses became increasingly common during late childhood and early adolescence. In Taranaki during 2005-2007, these included stress reaction / adjustment disorders, anxiety disorders, eating disorders and obsessive compulsive disorder.

Table 2: Number of Children and Young People aged 0-24 Years Accessing Mental Health Services with Selected Diagnoses*, Taranaki vs. New Zealand 2005-2007.

Diagnosis	Taranaki			New Zealand		
	No Annual Contacts per Individuals	No. of Individuals with Diagnosis	Rate per 100,000	No Annual Contacts per Individuals	No. of Individuals with Diagnosis	Rate per 100,000
Stress Reaction/Adjustment Disorder	12.0	269	751.7	10.6	5,196	361.2
Anxiety Disorders	10.7	139	388.4	12.0	3,201	222.5
Eating Disorders	16.8	27	75.5	17.3	971	67.5
Obsessive Compulsive Disorders	20.3	24	67.1	17.0	518	36.0

*Note: DHB numbers include any resident in DHB at any time during the reference period (irrespective of where they subsequently accessed services). This approach may increase DHB rates (vs. NZ Average) in situations where mobility between DHBs is high. As an individual may have more than one mental health diagnosis, columns do not sum to 100%. * Table does not include all children with mental health diagnoses accessing service s in the region, but rather provides an overview of the most common diagnoses only. Taranaki DHB ADHD services are delivered through both Paediatric services and Child & Youth Mental Health and Addictions Services.*

access to mental health services late adolescence

Inpatient Hospital Admissions with Mental Health Issues

In New Zealand during 2004-2008, the most common reasons for hospital admissions with mental health issues in young people were for schizophrenia, followed by depression and bipolar affective disorder.

Composite categories including schizotypal / delusional disorders and drug and alcohol related conditions also made a significant contribution. In Taranaki during this period, the most common reasons for inpatient admissions with mental health were for alcohol and drug problems, stress reaction / adjustment disorders schizophrenia

Table 3: Most Frequent Reasons for a Hospital Admission with a Mental Health Issue in Young People 15-24 years, Taranaki vs. New Zealand 2004-2008.

Diagnosis	Taranaki				New Zealand	
	Number Total 2004-2008	Number Annual Average	Rate per 100,000	% of Total	Rate per 100,000	% of total
Schizophrenia	70	14.0	107.1	15.7	116.6	25.7
Schizotypal/Delusional Disorders	32	6.4	48.9	7.2	53.1	11.7
Depression	55	11.0	84.1	12.3	63.5	14.0
Bipolar Affective Disorder	18	11.0	84.1	12.3	37.3	8.2
Other Mood Disorders	8	<5	s	s	11.4	2.5
Alcohol/Drug Mental Health Effects	95	19.0	145.3	21.3	51.8	11.4
Stress Reaction /Adjustment Disorder	71	14.2	108.6	15.9	51.8	11.4
Personality Disorders	<5	s	s	s	22.0	4.8
Eating Disorders	15	3.0	22.9	3.4	14.1	3.1
Other Mental Health Issues	80	16.0	122.4	17.9	43.2	9.5
Total	447	89.4	683.6	100.0	453.3	100.0

Source: Numerator National Minimum Dataset; Denominator: Census; Emergency Department cases removed.

Access to Mental Health Services (MHIC Data) – Schizophrenia, Schizotypal / Delusional Disorders, Personality / Behavioural Disorders and Organic Mental Disorders/

A number of mental health diagnoses became increasingly common during late adolescence. In Taranaki during 2005-2007, these included schizophrenia and schizotypal / delusional disorders, personality / behaviour disorders and organic mental disorders.

Table 4: Number of Young People Aged 15-24 Years Accessing Mental Health Services with Selected Diagnoses, Taranaki vs. New Zealand 2005-2007.

Diagnosis	Taranaki			New Zealand		
	No Annual Contacts per Individuals	No. of Individuals with Diagnosis	Rate per 100,000	No Annual Contacts per Individuals	No. of Individuals with Diagnosis	Rate per 100,000
Schizotypal/Delusional Disorders	37.4	49	374.7	34.1	1,816	317.9
Schizophrenia	37.1	63	481.8	42.1	1,731	303.1
Personality /Behaviour Disorders	32.7	50	382.4	24.1	1,349	236.2
Organic Mental Disorders	9.1	9	68.8	27.7	285	49.9

Depression, Bipolar Affective Disorder and Other Mood Disorders

A number of mood disorders became increasingly common during late adolescence. In Taranaki during 2005-2007, these included depression, bipolar affective disorder and other mood disorders.

Table 5: Number of Young People Aged 15-24 Years Accessing Mental Health Services with Selected Mood Disorders, Taranaki vs. New Zealand 2005-2007.

Diagnosis	Taranaki			New Zealand		
	No Annual Contacts per Individuals	No. of Individuals with Diagnosis	Rate per 100,000	No Annual Contacts per Individual	No. of Individuals with Diagnosis	Rate per 100,000
Depression	12.1	198	1,514.1	11.9	5,874	1,028.4
Bipolar Affective Disorder	19.1	41	313.5	27.7	1,008	176.5
Other Mood Disorders	16.9	65	497.1	17.4	1,184	207.3

Mental Health Issues Associated with Substance Use

In New Zealand during 2005-2007, alcohol related mental health issues were a very common comorbidity for those with other mental health diagnoses. For example 27% of those with a personality disorder, 23% of those with schizophrenia and 21% of those with schizotypal / delusional disorders had alcohol related issues recorded as co-morbidities. These figures suggest there is a considerable need for alcohol related issues to be addressed, as part of the care plan for those accessing mental health services with other diagnoses.

In comparison 35.6% of those with schizophrenia, 31.7% of those with schizotypal / delusional disorders, 26.1% of those with personality / behavioural disorders, ad 24.0% of those with a bipolar affective disorder had cannabis use listed as co-diagnosis. This was also similar with those taking drugs other than Cannabis.

7. Current Services Provided

Taranaki District Health Board Child, Adolescent and Maternal Mental Health Services

Taranaki DHB fund Child, Adolescent and Maternal Mental Health and Addictions Services through DHB Provider Arm and Kaupapa Maori Services in the NGO sector. While the benchmark for level of service is against the Blueprint for Mental Health Services in New Zealand resource guideline (November 1998), it has limitations. The unit of measure for each Blueprint service line does not always map to how we purchase mental health services. The Ministry of Health Mental Health Directorate work programme for 2010/11 includes a review of Blueprint, while the programme is yet to be approved it provides and opportunity to revisit the antiquated funding model and develop something that is more suitable in the current environment. The following table are the blueprint services for children, youth and

their families and maternal mental health services mapped to the current services purchased where possible.

Table 6: Blueprint mapping for children, youth and their families

Services for Children, youth and their families		Resource guideline per 100,000 tot pop	Resource guideline Taranaki per age group*			Taranaki funded services	
			0-14	15-19	Total	Total	% to Blueprint - Comment
2.1 Acute Inpatient	Beds or packages of care	2.0	1.2	0.98	2.18		2 beds available when needed. MHSC49 Assessment Tool funding of $12K through Provider Arm
2.2 Secure Inpatient	Beds or packages of care	0.4	0.22	0.22	0.44		Out of region services
2.3 Community mental health teams	FTEs	28.6	17.02	14.18	31.21	22.6	72% of Blueprint. Mix of Provider Arm and NGO services.
2.4 Respite Services	Care packages	0.8	0.44	0.44	0.87		Purchase units MHSC48, MHRE04 and MHRE05 map to Blueprint 2.4. These services purchased through provider a mix of carer support, crisis respite and warp around services – equates to $126K.
2.5 Day Programmes	Care packages	4.0	2.40	1.96	4.36		Not provided
2.6 Community residential services	Beds or packages of care	2.0	1.20	0.98	2.18		Residential facilities are accessed out of region. Services are accessed on the basis of demand – therefore would meet expectations of Blueprint.
9.2 Mothers and Babies – community staff	FTEs	1.75	0.25	1.50	1.91	2.5	The services funded are over the expected blue print level – however, 1.0 FTE in the NGO sector deliver 0.5 FTE Maternal Mental Health and 0.5 FTE Addictions

**Note: Blueprint resources per age group are based on the total population – this assumes that the proportion of children and young people are proportionate across New Zealand. This means actual resource required could be higher or lower depending on Taranaki's proportion of the age groupings across the total population.*

Current Services

The following table shows the number and type of full time equivalents delivering Child, Adolescent and Maternal Mental Health and Addictions Services. The total FTEs for Child and Adolescent Mental Health and Addiction Services is 22.5 FTEs and for Maternal Mental Health Services 3.0 FTEs.

Child and Adolescent Mental Health and Addiction Services

Taranaki DHB	Mahia Mai	Raumano	Manaaki Oranga
1.0 FTE MH Nurse Manager	2.0 CAMHS Counsellors	1.0 FTE CAMHS	
2.0 FTE Psychiatrists	1.0 FTE AOD Social Worker	1.0 FTE CAMHS RN	
2 x 0.5 FTE Psychiatrists	2 x 0.5 FTE AOD Counsellors		
7.0 FTE Nurses			
3.0 FTE SW Trained MH Therapists			
0.7 FTE SW Trained MH Therapists			
0.8 FTE SW Trained MH Therapists			
1.0 FTE Intake Coordinator			
Total FTEs: 16.5	Total FTEs: 4.0	Total FTEs: 2.0	
Maternal Mental Health Services			
Taranaki DHB	Mahia Mai	Raumano	Manaaki Oranga
0.2 FTE Consultant Psychiatrist			0.5 MMH SW
0.5 FTE Clinical Psychologist			0.5 MMH AOD
0.7 FTE Social Worker			
1.0 FTE Maternal MH Nurse			
Intake Co-ordinator? %			
Total FTEs 2.4			Total FTEs: 1.0

Other Services & Intersectoral Initiatives

Mental Health is an issue that cuts across traditional sectors and includes health, welfare, justice, education, housing, communities and NGOs. By establishing solid partnerships between these sectors we can improve mental health care and wellbeing for our population.

Collaboration has become an increasingly important feature of most welfare systems, because of the increasing specialisation of services and the increasing professionalisation of different occupational groups. Intersectoral collaboration is complex, since it includes inter-professional as well as inter-organisational collaboration between different sectors of the society. As part of the implementation of the action plan, more work will be undertaken with other social agencies, justice, MSD etc... To strengthen relationships, processes and expectations for our children and young person's accessing mental health services.

Primary Mental Health Initiative

The Taranaki Primary Mental Health Initiative, delivered by Taranaki Primary Connections with Peak Health as the lead PHO, have recently expanded the access to Primary Mental Health services by lowering the age range to include youth. While Taranaki has been successful in one off funding bids every opportunity, the demands on the services means there is still limited access. General Practice allocation to access is on the basis on their enrolled high needs population.

Out of Region Services

Taranaki currently has a number of regional beds accessed through Inter-district Flows (IDF's) utilising a population based funding model. The beds relevant to the CAMHS and Maternal Mental Health Continuum of care are:

Starship Hospital – Auckland Taranaki DHB has access to four Midland beds for general mental health and access to one Midland bed for Eating Disorders under 15 years. Referral pathways have been established for the four general mental health beds and are in the process of being developed for the Easting Disorders bed.
Te Waireka – Hawkes Bay Taranaki DHB has access to a fee for service bed for adolescent residential treatment for addictions clients. Referral pathways are in the process of being developed.

The funding methodology is a mix of inter-district flows, fee for services, and regional population based funding proportion. Reporting on service utilisation has improved however, the variety in services options and funding models can be challenging to monitor.

Gaps in Services

Throughout the project a number service gaps were highlighted. These include respite care and while there is a small amount of funding allocated for respite, there is a lack of suitable providers in Taranaki. There is no dedicated consumer and/or family advocacy and peer support roles within the CAMHS service. The expectations of Te Kokiri is for DHB's to expand the range of effective and integrated services to include independent peer-led services for service users and family/whanau which includes support, recovery, education and advocacy. There is no Needs Assessment and Co-ordination Services for CAMHS.

8. Project Work streams

Purpose/Methodology of the work streams was to serve as the projects experts on options for Child Adolescent and Maternal Mental Health and Addictions services to be delivered in a 'one service in joint venture' model for Taranaki; and propose, guide and direct the development of an implementation plan aimed at a seamless service delivery across the continuum within an agreed model of care.

8.1 Governance

The Governance work-stream comprised of Clinical Managers and Managers from across Provider Arm, NGO Kaupapa Maori Providers and Planning and Funding. The aim of the work-stream was to propose the most appropriate way forward for the development of governance structure for one service in joint venture. This aligns with the Minister of Health's expectation of developing a culture and structural process for clinical leadership and accountability.

Future State:

1. **We will develop Service Level Agreement(s) between the partners which is consulted on and signed**
    a. We will replace interim service level agreement arrangements with permanent agreed SLA's agreed by all parties

- The sector had been grappling with the issue of clinical responsibility for clients accessing NGO providers, as a result interim service level agreements were put in place with a three month review time frame.
- Tui Ora Ltd continued to meet with its Kaupapa Maori Mental Health Affiliated Providers throughout the project to discuss how 'one service in joint venture' could be structured. As a result project Kokiri was established to look at how a shared governance model may be developed with TOL Affiliated Provider network.
- There is a need to shift the interim service level agreements to more permanent arrangements between service providers.

2. **A Governance Model and infrastructure will be established to support all Child, Adolescent and Maternal Mental Health and Addictions service providers**
    a. Clinical and Corporate Governance will work in partnership and be clearly defined

- There is a lack of consistent Clinical Governance structure and processes across mental health and addictions services which have impacted at times on the quality and the seamless continuum of care across the services and increased risks to both health professionals and clients. It was agreed a Clinical Governance Board for Child, Adolescent Mental Health and Addictions Services will be established.

    b. We will have a Clinical Governance Board that would that will deal with (but is not limited to), ethics, problem solving, leadership, clinical audit

- It was agreed the Board would include a mix of management and clinicians from across the sector and provide accountability and continuous improvement in the quality of the services. High standards of care will be safeguarded by creating an environment in which clinical excellence can flourish.

    c. We will understand the critical success factors of strong governance and will monitor and evaluate its effectiveness by agreed key performance indicators

- The work-stream discussed the need for an agreed framework for monitoring and evaluating changes that result in the outcomes from the project.
- While the Governance work-stream provided input into the development of the Organisational Effectiveness and Clinical Governance Questionnaires that were circulated as part of the projects consultation process, it was agreed the development of standard questionnaires for future use would require an evaluation of the results and the overall usefulness of the tools used for this project.

d. We will have a Child, Adolescent and Maternal Mental Health and Addictions Clinical Governance Board that includes nominated representatives within a fixed 3 year term.

- It was agreed by the work-stream group that the board will remain with a focus on CAMHS and Maternal while the transition to the new way forward is undertaken, it was agreed that this board may change over time.
- It was agreed that while this group had a child, adolescent, youth and maternal focus, it is expected to include adult mental health and addictions into the future

3. We will have standardised documentation across services

a. All policies and procedures will be standardised and reflect agreed pathway of clinical accountability and duty of care for safety of clients and clinicians.

- It was agreed that all providers would operate under the same policies, procedures and use standard documentation.
- It was agreed Taranaki DHB Mental Health Services documentation will be the baseline. NGO Kaupapa Maori Service providers will review and amend to ensure inclusion of appropriate level of cultural information.

b. We will have one electronic client record.

- It was agreed that we will work towards one electronic client record that is linked and consistent with developments of the Midland Network Expression of Interest (EOI) Business Cases.
- It was agreed by the group that this would need to be planned for future work as the need to get organisation structures aligned and implementation of policies, procedures, processes and documentation would need to take precedence.

8.2 Client Pathway

The Client Pathway work-stream comprised of provider arm staff and leaders and NGO provider staff and leaders. There was excellent commitment to the work-stream meetings from all of the providers except one. Meetings were held on a fortnightly basis and then weekly throughout March and April 2010.

<u>Future State Position</u>

1. We will have one point of entry for all consumers

a. We will have clearly defined eligibility criteria across mainstream and kaupapa services

b. We will have service level agreements between service providers

   c. Our services will align with developments through the Midland Regional Primary Health Business Case

- It was agreed to ensure there was consistency there would be one point of entry through the Intake Coordinators and that additional resourcing would be needed to ensure that the NGO sector were supported. Clinical pathways would need to be developed that allowed for local ability to receive and accept referrals but linked to the provider arm relevant Multi-disciplinary Team.
- It was agreed by the participants that in order for the CAMHS, Addictions and Maternal Mental Health continuum of services to provide a range of effective services to the client, family and whanau, all services would need to align to the new national specification framework for mental health and addictions. Eligibility criteria across the continuum would be the same with flexibility for Kaupapa Maori services particularly in rurally remote areas.
- Where initially the group felt that a service level agreement needed to be developed with each provider and the provider arm, it was later agreed that one service level agreement with clinical pathways and process maps developed by the individual services would be more valuable. This would allow flexibility to amend as the continuum evolves.
- The group were cognisant of the Midland Primary Mental Health Business Case and are open to identifying the clinical pathways and process maps once there is clarity on the priorities.

2. We are committed to workforce development

   a. We will have a workforce development plan that will include implementation of the Werry Centre CAPA model and Real Skills Plus (enabling people to let go, how to deal with ethical dilemmas, professional development and clear supervision)
   b. By scoping workloads we will enable an effective and efficient use of all resources.
   c. The whanau ora approach will be evident across service delivery.

- This group provided feedback to the Workforce Development work-stream as matters arose. Of note was the lack of Maori mental health and addictions training that the provider arm staff were able to access in order to meet Te Tähuhu's Challenge 5: Maori Mental Health.
- The work-stream initially identified the need to undertake a more detailed analysis of staff workloads, however the group decided that this was un-necessary as there were little delay in referrals being allocated a keyworker. All stakeholders felt that they had robust processes in place to ensure that where delays did occur that the client and their family whanau were not lost to service. The clinical pathways and process mapping will need to clearly articulate this.

3. We are committed to operating a collaborative MDT

a. Our MDT has an agreed definition and we operate within shared policies and procedures
b. Our staff will have protected time to allow appropriate level of input into MDT's and other appropriate forums
c. We will work towards, one client record, and sharing technology across the sector
d. We will develop standardised collaborative documentation
e. All documents will be living, be age specific and regularly reviewed.

- It was agreed by the group that a collaborative Multi-disciplinary team centralised to the Provider Arm with shared policies and procedures would add value particularly for isolated clinical positions in rural areas. Further work is needed to identify ways for the Patea clinicians to access the MDT and reduce the amount of time the clinicians spend travelling. This could be via video conferencing.
- It was agreed that in order for all staff to fully participate in the MDT process that clinician time would need to be protected both in the provider arm and NGO services. The SLA clinical pathways, process mapping and individual job descriptions will need to reflect this as a key expectation.
- It was agreed that provider arm MDT's would be flexible to allow for NGO clinicians participation.
- Further work is needed in moving towards one client record and sharing technology across the sector which will provide access to those working with the client, family/whanau. There was a high level agreement by all of the work-stream groups that this will reduce duplication, the need for the client to tell their story multiple times and reduce clinical risk.
- Further work is needed to standardise documentation which is currently unique to each provider. This means that the client, family and whanau are completing multiple forms of the same kind as they move through the continuum. There was agreement that the provider arm documentation would be reviewed by the kaupapa services to ensure that Maori specific information was collected at intake, assessment, treatment and review.
- It was agreed by the group that currently all client documentation within the provider arm and NGO sector are living documents, age specific and there are regular review periods built into the individual client pathways which are generally adhered to. All of the providers are members of Telac who audit the DHB and Tui Ora Ltd affiliated providers utilising the national sector standards. All of the NGO providers also have contract audits undertaken by HealthShare who is the Midland Region Shared Auditing Agency. All provider arm and NGO residential services are audited annually by the MoH for inpatient bed and residential bed certification.

4. The treatment we offer is inclusive and holistic

a. We will have client/family/whanau participation
b. We will have agreed definitions for the roles in the service e.g. Case Manager / Key Worker
c. Discharge and transition
d. We will have robust contingency planning to manage risk.

- It was agreed by the group that there was a need to improve client and family whanau participation, however additional resourcing will need to be secured to ensure that this occurs. Currently the Supporting Families contract for family advice and support is only for adult services and the provider arm Family Advisor has limited hours and works predominately in the inpatient unit. The Consumer Advisor for the provider arm covers not only adult Mental Health Services, but also Alcohol and Drug and CAMHS services.
- It was agreed by the provider arm that a client and family survey would be undertaken and the recommendations from the results will assist the continuum to determine what is needed for the CAMHS and Maternal continuums of care.
- It was agreed by the group that transition between CAMHS and Adult MHS was difficult for the client and their family whanau. Although procedural documents exist within the provider arm this is often a time when the client gets lost to services. Further work is needed to develop transition process between the continuums of care that are seamless and does not leave the client and their family whanau trying to navigate the multiple relationships.

5. The needs of the client/family/whanau will be recognised in the way we deliver our services

a. We will adopt strengths based models of care
b. Needs assessments of clients and the coordination of the services will be in conjunction with the clients family/whanau.

- The models of care for CAMHS and Addictions are strengths based. There has been a lack of consistency in the application of agreed models of care training across the NGO sector. It was agreed that for the CAMHS NGO sector there is a need to implement The Werry Centres 7 Helpful Habits and CAPA, for the Addictions NGO sector there is a need to implement Matua Raki's Takarangi Competency Framework.
- The current Needs Assessment Service Coordination (NASC) services are all adult focused with no service being provided for CAMHS clients. It was agreed by the group that needs assessment and service coordination for this client group will be needed to ensure that package of care funding is allocated efficiently and is effective.

8.3 Maternal Mental Health

The Maternal Mental Health work-stream consisted of provider arm and NGO staff and leaders who were proactive and committed to scheduling and attending meetings. Meetings were consistently held

throughout the duration of the project. The pending development of a New Families/Whanau Centre for Taranaki will provide residential support and day stay opportunities within a homelike supportive environment for families or whanau who are experiencing severe difficulty or crisis in adjusting to parenthood and are at risk either to themselves or their babies. The concept is to provide wrap around support through the co-ordination of existing services for family/whanau in crisis with new babies (0-12 months). This service would benefit from specialist support from the Maternal Mental Health Team.

<u>Future State Position</u>

1. Consistency – use of standardised documentation

a. We will have an integrated service description and philosophy that captures our intent to deliver the best possible maternal mental health services for our Tangata Whaiora /clients and whanau/family

b. Our documentation, polices and procedures will be consistent across the sector.

c. We will implement the perinatal service specification consistently across the sector.

- There was considerable discussion around the changes in the national mental health purchasing framework which includes infant under a perinatal service specification. There were concerns around how the changes will impact the current resources delivering and supporting Maternal MH.
- It was agreed there needed to be more work around the expectations for delivering the infant mental health services specifications and the impacts on potential changes in the continuum with the broadened scope.
- As identified across other work-streams, there is the need to align all documentation, polices and procedures within the sector.

2. We will have streamlined communications

a. We will be responsive to the needs of our clients and work collaboratively with an aim to reduce the impact of mental illness.

b. We will have enhanced communication skills across internal and external providers and other stakeholders and improve inter-personal interactions so our patients' satisfaction, compliance and health outcomes improve.

c. We will focus on inter-personal communication skills recognised by service providers as most useful in the local context.

- Effective communication amongst the service providers is crucial for ensuring patients receive safe high-quality care, within most healthcare settings, effective communication is hampered by a number of barriers, including settings, technology, staff turnover and differing organisational ideologies.

- Streamlining communications links closely with the recommendation for consistency in the development and implementation of standardised policies, procedures and documentation across services.
- A service level agreement between NGO and TDHB Maternal Mental Health Team will be initiated to provide clear objectives, aims and directions and enhance the working relationship.

3. All referrals are presented to MDT

a. All initial assessments will be presented for acceptance against eligibility criteria to the Maternal Mental Health MDT weekly meeting.

b. All Maternal Mental Health clients will have Clinical Psychiatry oversight via the MDT.

- Throughout the project the NGO sector and Provider Arm strengthened the processes for attendance at the Maternal Mental Health MDT. This has been an example of a successful working partnership between two organisations.
- One of the challenges faced by the NGO resource was the demarcation between the Maternal Mental Health Social Worker 0.5 FTE role and the Addictions Role. This meant there were two separate service requirements and reporting for the 1.0 FTE. Under the new framework the resource will be delivering under one service specification.

4. Services will be delivered by dedicated FTE's

a. The Maternal Mental Health Team will come under the umbrella of Adult Mental Health Services, but will be a separate Specialist Team aligned, but not part of, the Adult Services

b. The Maternal Mental Health Team will provide consult/liaison to other health professionals internally and externally.

c. The Maternal Mental Health Team will aim to reduce risk by working collaborative with other healthcare professionals to raise more awareness.

- The group agreed that linkages with other services, e.g. Plunket, Well Child/Tamariki Ora, Maternity etc... will be strengthened. This is also true for external agencies often delivering services to the same families/whanau. Ensuring earliest possible intervention for clients needing Maternal Mental Health services reduces the risks/impact of mental health issues.
- The NGO 0.5fte dedicated Maternal Addiction position was agreed to be merged into a dedicated full time equivalent Maternal Mental Health position as addiction will continue to be addressed under this service in collaboration with the alcohol and Drug service.

5. All staff skilled in assessing Maori clients

a. We will ensure workforce development planning includes a component for ongoing training through the national workforce development organisations for responsiveness to working with Maori clients.

- All work-streams identified the need to ongoing training and support for mainstream providers in assessing and working with Maori clients. For Maternal Mental Health this was an imperative for the Intake Coordinator in undertaking initial needs assessments.
- This service will have access to kaupapa Maori kaumatua and whanau ora practitioners if and when required.

6. Entry and Exit Criteria are well defined to meet population needs

a. All written referrals will be accepted via the Intake Coordinator

b. We will have clearly defined eligibility criteria across mainstream and kaupapa services

- It was agreed there should be one point of entry for clients and one Multidisciplinary Team for the sector.
- The group agreed there needs to be active ongoing General Practice involvement for the management of these clients, which aligns to the "Towards Better, Sooner, More Convenient Primary Care", and improved integration, new models for collaboration and shared care opportunities between primary and secondary level services.

7. We will continually assess and address the gaps

a. We will carefully monitor the changes in the service continuum which is vital for improving services, treatment and care.

b. We will regularly assess our progress against Te Kokiri - Te Tahuhu – Improving Mental Health 2005-2015

c. We will have strengthened relationships with other intersectoral agencies and work towards streamlining the cross sector interface to better support our clients across the continuum of care.

- Mental Health is an issue that cuts across traditional sectors and includes health, welfare, justice, education, housing, communities and NGOs. The importance of strong cross sector interfaces and relationships is an important part of the continuum.

8.4 Addictions

The Addictions work-stream comprised of provider arm staff, leaders and family advisor and NGO provider staff and leaders from both the CAMHS and Addictions continuum. There was a commitment to the work-stream meetings from the provider arm and participation of the NGO sector was inconsistent. Meetings were scheduled fortnightly but due to inconsistent attendance of the work-stream leaders and

the sector participants the work-stream leadership responsibility was picked by the Co-chairs. Most of the output from the group was from the weekly meetings scheduled throughout March and April 2010.

<u>Future State Position</u>

1. We will have a collaborative Youth AOD MDT

a. The roles and responsibilities of members will be clearly defined
b. Our MDT processes will be needs lead
c. All of our clients will have well defined care pathways
d. We will be able to evaluate the outcomes of those care pathways

- One of the constant discussion points was identification of the client group. The CAMHS addiction participants described the client group as predominately youth (15 – 18 years) with co-existing problems, however the national specification described the client group as infant, child, adolescent and youth (0 – 18 years). Further, research and best practice clearly identifies that all clinical key workers should be capable of undertaking baseline screening and access specialist advice in a case management role as required.
- Roles within the provider arm and NGO sector are not clearly defined against the contract expectations or national specifications framework. The provider arm service has one clinical FTE identified as specialising in addictions and the NGO sector has a number of Dual Diagnosis clinical staff and Addictions non clinical staff who work in isolation. There is little to no integration between the provider arm CAMHS Addiction FTE and the Addiction service despite both services being in the provider arm. Further work is needed to determine what service Planning and Funding are wanting to purchase and then the positions and job descriptions will need to align to the relevant national specification.
- There is little alignment of the NGO clinicians to the MDT process. Where it has been agreed by the group that the CAMHS provider and NGO addiction staff need to align to a centralised MDT, the question that needs to be determined is which MDT? The CAMHS MDT or Addictions MDT? Once this has been determined then the development of defined clinical pathways can be completed. While uncertainty continues the CAMHS Addictions FTEs across the continuum will be expected to attend both the CAMHS and Addictions MDT dependant on the clients need.

2. We will have a workforce development plan

a. The workforce development plan will include implementation of the Werry Centre CAPA model; and
b. Include implementation of the Takarangi Competency Framework.

- The group agreed that for the NGO sector The Werry Centre 7 Helpful Habits and CAPA and Matua Raki's Takarangi Competency Framework would be endorsed.

- Group members participated in the two workshops facilitated by Te Rau Matatini which focused on the development of training for non-Maori staff and advanced train the trainers for Maori staff. The recommendations from the Te Rau Matatini report were endorsed by the group.

3. We will have our own identity and branding

a. we will develop up a brand that is ours
b. we will communicate and promote who we are
c. we will promote relationships we have with a range of stakeholders

- Where there was robust discussion regarding the development of a Youth Addiction service, this was difficult to progress due to the unanswered questions raised in point 1. Further work and resourcing is need to develop a Infant, Child, Adolescent and Youth Addiction service and will need to be undertaken once the current service is more clearly defined.

4. We will offer a range of services that meet the needs of youth/rangatahi

a. We will have a clearly defined age definition for our services
b. We will agree and adopt best practice protocols(s)
c. We will have a time line for delivery of services
d. We will have the best possible staff mix, skills and roles
e. Our location and environment will provide effective delivery of services and allow for virtual teams
f. We will have excellent internal and external relationships
   i. our relationships will allow for the delivery of a holistic range of treatment options
   ii. We will have focus on social inclusion
   iii. We will incorporate the needs of iwi, hapu and whanau
   iv. We will be responsive to other ethnic groups.

- Where there was robust discussion regarding the development of a Youth/Rangatahi Addiction service, this was difficult to progress due to the unanswered questions raised in point 1. Further work and resourcing is needed to develop a Infant, Child, Adolescent and Youth Addiction service and will need to be undertaken once the current service is more clearly defined.

5. Consumers and their family/whanau will be active participants in all levels of decision making

a. We will be inclusive in developing treatment options and the education of consumers and their family/whanau
b. We will seek to develop better support mechanisms for parents
c. Youth will be involved in the planning and evaluation of the services they access.

- The provider arm Addiction Service has employed a part-time Family Advisor which has made a significant difference to family participation and involve in education and treatment option development. Both the provider arms Consumer Advisor and Addiction Family Advisor work collaboratively to ensure that a consumer and family voice is heard. Clinical pathway and process mapping will need to include both the consumer and family advisor roles to ensure that clients and their families and whanau know how to access. CAMHS and Maternal models of care are inclusive of family, and the services would benefit from having a advisor position.
- Parent groups are offered by CAMHS which have had positive outcomes. Further work is needed to ensure that any parent group has an addiction module that is delivered by the addiction service and addictions family advisor.
- The discussion on service evaluation was put on hold until point 1 is addressed.

8.5 Workforce Development

The overall aim of this work stream is to improve and develop the mental health and addictions service workforce in a manner that is consistent with both regional and national directions. Planning and Funding is but one stakeholder within mental health and addictions field who has a responsibility for supporting workforce development. This work stream and Workforce Development Action Plan (Implementation Action Plan Phase III) outlines how Taranaki DHB Planning and Funding division intends to provide this support in 2010/2011 year in partnership with the mental health and addictions sector.

Workforce development is defined as any initiative that influences entry to, treatment of and exit from the mental health and addictions sector, movement within the sector, education, training, skills, attitudes, competencies, rewards and the associated infrastructure[4]. In simple terms, it means having the right mental health and addictions practitioners and staff in the right place and at the right time to give appropriate care and treatment to service users and their family whanau[5].

Workforce development comprises of five key strategic areas[6]:

1. Infrastructure Development

Developing the mental health and addiction workforce development infrastructure in Taranaki is required to support achievement of the short term, medium term and long term goals of the organisation. The systems required to provide a coordinated and consistent approach to long term

[4] Health Funding Authority, 2000. *Tuutahitia te Wero: Meeting the Challenges: Mental Health Workforce Development Plan 2000-2005.* Christchurch: Health Funding Authority.
[5] Ministry of Health, 2005. *Awhitia te Wero Embracing the Challenges National Mental Health and Addiction Workforce Development Plan 2006-2009.* Ministry of Health, Wellington.
[6] Ministry of Health, 2005. *Awhitia te Wero Embracing the Challenges National Mental Health and Addiction Workforce Development Plan 2006-2009.* Ministry of Health, Wellington.

workforce development are currently fragmented and apportioned across a number of roles with the Taranaki continuum of care.

An infrastructure that will gather and coordinate workforce information, educate stakeholders, develop expertise and competencies, utilise and build existing strengths and create a robust, accountable and self sustaining infrastructure that is connected to the national workforce development programmes and initiatives is required to achieve full alignment to national strategy. The development of the Taranaki Workforce Action Plan is an important step in developing this infrastructure.

As discussed previously, a Workforce Development Needs Survey was undertaken which provided a snapshot of the key areas that required further work. A key theme identified by the survey was need to develop enabling and supportive leadership style within the service.

2. Training and Development

Training and development continues to be an important priority for mental health and addictions organisations in Taranaki. This requires the coordination of the education, health and employment sectors and management to align pre-service entry, orientation and ongoing development of mental health workers with future service provision requirements. Taranaki organisations require a broad range of mental health and addictions workers, who are competent, trained within a qualifications framework and fit for service provider requirements post training. Stakeholder feedback has identified there is a need to address core competencies for mental health and addictions workers in Taranaki; the national Essential Skills Project sponsored by the Ministry of Health for implementation by the National Workforce Centres will provide training and development for the Taranaki provider arm and NGO sector. Of relevance to this project are:

- 7 Helpful Habits and CAPA for NGOs – The Werry Centre
- Lets Get Real – Te Pou
- Takarangi Competency Framework for Addictions – Matua Raki
- Real Skills Plus Sei Tapu – Le Va
- He Taura Tieke Workshops – Te Rau Mataini

A review of the Taranaki DHB Learning and Development unit which will amalgamate the various departments training and development budgets into a centralised administration point will impact on the provider arms ability to continue to offer the NGO sector access to the mental health and addictions training calendar. The impacts will need to be evaluated once the change occurs.

Leadership training is seen by the work stream group as an important requirement across the continuum of care. A number of management and leadership staff have risen up the ranks from clinical positions

and there is little training and development, coaching and mentoring opportunities to transition staff into their new expectations

3. Retention and Recruitment

Recruiting good staff and retaining them within an organisation is important to employers, mental health service users, family / whanau, staff and the Taranaki community. Moving from a recruitment and retention environment which is often reactive and crisis driven requires effective coordination, collaboration and strategic planning. Utilising national recruitment and retention project findings, current research, DHB and NGO strategies and identifying local best practice will contribute to a local strategy for recruitment and retention.

As discussed previously, a Workforce Development Needs Survey was undertaken which provided a snapshot of the key areas that required further work. A key theme identified by the survey was a need to ensure it is able to recruit and retain staff to meet the needs of the region. Recruitment within the provider arm has been successful over the last two years with very few vacancies being carried within the service due to a concentrated focus by the Managers to ensure that the staff appointed had the right skills to support and further enhance the teams. Further work is needed in the NGO sector to ensure that recruitment to clinical positions is not diluted due to difficulty to recruit by reducing the clinical expertise and competency requirements.

There has been success with the joint appointment strategy implemented between the provider arm and Te Rau Pani and it is suggested that for clinical positions that are difficult to recruit within the NGO sector that it be considered to change them into joint appointments as the provider arm is more likely to be able to attract, retain and provide ongoing professional support to clinical staff.

4. Organisational Development

Organisational development is about developing the organisational culture and systems necessary to sustain the workforce. A supportive environment, good team work, flexibility and enhancing the balance between work and family have all been identified in stakeholder feedback from the Workforce Development Needs Survey process as key success factors. During the project process the continuum of care have identified that relationships between and within providers of the continuum of care has improved significantly over the last 18 months which has resulted in the development of shared visions, values and a strengthening of shared processes.

The work stream group strongly agreed that continuing with shared strategic planning, evaluation with a robust focus on solutions will assist the Taranaki continuum of care to further develop a culture that

allows flexibility to retain organisations individual culture but still belong to a larger organisational culture.

5. Research and Evaluation

Ensuring that information about the capacity (ability to provide) and capability (competence, aptitude, and qualifications) of Taranaki's mental health and addictions workforce is available will be crucial to both services and workforce planning. Evaluating workforce initiatives will also provide important information that can assist with our future directions. Ensuring that local, regional, national and international research and evaluation findings can have a productive application within mental health and addictions organisations for the benefit of employers, staff and service users is the aim of this imperative.

Based on the above strategies the activities the Taranaki DHB continuum of care needs to be involved in are[7]:

- Taranaki Knowing Your People project
- Coordination of DHB wide workforce activity particularly with a focus on training and development
- Participation in the Midland regional Needs Analysis project 2010/11
- Access national workforce data for local/planning projects through the National Workforce Centres
- Develop and maintain relationships with local / regional / national training providers to progress workforce development
- Relationships with national Workforce Centres to influence programmes to meet local needs;
- Develop projects in key areas of workforce development relevant to local need, and
- Participate in the Midland regional Addictions Competency project 2010/11

The key driver for the Workforce Development Action Plan is to build on the collaborative approach that the Taranaki continuum of care has established. The plan links to the overarching workforce development strategies of the Midland Region Mental Health and Addictions Workforce Development Plan. It will be reviewed annually to ensure that collaborative approaches enhance the synergies between all of Midland health workforce development and mental health and addictions specific workforce development planning.

[7] DHB/DHBNZ Workforce Action Plan 2003.

IMPLEMENTATION ACTION PLAN (PHASE III)

1. Executive Summary

Phase III which includes the implementation of the Action Plan, will focus on the establishment of the Clinical Governance Board for Child Adolescent and Maternal Mental Health and Addictions Services which will provide oversight and guidance to implementation of the Action Plan. The Portfolio Manager for Mental Health will lead Phase III with support from Midland Regional Mental Health resources as required. Reporting will be to the General Manager, Planning, Funding & Population Health and the Clinical Governance Board.

The Action Planning templates included in this document align to the work-streams in Phase II, Governance, Client Pathway, Maternal Mental Health, Addictions and Workforce Development. There are commonalities in a number of actions across several of the action plans which will be monitored and managed via the Clinical Governance Board, these include, but are not limited to, multi-discplinary teams processes and operations, family/whanau participation, risk management and discharge and transition planning.

A comprehensive workforce training schedule will be developed with the national workforce development and training agencies, Taranaki DHB, NGO providers and be coordinated through the Midland Regional Mental Health Workforce Co-ordinator.

Further work will be undertaken by a working group to standardise policies, procedures and documentation across the sector. With Taranaki DHB Mental Health service documentation used as the baseline.

There is an identified need to better understand the issues with a clients continuum of care across other sector agencies, with proposed option of setting up a cross sector working party to look at the gaps.

The action plans include short, medium and longer term objectives spanning a timeframe from June 2010 to June 2012. Longer term actions include the commitment to undertake ongoing review of progress against Te Tahuhu's 10 leading challenges and involvement in regional needs analysis, other regional projects flagged for the next 18 months and workforce development and training imperatives. Shorter terms goals include the establishment of the Clinical Governance Board and work programme for the year, formalising service level agreements and the development of the workforce development and training schedule, and medium term outcomes include one set of policies, procedures and documentation.

2. Implementation Structure

sponsor

Phase III Implementation Action Plan will be sponsored by Sandra Boardman, General Manager, Planning, Funding and Population Health (GM, PF&PH).

implementation governance structure and reporting

It is proposed oversight of implementation of the Action Plan will be by the Child, Adolescent and Maternal Mental Health and Addictions Governance Board which will be established as part of Phase III. The Portfolio Manager will monitor and report progress to GM, PF&PH, Taranaki DHB Executive Clinical Director, Taranaki Local Advisory Group (TLAG), and Managers of Taranaki NGO Mental Health Services. The Midland Regional Mental Health and Addictions Workforce Coordinator will work with the National Workforce Development agencies and Taranaki DHB to finalise the training schedule and other workforce imperatives as outlined in the Action Plan.

communications

A communications plan was developed and signed off as part of Phase II of the Project. The Plan is a living document that will be reviewed and updated in accordance with expectations of implementing the action plan.

resources required

Stakeholders

- Taranaki DHB Portfolio Manager, Child, Youth and Mental Health and Addictions
- Midland Regional Mental Health and Addictions Workforce Coordinator
- Child Adolescent and Maternal Mental Health and Addictions Clinical Governance Board
- Other sector agencies
- Taranaki DHB and NGO Sector Mental Health Services
- National Workforce Development Organisations including:
    - Te Rau Matini
    - Matua Raki
    - Te Pou
    - Werry Centre
    - Ministry of Health

Budget

Generally there are no costs for the national Workforce Training and Development centres to conduct training to Taranaki Mental Health Services, as part of the Te Rau Matatini training requirements there maybe some aspects which are outside of their nationally funded brief. If this is the case, costs would

include travel and accommodation. In addition where training days cover one or two full days, there will be a need for catering. In the Phase II budget an allocation was made for $10K for Te Rau Matatini the costs of two workshops were split between Maori Health Unit and the Project Budget.

There are a number of resource gaps identified in the Action Plan, including 1.0 FTE for Consumer & Family/whanau Advisor and a 1.0 FTE for a Needs Assessment and Service Co-ordinator (NASC).

Description	Costs
Workforce Development Training Costs	$ 4,000 (Travel and accommodation)
Catering Budget	$ 500
Sub Total	*$ 4,500*
2.0 FTE Consumer Advisor & NASC	$ 150,000 (Prioritisation Process)
Total	*$ 154,500*

3. Action Plan Execution

rationale for the planned actions

If Taranaki DHB and the providers of the services did not have the opportunity to implement in full or in part the Action Plan for Phase III, we would continue to see:

- Demarcated continuum of care across services
- Lack of clear clinical pathways for children, adolescents, young people and mothers and babies.
- Continued risk of clinical and professional isolation and no clearly defined duty of care expectations
- Ambiguity and inconsistencies with policies, procedures and documentation
- No formalised clinical leadership to support service improvements and provide structure for intersectoral service developments.

implementation timeframe

The Action Planning timeframes are from June 2010 – June 2012 (a small number of actions are flagged beyond December 2011). Workforce development imperatives began implementation in June 2010. The Action Plan milestones are for full roll out of workforce development training by June 2011. The establishment of the Clinical Governance Board is to be completed by end August 2010.

interdependencies and other considerations

- Taranaki DHB - External Review of the Child & Adolescent Mental Health Services
- Taranaki DHB – 'Better, Sooner More Convenient', A vision for TDHB Mental Health and Addiction Services: A service review
- Tui Ora Limited - Project Kokiri

- July 2010 Process for review of Internal Service Level Agreements
- Better, Sooner, More Convenient, EOI – Midland Regional Business Cases
- Maru Wehi Hauora Integrated Whanau Ora Centre
- Achieving Te Kokiri – The Mental Health and Addiction Action Plan 2006-2015
- Development of the New Families Centre
- Ministry of Health Mental Health and Addictions Demonstration Project
- Ministry of Health Co-existing Addiction and Mental Health Problems (CEP) Project
- Re-contracting under the new Mental Health and Addictions Services Framework

Action plan templates

Each work-stream future state positions were developed into key action areas. There are a number of similarities across a number of goals, objectives and actions which will be managed as part of rolling out implementation. The action plans are as follows.

3.1 Governance Action Plan 2010/2012

Clinical Governance
Goal 1: We will have strong joint participatory Clinical and Managerial Governance that spans across all Child, Adolescent and Maternal Mental Health and Addictions Services.
Outcome: Strengthened cohesive and integrated services which are of acceptable standard of quality, supported and overseen by a structure of robust leadership

Objective		Action	KPI	Responsibility	Completion Time frame	Resources Required
1.1	Established Clinical Governance Board for Child, Adolescent and Maternal Mental Health and Addictions.	• Seek nominations for board • Agree Terms of Reference	• 100% completion • 100% completion	Portfolio Manager	August 2010 August 2010	Nil Nil
1.2	SLAs Reviewed and recommendations for changes provided	• Review of Sector Service Level Agreements. • Recommendation of changes to existing SLA and identify areas where SLAs are required.	• 100% completion • 100% completion	Clinical Governance Board CGB and Managers	July 2010 September 2010	Nil Nil
1.3	A programme of key priorities and work plan is developed for 2010/2011	• Review of the current priorities work areas – developed into a plan.	• 100% completion	Clinical Governance Board	September 2010	Nil

Standardised Documentation
Goal 2: We will have one set of policies and procedures and standard documentation across all providers.

Objective		Action	KPI	Responsibility	Completion Time frame	Resources Required
2.1	All service providers are using the same set of policies, procedures and service documentation which are living documents, age specific and are regularly reviewed.	• Identify and set up key working party(s) to review the sectors documentation. • Kaupapa Maori services to review provider arm	• 100% completion • 100% completion	Portfolio Manager / Clinical Governance Board Organisational Managers / CGB	August 2010 September 2010	Nil Nil

Standardised Documentation **Goal 2:** We will have one set of policies and procedures and standard documentation across all providers.						
Objective		Action	KPI	Responsibility	Completion Time frame	Resources Required
		documentation and amend to include appropriate Kaupapa Maori responsiveness. • Formalise documentation of Clinical Pathway through services • Clinical Governance Board to sign off documentation (agree regular review period)	• 100% completion • 100% completion	Organisations Mangers/CGB Clinical Governance Board	September 2010 October 2010	Nil Nil

Shared Electronic Notes **Goal 3:** We will work towards having one electronic client record **Key Outcome:** We will have one client record accessible by all Mental Health Service Providers and where applicable be involved with the MoH demonstration project seeking to integrate primary and secondary care access to client mental health information						
Objective		Action	KPI	Responsibility	Completion Time frame	Resources Required
3.1	As part of the broader sector developments we will be actively involved in future developments to ensure mental health information needs are specifically captured. An example of these developments could include developments between Tui Ora Ltd and HIQ, Better Soon More Convenient – Primary and Secondary better integration we will be actively involved in future developments.	• Identify the key developments in the sector. • Identify key resources to support projects around one electronic client record.	• 100% completion • Active participation	Portfolio Manager / Organisational Managers	September 2010 Ongoing	Nil Nil

Organisational Effectiveness and Culture **Goal 4:** We will regularly monitor the culture of our mental health services and the Clinical Governance knowledge base of our staff and actively response to any identified issues. **Key Outcome:** The culture within our mental health services is important and we can demonstrate responsiveness to any issues and concerns and take steps to improvement.						
Objective		Action	KPI	Responsibility	Completion Time frame	Resources Required
4.1	We will have a standard set of agreed tools that will allow us to evaluate aspects of our mental health services that are important e.g. organisational culture and knowledge of clinical governance, workforce development etc...	• Evaluate and review the outcomes from the survey tools used in the Project Phase II. • Develop/modify and agree a suite of tools and timeframe for use.	• 100% completion • 100% completion	Clinical Governance Board Clinical Governance Board	November 2010 December 2010	Nil Nil

Intersectoral Collaboration **Goal 5:** We will have strong inter-agency and interdepartmental relationships that enables a more holistic approach to the care of our clients **Key Outcome:** We will have continuity of care and improved communication between Child, Adolescent and Maternal Mental Health and Addictions, Adult Mental Health Services, between Health and wider government social services. *(Te Kokiri – Leading Challenge: Building Mental Health Services, Specific Action 2.6).*						
Objective		Action	KPI	Responsibility	Completion Time frame	Resources Required
5.1	We will have formalised arrangements on how we work with other agencies, including service level agreements where applicable.	• Identify key stakeholders from other agencies that are part of the mental health continuum for the clients accessing Child Adolescent and Maternal Mental Health. • Set up cross sector working party to identify the issues for the client group and service	• 100% completion • Formalised Working group established	Portfolio Manager and Managers Portfolio Manager	September 2010 October 2010	Nil Nil

Intersectoral Collaboration **Goal 5:** We will have strong inter-agency and interdepartmental relationships that enables a more holistic approach to the care of our clients **Key Outcome:** We will have continuity of care and improved communication between Child, Adolescent and Maternal Mental Health and Addictions, Adult Mental Health Services, between Health and wider government social services. *(Te Kokiri – Leading Challenge: Building Mental Health Services, Specific Action 2.6).*							
Objective		Action	KPI	Responsibility	Completion Time frame	Resources Required
		providers. • Develop plan of cross sector improvements that will support the management and recovery of the client group.	• Plan completed and agreed			

3.2 Workforce Development Action Plan 2010/2012

Workforce Infrastructure Development

Goal 1: To ensure that there are infrastructure supports in place that progress workforce development

Objective		Action	KPI	Responsibility	Completion Time frame	Resources required
1.1	Appropriate leadership and management training to assist new managers to transition from clinical into leadership roles are identified	• Identify staff group through performance appraisal process • Identify opportunities and funding sources with national Workforce Centres	• 100% Performance Appraisals for Mgrs are completed • 80% of identified staff are offered training is leadership and management	Taranaki Managers Midland Workforce Coordinator	June 2011 June 2011	Nil Nil

Training and Development

Goal 2: To assist mental health and addictions services to develop training and development priorities that build a capable and competent workforce

Objective		Action	KPI	Responsibility	Completion Time frame	Resources Required
2.1	7 Helpful Habits and CAPA training for the NGO sector is implemented	• Schedule workshop with The Werry Centre and NGO providers • Schedule Evaluation Workshop 3 months post workshop	• 100% completion • 100% implementation	Midland Workforce Coordinator Midland Workforce Coordinator	December 2010 March 2011	Nil Nil
2.1	Lets Get Real training across the provider arm and NGO sector is implemented	• Schedule Let Get Real provider arm workshop • Schedule Lets Get Real Evaluation Workshop with NGO sector	• 100% completion • 100% implementation	Midland Workforce Coordinator Midland Workforce Coordinator	July 2010 September 2010	Nil Nil

Training and Development Goal 2: To assist mental health and addictions services to develop training and development priorities that build a capable and competent workforce						
Objective		Action	KPI	Responsibility	Completion Time frame	Resources Required
2.2	Takarangi Competency Framework across the Addictions sector is implemented	• Schedule Takarangi Framework workshop • Schedule Takarangi Framework Evaluation workshop within 3 months	• 100% completed • 100% completed and Champions identified	• Midland Workforce Coordinator • Midland Workforce Coordinator	June 2010 September 2010	Nil Venue and catering costs
2.3	Real Skills Plus Sei Tapu competency across the provider arm and NGO sector is implemented	• Schedule RS+ Sei Tapu workshop • Complete Evaluation workshop within 3 months	• 100% completed • 100% completed	• Midland Workforce Coordinator • Midland Workforce Coordinator	October 2010 February 2010	Nil Venue and catering costs
2.4	Maori Competency Framework training across the provider arm and NGO sector is implemented – He Taura Tieke Workshops	• Plan and deliver with Te Rau Matatini the delivery of the training framework for non-Maori staff • Plan and deliver with Te Rau Matatini the delivery of the training framework for Maori staff • Schedule an Evaluation workshop with 3 months	• 100% completed • 100% completed • 100% implementation and development of ongoing training	• Portfolio Manager and WFC • Portfolio Manager and WFC • WFC	Dec 2010 Dec 2010 March 2010	TBC TBC Venue and catering costs
2.5	The impacts of the centralised Learning and Development budgets on the NGOs ability to access the provider arm mental health and addictions training calendar is evaluated	• Discuss and identify the options available which includes NGO sector contributing towards costs • Implement agreed options	• Agreed options are identified • 100% implementation completed	• Portfolio Manager and provider arm Manager • Portfolio Manager and provider arm Manager	October 2010 January 2011	Nil Nil

Training and Development

Goal 2: To assist mental health and addictions services to develop training and development priorities that build a capable and competent workforce

	Objective	Action	KPI	Responsibility	Completion Time frame	Resources Required
2.6	Implementation of the Co-existing Problems (CEP) National Project – A Mental Health and Addictions sector that is CEP capable	• Organisation Self Assessment Checklist: CEP Service Development Outcomes • Completion of the Planning Template – Towards being a more CEP Capable Service • Plan and deliver with Matua Raki the delivery and training framework.	• Template status clearly identifies the level of training need for the sector. • Sector endorsed plan for implementation • 100% implementation completed.	• WFC – Portfolio Manager • Taranaki Managers • WFC / Portfolio Manager	October 2010 October 2010 TBC	Nil

Retention and Recruitment

Goal 3. Support Recruitment and Retention Strategies

	Objective	Action	KPI	Responsibility	Completion Time Frame	Resources Required
3.1	The Human Resource enabler modules of Lets Get Real is implemented for the NGO providers to develop consistent recruitment and retention policies, procedures and processes	• Schedule Lets Get Real Human Resource Enabler for the NGO managers and leaders • Develop agreement on standardising policies, procedures and processes in workshop within 3 months • Implement agreements	• 100% training completed • 100% agreement achieved • 100% implementation	WFC WFC WFC	October 2010 January 2011 February 2011	Nil Venue and catering costs Nil
3.2	Difficult to recruit clinical roles held in the NGO sector are reviewed and opportunities for redesign or joint venture are identified.	• Proposals to re-configure NGO clinical positions is discussed with the wider sector and agreement achieved • Redesigned positions are fully implemented	• 100% agreement achieved • Positions are recruited	Portfolio Manager NGO Managers	December 2010 Feb 2011	Nil Nil

Organisational Development Goal 4: Ensure there are opportunities for the sector to undertake shared organisational development strategic planning						
Objective		Action	KPI	Responsibility	Completion Time Frame	Resources Required
4.1	Bi-monthly strategic planning workshops that focus on reviewing progress against Te Tahuhu's 10 Leading Challenges is implemented	• Schedule workshops throughout the year	• 100% engagement of the sector	Portfolio Manager	June 2011 & 12	Venue and catering

Research and Evaluation Goal 4: Support Ongoing Training of Mental Health and Addictions Workforce						
Objective		Action	KPI	Responsibility	Completion Time Frame	Resources Required
4.1	Knowing Your People project within the provider arm is implemented	• Knowing Your People is fully implemented in the provider arm	• Project scope is developed and implemented	Provider Arm Manager and Clinical Director	Jan 2011	TBC
4.2	Participate in the Midland regional Addictions Competency Project 2010/11	• Taranaki representatives are identified to participate in the project	• 100% project deliverables are achieved	Midland Regional Director	June 2011	Nil
4.3	Participate in the Midland region Needs Analysis project 2010/11	• Taranaki representatives are identified to participate in the project	• 100% project deliverables are achieved	Midland Regional Director	Dec 2011	Nil

3.3 Addictions Action Plan 2010/2012

Collaborative Multi-disciplinary Team Goal 1: To establish one point of entry for all consumers and family whanau						
Objective		**Action**	**KPI**	**Responsibility**	**Completion Time frame**	**Resources required**
1.1	The roles and responsibilities of members will be clearly defined	• Clearly define the services that are being purchased and align the service to the national specifications	• Services are purchased against the national specifications	Portfolio Manager	Dec 2010	Nil
1.2	Our MDT processes will be needs lead	• Align service positions to the most appropriate MDT to reduce duplication	• Both provider and NGO FTE are provided with consistent MDT support	Clinical Director and Service Manager	Dec 2010	Nil
1.3	All of our clients will have well defined care pathways	• Client pathway for both NGOs and provider arm services aligns to the provider arm documentation	• Standards of documentation are met	Clinical Governance Board	Dec 2010	Nil
1.4	We will be able to evaluate the outcomes of those care pathways	• Internal audits are established and undertaken annually	• Audits evidence a change in practice and implementation of best practice	Managers of Provider Arm and NGO providers	June 2011	Nil

Workforce Development Goal 2: To assist mental health and addictions services to build a capable and competent workforce						
Objective		**Action**	**KPI**	**Responsibility**	**Completion Time frame**	**Resources Required**
2.1	The workforce development plan will include implementation of the Werry Centre CAPA	• A Workforce action plan is developed that includes addiction workforce development	• All staff are provided with opportunities to participate in	Midland Workforce Development Coordinator	Aug 2011	Nil

Workforce Development Goal 2: To assist mental health and addictions services to build a capable and competent workforce						
Objective		**Action**	**KPI**	**Responsibility**	**Completion Time frame**	**Resources Required**
	model; and		appropriate training			
2.2	Include implementation of the Takarangi Competency Framework.	• Implement Phase 1 Takarangi competency framework • Implement Phase 2 Takarangi competency framework	• Addictions staff are provided with a competency framework which supports staff to work with Maori	Midland Regional Network Midland Regional Network	July 2011 June 2011	Nil Nil

Effective Treatment Goal 3: Ensure that treatment offered is inclusive and holistic						
Objective		**Action**	**KPI**	**Responsibility**	**Completion Time Frame**	**Resources Required**
4.1 4.2 4.3 4.4	We will have client/family/whanau participation We will have agreed definitions for the roles in the service e.g. Case Manager / Key Worker Discharge and transition We will have robust contingency planning to manage risk.	• Align the addiction continuum to the project Client Pathway action plan	• The addiction continuum is aligned to the mental health continuum and best practice	Provider Arm and NGO managers	June 2011	Nil

Consumer, Family and Whanau Goal 4: The needs of the consumer, family and whanau will be recognised in the way we deliver services						
Objective		**Action**	**KPI**	**Responsibility**	**Completion Time Frame**	**Resources Required**
4.5	We will adopt strengths based models of care	• Consumer and Family advisors are strengthened to build sustainability	• Consumer and family audits and satisfaction surveys are undertaken annually • CAPA is fully implemented	Portfolio Manager and Provider Arm Manager Midland Workforce Coordinator	Dec 2011 Dec 2011	1 FTE funding Nil
4.6	Needs assessments of clients and the coordination of the services will be in conjunction with the clients family/whanau.	• Participate in the regional NASC project • Implement CAMHS NASC aligned to national specifications • Align POC funding to NASC to ensure activity can be monitored	• All clients requiring POC funding has their needs assessed and wrap around services coordinated	Portfolio Manager and Provider Arm and NGO managers	Dec 2011	1 FTE funding

3.4 Client Pathway Action Plan 2010/2012

One Point of Entry

Goal 1: To have one point of entry

Objective		Action	KPI	Responsibility	Completion Time frame	Resources required
1.1	We will have clearly defined eligibility criteria across mainstream and kaupapa services	• The continuum will align to one entry criteria with agreed flexibility for Maori	• 100% compliance and agreement to the entry criteria	Provider Arm and NGO managers	June 2011	Nil
				Clinical Governance Board	June 2011	Nil
1.2	We will have service level agreements between service providers	• A one service in joint partnership agreement will be developed which clearly aligns to the national specifications	• A partnership agreement is signed off by all parties	Portfolio Manager Provider Arm NGO Clinical Director and managers	June 2011	Primary MH funding
1.3	Our services will align with developments through the Midland Regional Primary Health Business Case	• The continuum of care will include primary, community, secondary and tertiary services	• Agreements are flexible to include the primary mental health strategy			

Workforce Development

Goal 2: To be committed to workforce development

Objective		Action	KPI	Responsibility	Completion Time frame	Resources Required
2.1	We will have a workforce development plan that will include implementation of the Werry Centre CAPA model and Real Skills Plus (enabling people to let go, how to deal with ethical dilemmas, professional development and clear supervision)	• See Workforce Development Action Plan	• See Workforce Development Action Plan KPIs	Clinical Governance Board and Managers GM Maori Health and Maori Management Group	Dec 2010	Nil

Workforce Development Goal 2: To be committed to workforce development						
Objective		**Action**	**KPI**	**Responsibility**	**Completion Time frame**	**Resources Required**
2.2	By scoping workloads we will enable an effective and efficient use of all resources.	• Use international benchmarks and PRIMHD data to determine appropriate caseloads and case mix	• 100% consistency between Provider Arm and NGO caseloads		Dec 2010	Nil
2.3	The whanau ora approach will be evident across service delivery.	• Align to the Midland Iwi Governance definition of Whanau Ora and national specifications	• Whanau ora is well defined from a Taranaki mental health and addictions perspective			

Multidisciplinary Team Goal 3. To be committed to developing a collaborative MDT						
Objective		**Action**	**KPI**	**Responsibility**	**Completion Time frame**	**Resources Required**
3.1	Our MDT has an agreed definition and we operate within shared policies and procedures	• A client pathway included policies and procedures is developed and agreed by all parties	• 100% achievement of shared policies and procedures	Provider Arm CD, SMgr and NGO Managers	June 2011	Nil
3.2	Our staff will have protected time to allow appropriate level of input into MDT's and other appropriate forums	• All NGO staff will attend and participate in the relevant MDT process	• 100% compliance to attending a provider arm MDT • A project plan is developed and progressed		Dec 2010 Dec 2010	Nil Nil
3.3	We will work towards, one client record, and sharing technology across the sector	• The continuum will work towards one client record and client management	• 100% compliance to shared documentation		Dec 2010	Nil

Multidisciplinary Team Goal 3. To be committed to developing a collaborative MDT						
Objective		**Action**	**KPI**	**Responsibility**	**Completion Time frame**	**Resources Required**
3.4 3.5	We will develop standardised collaborative documentation All documents will be living, be age specific and regularly reviewed.	system • Provider arm documentation will be integrated into the NGO providers • Internal audits will be undertaken annually by all providers	• 100% compliance to annual audits		June 2011	Nil

Inclusiveness Goal 4: To be inclusive and holistic						
Objective		**Action**	**KPI**	**Responsibility**	**Completion Time frame**	**Resources Required**
4.1	We will have client/family/whanau participation	• Ensure there is effective family whanau advice into the CAMHS continuum	• Family surveys are undertaken annually to measure satisfaction	Portfolio Manager	Dec 2010	1 CAMHS Family Advisor
4.2	We will have agreed definitions for the roles in the service e.g. Case Manager / Key Worker	• Roles and responsibilities are well defined in the Service Level Agreement	• 100% consistency between NGO and Provider arm expectations of roles and responsibilities	Provider arm CD, SMgr and NGO Managers	Dec 2010	
4.3	Discharge and transition	• Discharge planning and transition planning policies and procedures are fully implemented across the continuum	• 100% compliance in annual audits	Provider arm CD, SMgr and NGO Managers	June 2011	
4.4	We will have robust contingency planning to manage risk.	• Risk management planning is fully implemented across the continuum	• 100% compliance to annual audits	Provider arm CD, SMGr and NGO Managers	June 2011	

Client family whanau focused Goal 5: Support Ongoing Training of Mental Health and Addictions Workforce						
Objective		**Action**	**KPI**	**Responsibility**	**Completion Time frame**	**Resources Required**
5.1	We will adopt strengths based models of care	• Consumer and Family advisors are strengthened to build sustainability	• Consumer and family audits and satisfaction surveys are undertaken annually	Portfolio Manager and Provider Arm Manager	Dec 2011	1 FTE funding
5.2	Needs assessments of clients and the coordination of the services will be in conjunction with the clients family/whanau	• Participate in the regional NASC project • Implement CAMHS NASC aligned to national specifications • Align POC funding to NASC to ensure activity can be monitored	• CAPA is fully implemented • All clients requiring POC funding has their needs assessed and wrap around services coordinated	Midland Workforce Coordinator Portfolio Manager and Provider Arm and NGO managers	Dec 2011 Dec 2011	Nil 1 FTE funding

3.5 Maternal Mental Health Action Plan 2010/2012

Multidisciplinary Team

Goal 1: All referrals are presented to MDT

Objective		Action	KPI	Responsibility	Completion Time Frame	Resources Required
1.1 1.2	We will have clearly defined eligibility criteria for the service – entry an exit. We will have one set of standard policies, procedures an	• The continuum will align to one entry and exit criteria with agreed flexibility for Maori. • One set of standard policies, procedures and documentation which is agreed by all parties.	• 100% compliance and agreement to entry criteria • Agreed set of documentation 100% compliance in its use.	Provider Arm, CD, SMgr and NGO Manager	Dec 2010	Nil
1.3	All maternal mental health clients will have clinical psychiatry oversight via the MDT	• NGO staff will attend and participate in the MDT process • A client pathway will be included in policies and procedures and is agreed by all parties.	• 100% compliance to attending a provider arm MDT • 100% achievement of shared policies by providers.		Dec 2010	Nil
1.4	We will have one point of entry	• All written referrals will be accepted and assessed via the Intake Co-ordinator	• Standards of documentation are met.		Dec 2010	Nil

Workforce Development

Goal 2: Services will be delivered by dedicated FTEs

Objective		**Action**	**KPI**	**Responsibility**	**Completion Time frame**	**Resources Required**
2.1	The roles and responsibilities of staff delivering against the new framework will be clearly	• Clearly define the services that are being purchased and align to the new Perinatal	• Services are purchased against the national service specifications	Portfolio Manager	June 2011	Nil

Workforce Development Goal 2: Services will be delivered by dedicated FTEs							
Objective		**Action**	**KPI**	**Responsibility**	**Completion Time frame**	**Resources Required**
	defined.	Service specifications. • Further work is undertaken on assessing the impact on including infant responsiveness in the delivery of Maternal Mental Health Services • 2 x 0.5 FTE positions for Maternal MH and Addictions combined into one role	• 100% Completed review impact of the change to the new Perinatal Service specification • New contract has combined FTE role. • Reduced duplication in service reporting and administration	Provider Arm NGO managers.	Oct 2010 Oct 2010 Oct 2010	Nil Nil Nil
2.2	All staff will be able skilled in assessing Maori and will by undertake Maori Competency Framework Training.	• Refer Workforce Development Action Plan – Training and Development Needs.	• 100% completed	Portfolio Manager and WFC	Dec 2010	TBC

Standardised Documentation and Communications Goal 3: We will have streamlined communications						
Objective		**Action**	**KPI**	**Responsibility**	**Completion Time frame**	**Resources Required**
3.1 3.2	We will have enhanced communication skills across internal and external stakeholders to provide consultation/liaison service. We will work collaboratively with other health professionals to raise awareness of Maternal	• We will formalise and strengthen our relationships with other stakeholders for access to our specialist support, information, education and advice. • We agree a continuum of care that recognises the need	• Partnerships are agreed and working effectively. • Agreed pathway included policies and procedures	Provider Arm and NGO SMgrs	June 2011 June 2011	Nil Nil

Standardised Documentation and Communications Goal 3: We will have streamlined communications						
Objective		**Action**	**KPI**	**Responsibility**	**Completion Time frame**	**Resources Required**
	Mental Health	for early intervention responsiveness to reduce risks/impacts of mental health issues.				

Assessing and Addressing the Gaps Goal 4: We will actively strive for continuous service improvement.						
Objective		**Action**	**KPI**	**Responsibility**	**Completion Time frame**	**Resources Required**
4.1	We will regularly assess our progress against Te Tahuhu's 10 leading challenges.	• Refer Workforce Development Action Plan – Organisational Development Goal 4.	• Attendance at scheduled workshops	SMGrs	June 2011 & 12	Nil
4.2	We will adopt a reflective practice of working to enable proactive approach to service and quality improvement	• We will actively contribute to strategic and operational planning opportunities which enables ongoing assessment of service delivery options.	• Participation in schedule workshops.			Nil

4. Risk Management

Risks will be monitored, reported and managed as part of the implementation. This will include done through regular feedback to the GM, PF&PH and the Clinical Governance Board.

Risk Description	Impact	Likelihood	Actions	Responsibility
Workforce development unable to be completed within 10 month time frame	Med	Low	• Monitoring progress against action plan • Amend Workforce Development Training calendar accordingly	WFC / Portfolio Manger
Adult Continuum Project identifies further gap in the child and adolescent continuum	Med	Med	• Assess issues in conjunction with action plan. • Determine the need to include as part of implementation. • Assess how it aligns to the models of care	Clinical Governance Board
Consumer and Family Advocacy continues to be under resourced	Med	High	• Ensure resource gaps are prioritised accordingly within DAP planning cycles. • Grow and maintain consumer family/whanau advisory support network • To promote the document "Guidelines for Enabling Effective Family/Whānau Peer Support in CAMH/AOD Services in New Zealand." to encourage peer support for families.	Clinical Governance Board / Portfolio Manager
Governance restructure of Kaupapa Maori Services (Project Kokiri) unable to be completed in timely manner	Med	Low	• Ensure all service providers are operating under agreed service level agreements.	Clinical Governance Board
Losing sight of the cultural agenda with the focus on family/whanau and consumer as the centre of the service model	Med	Med	• Ensuring all training requirements are implemented with appropriate ongoing refresher courses. • Linkages between Kaupapa Maori and Provider Arm services are strengthened and include cultural input	Clinical Governance Board / Smgrs

5. Documentation Required

The following are the list of the core documents required as part of the implementation of the action plan.

	Document	Responsibility
5.1	Workforce Development and Training Schedule through to December 2011.	Workforce Co-ordinator (WFC) / Portfolio Manager
5.2	Draft Terms of Reference – Clinical Governance Board	Executive Clinical Director (ECD) / PM
5.3	Clinical Governance Board work programme to June 2011	Clinical Governance Board
5.4	Draft Terms of Reference - Policies, Procedures and Documentation work party	Portfolio Manager
5.5	Communications Plan update	Portfolio Manager
5.6	Progress Reporting Template	Portfolio Manager

References

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