

Midland Region Mental Health and Addiction Needs Assessment

May 2005

FOREWORD

It is with pleasure that we present the 2005 Midland Regional Mental Health and Addiction Needs Assessment. The Midland Regional Mental Health Network (MRMHN) was established in December 2001 to enhance the delivery of services to mental health service users in the Midland region through greater co-operation amongst regional health services and district health boards (DHBs). The Midland region consists of five district health boards; Bay of Plenty DHB, Lakes DHB, Tairāwhiti DHB, Taranaki DHB, and Waikato DHB.

Assessing the mental health needs of the Midland population is a high priority for the five Midland district health boards. Assessment and analysis of need is a fundamental part of health planning. It provides the justification for maintaining or changing priorities, informs bids to obtain new funding, provides information to support service development and provides key information to inform strategic planning. The key components of health needs assessment are: socio-economic status, health status, prevalence, services provided and views of community and stakeholders.

This document is the result of a commitment by MRMHN to focus on an integrated approach to strategic planning and service development. To effect this new direction a Regional Strategic Planner was appointed to work with all five Midland district health boards.

The key output of the role will be the development of a five year Midland Regional Mental Health and Addiction Strategic Plan that has as its foundation an environmental scan, a mental health needs assessment, and linkages to regional and national directions in mental health.

The MRMHN recognises the importance of stakeholder involvement and accordingly considerable effort has been made to engage the local and regional consumers, Māori, the MRMHN Network, Pacific, family/whānau and other key stakeholders in the Midland region in the health needs assessment process.

Key themes and priorities identified in this health needs assessment will form the basis of the 2005-2015 Midland Region Mental Health and Addiction Strategic Plan.

ACKNOWLEDGEMENT

This project has combined the efforts and expertise of the Midland Region Mental Health Advisory Network including all stakeholders who participated in the local and regional meetings, and contributed their experience and knowledge and of course their time, to the process.

We would like to thank the staff of the five Midland DHBs including the Planning & Funding division and the provider arm, and the Midland Region Mental Health team. Special thanks to the staff of the Planning & Population Health of Lakes District Health Board who helped edit and finalise the document.

We are grateful to those who provided us the data including Central TAS, the Ministry of Health's Public Health Intelligence and the New Zealand Health Information Service, Statistics New Zealand, and of course all those who participated in the 2001 Census and the New Zealand Health Survey and all mental health and addiction providers who submit their utilisation data to MHINC.

Finally, we would like to express our thanks to the members of Midland Region Network Operational Group (MR NOG) and especially to Mary Smith, Lakes DHB GM Planning and Population Health and Janice Donaldson, Taranaki DHB GM Planning and Funding, who supervised the project and provided on going encouragement.

EXECUTIVE SUMMARY

Good mental health enables a positive sense of social and emotional wellbeing, helping individuals to live their lives well, and to lead lives within a wider society. Mental health and neurological disorders, however, affect people of all countries and societies, individuals at all ages, women and men, the rich and the poor, from urban and rural environments. One in four families is likely to have at least one member with a neurological or mental health disorder. These families provide physical and emotional support, and bear with their affected family member the negative impact of stigma and discrimination.

The World Health Organisation (WHO) estimated that in 1990 mental health and neurological disorders accounted for 10% of the total “global burden of disease” (expressed in Disability Adjusted Life Years, DALYs) and in 2020 it will have increased to 15%. Taking the disability component of burden alone, 2004¹ estimates show that globally, mental and neurological conditions account for 32.7% of all years lived with disability (YLDs), and 42% in the developed countries. Six neuropsychiatric conditions are among the top twenty causes of disability in the world, including unipolar depressive disorders, alcohol use disorders, schizophrenia, bipolar affective disorder, Alzheimer's and other dementias, and migraine.

As mental health is fundamental to the wellbeing of individuals, families/whānau, communities and society as a whole, it is exceedingly important to understand and assess the need for effective mental health and addiction services. The assessment process is a method which helps inform strategic planning, annual planning and service planning for communities and individuals within communities, providing the rationale for re-focusing and re-designing funding and services to better address need. At the same time the process can also be a powerful learning experience for those involved, including key stakeholders – consumers, family members, providers, funders, and the community at large.

The Midland Region Mental Health and Addiction 2005 Needs Assessment was carried out in 2004-05 as the first step to developing a Mental Health and Addiction Strategic Plan for the region. The impetus for this process was a desire to change the region's approach from focusing predominantly on Blueprint allocation to a more robust strategic focus that will provide and support sustainable mental health service development across the region for the next five to ten years (2005 to 2015)².

A triangulation approach was used in this needs assessment, whereby a number of methods of data collection were utilised, providing robust information. Engagement with key stakeholders was carried out through the Midland Region Mental Health Advisory Network, while socio-demographic data and service funding and utilisation data were obtained from the Ministry of Health, Central TAS and directly from Statistics New Zealand. An in-depth literature review was also conducted to compile an environmental scan and identify current issues facing the mental health and addiction field in the region, nationally and internationally. Input from the five DHBs in the region was solicited continuously and information was shared between the regional mental health team and the Planning & Funding divisions compiling their own global health needs assessments and working toward the completion of the 2005/08 District Annual Plans.

¹ The World Health Report 2004. WHO. 2004.

² Midland Region 2004/05 Mental Health Plan.2004.

The needs assessment document is comprised of five main sections:

- Environmental scan
- Socio-demographic indicators of mental health
- Prevalence of mental illness and alcohol and other drugs use
- Consultation with key stakeholders
- Mental health service in the midland region

Environmental scan

This section covers the current key issues of the sector, ranging from the legislative and key policy aspects of both health in general and the mental health and addiction in particular. Of great importance is the 2nd *National Mental Health and Addiction Plan 2005-2015: Improving Mental Health*, a consultation document released by the Ministry of Health in later 2004, that potentially will set the direction for the sector for the next ten years. Other key issues discussed in this section are

- Age and demographic changes of the population
- Changes in the primary health care sector
- Blueprint funding
- The recovery approach
- The consumers movement
- New issues in the mental health and addiction field such as problem gambling
- New drugs that have been impacting dual diagnosis, and the impact of the new antipsychotic drugs on the physical health of consumers (diabetes, obesity, heart disease, dental care, etc).

The final part of the section summarizes the new directions in research and development and workforce development nationally and regionally.

Socio-demographic indicators of mental health

The Midland region is made up of five district health boards (DHBs) – Bay of Plenty, Lakes, Tairāwhiti, Taranaki and Waikato, and covers 56,738 km², or 21% of the New Zealand land mass. The total population of the region is 738,918, comprising of 171,213 (21.9%) Māori, 11,844 (1.6%) Pacific People, 17,235 (2.3%) Asian, and 538,596 (72.9%) Other. It is projected that the region's population will increase to 811,860 in 2011 and to 828,210 in 2016, a total increase of 12.1% over 10 years.

The recognition that health status of individuals and communities is impacted by the environment, human biology, lifestyle, and the health care system, has been accepted since the early seventies. The relationships between mental health/illness and the determinants of health are bi-directional and reciprocal. The region's population is relatively more deprived compared to the national population with 28% of the total region population living in the highest deprivation quintile and only 10% in the lowest quintile. 50% of Māori and 52% of Pacific people in the region are represented in the highest deprivation quintile and only 3% in the lowest quintile.

Prevalence of mental illness and alcohol and other drugs use

There is currently no direct data on the prevalence of mental health problems in the region.

Applying the Blueprint access target of 3% for the total population, provides an estimate that in any one month in 2001 **22,168** people in the Midland region might require mental health and addiction specialist services. Further breakdown by age provides estimates that 1,109 children under 10 (1.0%), 2,443 children 10 to 14 (3.9%), and 2,895 young people 15 to 19 (5.5%) require services.

Other estimates can be made from studies conducted in New Zealand and overseas. The recently completed New Zealand Health Survey provided national estimates of serious mental disorders, alcohol and marijuana use. Applying the national rates to the region suggest that there are currently 19,067 people in the region that at some time in their life were diagnosed with a serious mental disorder (2.5%), 14,491 people in the region that at some time in their life were diagnosed with a depressive disorder (1.9%), 3,813 people in the region that at some time in their life were diagnosed with a bipolar disorder (0.5%), and 1,525 people in the region that at some time in their life were diagnosed with schizophrenia (0.2%).

The survey also suggests that 125,393 people in the region had a potentially hazardous drinking pattern and 13,964 people smoke marijuana regularly. The last part of the section reviews the recent trends in suicides in the region which fluctuated over the last 14 years between a low of 73 (1989) to a high of 129 (1998). The latest mortality statistics show that in 2001 there were 106 recorded suicides in the region. Similarly the rates fluctuated between a low of 10.6 per 100,000 population (1989) to a high of 17.1 per a 100,000 population (1998). The rate for 2001 was 12.7. If a trend-line is applied to the rate, a small gradual increase can be seen.

Consultation with key stakeholders

As mentioned earlier the region's Mental Health and Addiction Advisory Network played a major part in the health needs assessment. In addition to the monthly local advisory groups meetings, special planning meetings were held in late 2004 to identify progress, gaps, and needs. The minutes of all meetings are available in the appendix, while summaries are included in the document itself.

Mental health and addiction services in the Midland region

This section identified the current composition and the 2003/04 utilisation of mental health and addiction services in the region, including local and regional services and services provided to residents of the region in DHBs outside of the region.

- There are currently a total of 187 inpatient beds in Mental Health units in the five DHBs' provider arm and a kaupapa Māori inpatient facility in Hamilton (Hauora Waikato). In addition, each of the five DHBs provider arm as well as Hauora Waikato, provide community mental health services in the main centres and in rural communities across the region.
- Inpatient regional forensic services are delivered in Hamilton by Waikato DHB and Hauora Waikato, while regional community forensic services are delivered by these two providers across the region. Additional forensic services are currently also purchased from other DHBs.
- In addition to the provider arm mental health services, there are currently a large number of NGOs that are contracted by the five DHBs to provide a range of mental health services in the region

The analysis of service utilisation is based on Mental Health Information National Collection (MHINC) data analysed by Central Technical Advisory Services (TAS) and provided to the Midland region, and the MHINC DHBs Service Profile reports accessed through the HIN system. Although all DHBs' provider arm supply data to MHINC, the majority of NGOs in the region do not.

Reviewing the Total Services Provided data reveals that 98-99% of the data represents provider arm services. Consequently the data in this Needs Assessment **should be interpreted with caution** as it misses out NGO services, including Hauora Waikato. Furthermore, provider arm data appears to have a certain level of errors that may render this data inaccurate. We cannot at this point accurately quantify the error rate.

(Note: The issue of data accuracy and validity was one of the major stumbling blocks in the engagement, verification and acceptance processes with respect to this document – and data quality remains a critical success factor for confident planning into the future).

In 2003, 6,922 people were seen by all mental health services reporting to MHINC in the Midland region. This was comprised of a median monthly of

- 514 acute inpatients
- 4,962 adults (4,869 in provider arm)
- 1,976 Māori (1,908 in provider arm)
- 780 older persons (all provider arm)
- 1,238 children and youth (all provider arm)

Nationally, all funded mental health services received \$773M in 2003/04, averaging \$207 per capita. Midland region received \$149.4M, averaging \$202 per capita. This included \$146.5M of Midland DHBs mental health contracts and additional \$2.9M regional and national contracts that Midland residents had access to throughout 2003/04. 63% of the contracts were DHB provider arm and 37% non-provider arm contracts, including \$9M Hauora Waikato contracts. Kaupapa Maori mental health and addictions services in the region accounted for \$8.4M.

The final review of all the data, quantitative as well as qualitative, led to recommendations for the following strategic directions for the Midland Region:

- **Whānau Ora**
Recovery and Wellbeing model that is consumer focused and whānau supportive. Whānau ora will achieve Māori health outcomes
- **Social Inclusiveness**
Social and economic barriers to recovery are removed through integration and intersectoral collaboration
- **Workforce Capacity and Capability Development**
Workforce competency based, valued and motivated to meet consumer needs and expectations
- **Systems Approach**
Consumer responsive services have robust infrastructures, systems and processes Information, Planning, Prioritisation, Funding, HR, Quality, Research & Development, and Outcomes focus

The strategic directions were reviewed by the Midland Region Mental Health and Addiction Advisory Network in early 2005 and were further developed through consultation with the local advisory groups, the DHBs and other key stakeholders in the region culminating in the Midland Region Mental Health and Addictions Strategic Plan 2005-2015.

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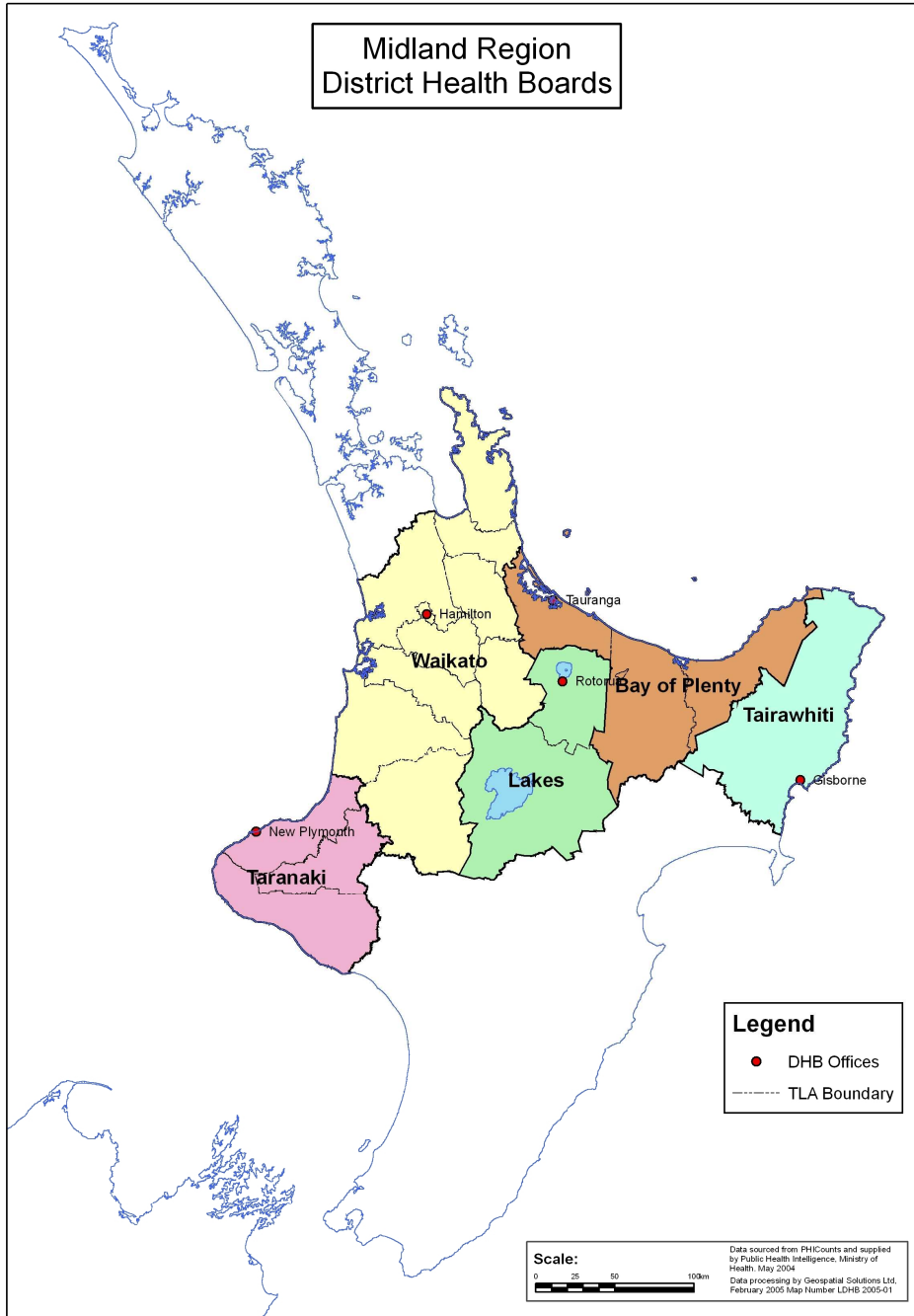
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INTRODUCTION

Mental health and neurological disorders are common, affecting about 25% of all people at some time during their lives. They are also universal, affecting people of all countries and societies, individuals at all ages, women and men, the rich and the poor, from urban and from rural environments. Mental health and neurological disorders have an economic impact on societies and on the quality of life of individuals and families. Mental and neurological disorders are present at any point in time in about 10% of the adult population. Around 20% of all patients seen by primary health care professionals have one or more mental disorders. One in four families is likely to have at least one member with a neurological or mental health disorder. These families provide physical and emotional support, and bear with their affected family member the negative impact of stigma and discrimination.

It was estimated³ that, in 1990, mental and neurological disorders accounted for 10% of the total DALYs⁴ lost due to all diseases and injuries. This increased to 12% in 2000. By 2020, it is projected that the burden of these disorders will have increased to 15%. Taking the disability component of burden alone, 2004⁵ estimates show that globally mental and neurological conditions account for 31.7% of all years lived with disability (YLDs) and to 41.9% in the developed countries. Six neuropsychiatric conditions figured in the top 20 causes of disability in the world, these being unipolar depressive disorders, alcohol use disorders, schizophrenia, bipolar affective disorder, Alzheimer's and other dementias, and migraine. Mental health is fundamental to the wellbeing of individuals, family/whānau, communities and society as a whole.

Good mental health enables a positive sense of social and emotional wellbeing that helps individuals to live their lives well, and to lead rewarding lives within a wider society that values their participation⁶.

The current mental health strategy, comprising of *Looking Forward* (1994), *Moving Forward* (1997) and the *Blueprint for Mental Health Service in New Zealand* (1998), had set up the stage for major changes in the sector, focusing on recovery, and establishing service levels for specialist mental health services. The *New Zealand Health Strategy* (2000) had placed mental health in the context of the whole of health, as one of the main strategic population health priorities for the nation. It had brought to the forefront the priorities that represent higher burden of disease, and those that have significant areas of relative social and health disparities.

The recent *Improving Mental Health – the 2nd Mental Health and Addiction Plan* (Consultation Document) is another step in widening the scope of mental health and addictions, emphasising the social and economic determinants that impact on mental health of individuals, and the need for holistic approach.

The assessment of need for mental health and addiction services is a process which helps inform strategic planning, annual planning and service planning for communities and individuals within communities, providing the rationale for re-focusing and re-designing funding and services to better address need. At the same time the process can also be a powerful learning experience for those involved,

³ The World Health Report 2001. Mental Health : New Understanding, New Hope. WHO. 2001.

⁴ Disability-adjusted life year (DALY).

⁵ The World Health Report 2004. WHO. 2004.

⁶ Improving Mental Health: Consultation document. Ministry of Health. 2004.

including key stakeholders – consumers, family members, providers, funders, and the community at large.

Historically, developments in mental health services have been service and funding stream led. However, to effectively respond to consumers' needs, a user-centred approach, taking into account family, community and social contexts, must be taken⁷.

The Midland Region Mental Health and Addiction Needs Assessment was carried out during 2004-05 as the first step of developing a mental health and addiction strategic plan for the region. The impetus for this process was a desire to change the region's approach from focusing only on Blueprint allocation to a more robust strategic focus that would provide and support sustainable mental health service development across the region for the next five to ten years (2005 to 2015)⁸.

THE NEEDS ASSESSMENT APPROACH

A triangulation approach was used in this needs assessment, whereby a number of methods of data collection are utilised, providing robust information from a number of sources. The rationale for applying this approach is that different stakeholders may interpret "needs" differently. Different sources of information can give different views of needs demonstrating the different ways in which the concept of need can be expressed depending on its social context. In addition, an environmental scan was also carried out to summarise some of the current issues facing the mental health and addiction sector, including legislation and policies, co-morbidity and changes in drug use, research and development and new medications side effects.

A user-centred approach is an underlying principle of both the needs assessment and the strategic plan. The MRMHN acknowledges that people with mental health needs should be at the centre of the assessment process. This does not deny the part that other key stakeholders play in defining need but provides the context within which the process has taken place; i.e. that places the consumers' vision at the centre. A recent expression of consumer's vision is outlined below:

In 2014 all tangata motuhake in New Zealand have personal power, a valued place in our whānau and communities and services that support us to lead our own recovery⁹.

It is recognised that a variety of factors affect the expression of need:

- Social circumstances and cultural traditions affect levels of tolerance of unmet needs and what is acceptable.
- Low expectations of needs being met will be a barrier to needs being recognised and reported.
- Needs may be reported only if services are known to be available to meet them.
- People may choose not to express needs for a variety of personal reasons.
- At times people may not be able to express their needs, and their interests in service provision must be protected (e.g. through advocacy).
- People may no longer have a need for services, but a "need" to be more independent.

⁷ Needs Assessment for a Comprehensive Local Mental Health Service. Mental Health Reference Group. Scottish Executive.

⁸ Midland Region 2004/05 Mental Health Plan. 2004.

⁹ Our Lives in 2014. A Recovery Vision from people with experience of mental illness for the second mental health plan and the development of health and social sectors. Published with the assistance of the Mental Health Commission.

Engagement with key stakeholders – the Midland Region’s formal mental health advisory structure was used as the main setting for engagement with stakeholders. The Midland Region Mental Health Network, which was established in line with Ministry of Health requirements, is comprised of the DHBs CEOs and the GMs Planning & Funding for the five DHBs in the region. To provide advice to the CEOs and GMs, a two-tiered Advisory Network was also established, comprised of local and regional advisory groups representing key mental health stakeholders. The purpose of these groups is to contribute to the strategic direction to improve mental health, as well as to provide advice on service development, innovation and the prioritisation of new services at the local and regional level.

During August – October 2004, planning sessions were held with each of the stakeholders groups. Some sessions were facilitated by external facilitators while other were aided by staff. In the last meeting, the Midland Region Mental Health and Addiction Planning Day, delegates from each of the regional forums engaged in a facilitated strategic planning workshop. During the day, participants discussed the mental health and addiction issues, gaps and needs of the Midland Region, and identified priorities for the next five to 10 years. A second key stakeholders planning day was held in February 2005 to review the results of the needs assessment and discuss the outcomes of the consultation.

The following is a list of the sessions held in the region:

Table 1 : Key Stakeholders Meetings

Group	Date	Facilitated by
Midland Regional Consumers Advisory Group (MR CAG)	11 August 2004	Lina Samu
Nga Purei Whakataa Ruamano (Midland Regional Māori Advisory Group (MR MAG))	12-13 August 2004	Moe Milne
Midland Regional Pacific Network (MR PN)	26 August 2004	Staff
Midland Regional Group Advising Families (MR GAF)	27 August 2004	Maxine Gay
Midland Regional Alcohol and Other Drugs Forum (MR AOD)	29 September 2004	Paula Parsonage
Midland Regional Child Adolescents Tamariki Rangatahi Forum (MR CATR)	4 October 2004	Staff
General Managers & Clinical Directors (MR GMs & CDs)	20 October 2004	Staff
Midland Region Mental Health & Addiction Planning Day 1	27 October 2004	Anne Patillo
Midland Region Mental Health & Addiction Planning Day 2	10 February 2005	Staff

Socio-demographic profile of the regional population - the recognition that health status of individuals and communities is impacted by the environment, human biology, lifestyle, and the health care system, has been accepted since the early 1970s. It was defined through the *Ottawa Charter for Health Promotion*¹⁰, which recognised the fundamental conditions and resources for health to be peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. The concept was adopted and adapted to systems internationally and was lately re-drafted into the *Model of Social and Economic Determinants of Health*¹¹.

The relations of mental health/illness and the determinants of health are clearly bi-directional and reciprocal. For example, lack of adequate housing may influence a person’s mental health, and in turn the presence of mental illness may influence whether or not a person can access adequate housing. Similarly, the relations between determinants of health and mental health are multi-faceted and interactive – employment status may influence whether or not a person with mental illness has adequate income, housing and even social networks and supports. And lastly,

¹⁰ WHO. The Ottawa Charter for health promotion. Health Promotion 1986; 3-5.

¹¹ Reducing Inequalities in Health. Ministry of Health, 2002.

access to the determinants of health is affected by the economic and social forces locally, nationally and globally (Frankish et al, 1999)¹².

To emphasise the importance of socio-demographics on the population, a detailed profile of the region is provided. The information in this section is based on the 2001 Census of the New Zealand Population (obtained from Statistics New Zealand), while population estimates and projections and deprivation scores were obtained from the Ministry of Health, Central TAS and the Public Health Intelligence Unit (PHI).

Epidemiology – estimates of prevalence and incidence data from national and international surveys and literature.

Information was taken from the 2002/03 New Zealand Health Survey, the third national population-based health survey to be carried out by the Ministry, the earlier surveys having been fielded in 1992/93 and 1996/97. One of the objectives of the survey was to measure the health status of New Zealand adults, including their self-reported physical and mental health status, the prevalence of selected health conditions, and the prevalence of risk and protective factors associated with these health conditions. The target population of the survey included in addition to the adult population living in permanent private dwellings also adults residing with relative permanency in hospitals and IHC and rest homes, and those who were 'dependent persons'¹³.

Service utilisation – review the utilisation data of local, regional and national services providing services to residents of the five Midland DHBs. This section was comprised of:

- MHINC data (Mental Health Information National Collection), the national database of information on secondary mental health and alcohol & drug services. The source for MHINC data was a) MHINC reports from the HIN; b) Central Technical Advisory Services (TAS) analysis for the DHBs' health needs assessment.
- Stocktake of current mental health funded services.

¹² Frankish C.J., A. Bishop, M. Steeves. Challenges and Opportunities in Applying a Population Health Approach to Mental Health Services. A Discussion Paper. 1999.

¹³ The 'dependent persons' group refers to people primarily released into communities during the phasing out of the large mental health residential institutions. This group may include people with mental health, drug or alcohol problems, or the residual effects of these.

ENVIRONMENTAL SCAN

A scan was undertaken to review the current environment within which the regional mental health sector exists, including relevant legislation, governmental policy and national directions, recent and expected changes in the sector, and research and development.

LEGISLATION

The provision of mental health and addiction services in New Zealand is subject to a number of acts that impacted on the way services were developed and are provided, and determine future demand for services:

- Criminal Justice Act 1985
- Health and Disability Commissioner Act 1994 (Health Disability Code of Rights).
- Health and Disability Services Safety Act 2003
- Health Information Privacy Code 1994 (amendments of 1995, 1998, and 2000)
- Health Practitioners Competency Assurance Act 2003
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- New Zealand Public Health and Disabilities Act 2000
- Public Finance Act 1989.

The Forensic Services are delivered in the context of the following legislation:

- Criminal Procedure (Mentally Impaired Persons) Act 2003, which replaced Part VII of the Criminal Justice Act 1985.
- Victims Rights Act 2002
- Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Assessing health needs of local populations is a key function of district health boards, identified in the New Zealand Public Health and Disability Act 2000 (“...regularly investigate, assess and monitor the health status of its resident population, any factors that the DHB believes may adversely affect the health status of that population, and the needs of that population...”). In addition, the Act lays out a philosophy of increasing community participation, involvement and access to information.

POLICY AND KEY NATIONAL DIRECTIONS

A number of national policies, strategies and key government directions are impacting on the current and future of the mental health sector. The New Zealand Health Strategy (2000) (NZHS) sets the platform for the Government’s action on health, identifying Government’s priority areas and aiming to ensure that health services are directed at those areas that will provide the highest benefits for the New Zealand population, focusing in particular on tackling inequalities in health. Three of its short to medium term population health objectives directly apply to mental health:

- Improve the health status of people with severe mental illness
- Reduce the rate of suicides and suicide attempts
- Minimise harm caused by alcohol and illicit and other drug use to both individuals and the community.

In addition, the NZHS highlights “improving the responsiveness of mental health services” as one of the five service delivery areas on which the Government wishes the health sector to concentrate. “Better Mental Health” is also one of the seven goals of the strategy, comprising the following objectives:

- (34) Reduce the incidence and impact of stress

- (35) Reduce the incidence and impact of depression
- (36) Improve the health status of people with severe mental illness
- (37) Reduce the rate of suicides and suicide attempts
- (38) Reduce stigma and discrimination associated with mental illness
- (39) Reduce the impact of dementia.

The New Zealand Disability Strategy (2001) has 15 objectives that are intended to change New Zealand from a disabling to an inclusive society. This vision of an inclusive society is consistent with the directions for mental health.

The Primary Health Care Strategy (2001) and the establishment of primary health organisations provide opportunities for the continued development of primary mental health care including mental health promotion.

The current mental health system has developed largely as a result of the implementation of recommendations set out in *Looking Forward: Strategic Directions for the Mental Health Services* (1994), *Moving Forward: The National Mental Health Plan for More and Better Services* (1997) and the Mental Health Commission's *Blueprint for Mental Health Services in New Zealand: How things need to be* (1998) which became an important document in establishing national service levels. In addition, a number of strategies specific to mental health have been developed, such as *Te Puāwaitanga: Māori Mental Health National Strategic Framework* (2002).

In late 2004, *Improving Mental Health, the 2nd National Mental Health and Addiction Plan 2005-2015*, was released by the Ministry of Health for consultation. This draft plan provides a strategic work plan for service development in mental health, outlining strategic directions for the next ten years and a series of actions for the next five to seven years. It clarifies the vision and direction of mental health services over this period and specifies the actions that need to be taken so that the sector can move closer to achieving the vision of better mental health services for all New Zealanders. Most of the actions constitute a requirement on DHBs and the Ministry of Health, although some are directed at the whole range of mental health service providers.

The draft plan is organised around seven interlinked strategic directions that provide the essential components of a comprehensive and integrated mental health system:

1. More and better specialist services
2. More and better services for Māori
3. Responsiveness of services
4. Systems development
5. Mental health in primary health care
6. Mental health promotion and prevention
7. Social inclusion – removing social and economic barriers to recovery.

DEVELOPMENTS IN THE SECTOR

A number of government policy changes in recent years have had a major influence on the delivery of health services generally and mental health services specifically. The establishment of 21 district health boards in 2001 brought with it major changes in the way health services are planned, funded, organised and delivered. DHBs have responsibility for determining the mental health needs of their communities, and for planning and organising services to meet those needs. DHBs' provider arm have a major role in the provision of mental health services. For its part, the Ministry of

Health functions to provide strategic advice to the Government, monitor DHB performance and administer legislation and regulations.

As mentioned earlier, a number of health strategies were released in the last four years that are having a major impact on the way mental health services can be delivered and organised. One of the major shifts taking place in the health system is a direct result of the implementation of the Primary Health Care Strategy, aiming to place a greater emphasis on population health, health promotion and preventative care, increase community involvement as well as involving a range of professionals and encouraging multidisciplinary approaches to decision making, improving accessibility, affordability and appropriateness of services, improving co-ordination and continuity of care, and providing and funding services according to the population's needs as opposed to fee for services when people are unwell.

The establishment of Primary Health Organisations (PHOs) provides an opportunity for health providers to ensure mental health services are an integral part of primary health services. PHOs can develop services that address the mental health needs of their enrolled populations who present with mild to moderately severe mental health problems or disorders, as well as form strong relationships with existing mental health services for more effective care for people with moderate to severe disorders. Funding is currently available for PHOs to develop and provide services in a variety of areas including education of GPs practice nurses and community groups on how best to meet the needs of the 17% who present to primary care services with mild to moderate mental health problems, liaise with mental health providers or provide actual clinical service such as assessment, treatment and support to those meeting the criteria.

Another important factor that is having a potential impact on mental health services is the changes in the demographic composition of the population, including both the ongoing changes in the age group composition and the changing ethnic composition both nationally and locally.

Age composition (refer also to the Socio-demographic section) – with increased life expectancy and reduced fertility rates, it is expected that the percentage of older persons (65+) will continue to increase while the percentage of children and youth (under 20) will decrease. This will impact on the types and volumes of health services in general and mental health services specifically that will have to be funded in the future. Ethnic groups, such as Māori, Pacific, and Asian peoples may have different age profiles to non-Māori that will influence the types and volumes of services required to be delivered to meet the needs of these communities.

Ethnic composition – Māori mental health services have been and will continue to be a national, regional and local priority. Pacific mental health services are rapidly becoming a priority as well. However, it is continuously being recognised that the mental health needs of people from diverse cultures and ethnic groups are also a priority. Asians make up the fastest-growing ethnic population in New Zealand today. In the decade between 1991 and 2001, the number of people identifying with cultural groups linked to countries in Asia more than doubled to almost 240,000, or 6.4% of the total population, and many are recent arrivals and refugees. Chinese is the largest ethnic group within the Asian population, followed by Indian and Korean. Other ethnic groups that make up the Asian population include Thai, Filipino, Japanese, Sri Lankan, Malay, Cambodian and Vietnamese. Mental health problems often arise due to language difficulties, employment problems, disruption of family and social support networks, acculturation attitudes and traumatic experience prior to

immigration. The high risk groups among the Asian population are women, older persons, students and refugees.¹⁴

Blueprint funding - The Mental Health Commission's Blueprint for Mental Health Services in New Zealand (1998) has provided resource guidelines for achieving the capacity in specialist mental health services that is needed to meet the 3% access rate originally identified in *Looking Forward* (Ministry of Health 1994). Having resource guidelines has been important as it has allowed everyone to know what service levels should look like. The resource guidelines have also been important in monitoring progress. The Blueprint is the accepted government policy in relation to service availability of specialist mental health services, and the Government is committed to implementing the service levels set out in the Blueprint.

Government has made a considerable investment in specialist mental health services. It has provided a number of funding packages that have increased funding for specialist services. Since *Moving Forward* was released in 1997, total public sector funding nationally for mental health services has increased from \$523.7 million in 1997/98 to \$839.2 million in 2002/03. In the Midland Region, Blueprint allocations included \$2.76M (2000/01), \$8.24M (2001/02), \$5.0M (2002/03), \$4.1M (2003/04), \$6.02 (2004/05) and \$2.1M (2005/06). Additional \$2.67M are expected to be allocated in 2006/07 and in 2007/08.

Although the Government requires DHBs to implement and report on progress of the Blueprint implementation, it is now recognized that the Blueprint was written as a tool for national and regional planning purposes, prior to the establishment of DHBs with their individual accountabilities and funding teams. The Commission intended to update the Blueprint guidelines as services and access increased, but neither the Blueprint guidelines nor the population targets of the national mental health strategy have changed. It is important, therefore, to be careful when applying the guidelines, supplementing them with careful needs analysis at the district, regional and national levels.

Growth of consumers movement - Traditionally mental health services have been based on a 'benevolent paternalism' model assuming 'best interest' decision making by clinicians on behalf of consumers. The two concepts that have kept this philosophy dominant are the 'authority of position' held by providers of welfare services and the 'authority of knowledge' held by clinicians. Many consumers, particularly those who spent periods of time in institutions, lacked faith in their ability to assert control over their own affairs, or to represent others.

More recently, many of these assumptions have been challenged. The traditional model has become unacceptable and all stakeholders today recognise that each have a valuable contribution to make. Consumers, especially, have the first hand knowledge of their own needs and experiences that can be shared and be an essential part of all planning levels. The past decade has seen the growth of a strong consumer voice and the increasing recognition that services must be built around the needs of service users / tangata whaiora.

Participation by service users in the mental health sector means involvement in any activity that gives them influence over the systems and services that affect their lives. This can take many forms including individuals working in partnership with their health care workers towards recovery, responding to satisfaction questionnaires, participating in advisory groups or other formal and informal networks, advising on

¹⁴ Mental Health Issues for Asians in New Zealand: A Literature Review. University of Waikato. 2003.

service policy, planning, development or monitoring, volunteering as support a person for other service users, working as an advocate or representative for other service users, paid or volunteer provider of mental health services (including clinical and support services) or a trainer.

Recovery - Recovery is broadly defined as the ability to live well in the presence or absence of mental illness. The definition is intentionally broad because the experience of recovery is different for everyone. Each person defines for themselves what 'living well' means to them. Recovery is both a process and an outcome, involving service users/tangata whaiora, family/whānau, communities, health services, and society as a whole – all those that play a role in supporting people with mental illness or mental health problems to achieve and maintain recovery.

Recovery is continuing to be a major focus of the mental health system, and is the foundation of the 2nd *National Mental Health and Addiction Plan* which aims at creating supportive communities and responsive, safe clinical environments for people in recovery. Good mental health and recovery from mental illness are built on the recognition of human dignity and the personal empowerment of service users. Recovery happens when service users can have the confidence that services are provided and are well coordinated, and that services, while being flexible, are operating within an evidence-based framework and focused on achieving better outcomes. Recovery happens when service providers support service users to achieve and maintain the life they want.

Problem gambling - Problem gambling (PG) is defined as a pattern of gambling behaviour that disrupts and damages a person's life, their friendships, family relationships and job interests. It is a serious issue and concern about it is growing. Problem gamblers suffer from increased rates of bankruptcy, arrest, imprisonment, unemployment, divorce and poor physical and mental health. There is also evidence to suggest that problem gamblers have higher rates of suicide¹⁵, and that around seven other people are affected to some extent by a severe problem gambler's behaviour.

It is estimated that between 22,000 and 50,000 people nationally have some form of gambling problem. The opening of new casinos and the addition of new gambling options through the Lotteries Commission, TAB, the Internet, and gaming machines ('pokies') in pubs and clubs, has resulted in an increased gambling activity followed by increases in the numbers of people seeking help. New callers to the Gambling Helpline have more than doubled in the past six years, with 4,644 new callers in 2003. The number of those receiving personal counseling had almost tripled by 2002, from 890 in 1,997 to 2,467. Over the past five years, Māori have shown the largest increase in people seeking help from problem gambling services. Māori comprised 23.9% of all callers to the Gambling Helpline in 2003, while rates for Asian and Pacific peoples have consistently increased over the last five years as well. In 2003, 83.6% of callers to the Gambling Helpline said that 'pokies' were the primary cause of their problem.

There are a number of problem gambling services available nationwide including Māori, Pacific and Asian services in some regions. Referrals can be self-referrals, from other health and social service providers, from family and whānau, or from community organisations. Branches of the self-help group, Gamblers Anonymous (GA), are also active in some areas.

¹⁵ Problem Gambling in New Zealand. Fact Sheet 1. Ministry of Health. 2004.

Funding for services was transferred from the Problem Gambling Committee to the Ministry of Health on 1 July 2004. There are currently a number of services in Midland including Hauora Waikato (Waikato), Pacific Peoples Addiction Services (Waikato), Oasis Services (Waikato), Kahui (Rotorua) and PGF (Tauranga, Whakatane, Rotorua). A need has also been identified in South Waikato and Thames (Waikato DHB) and services are currently being developed.

To help the prevention and minimize the harm of gambling in New Zealand, a national strategic plan for 2004-2010 and a three-year funding plan were released in early March 2005.

Co-morbidity and the changing face of drug use - The co-existence of substance use and abuse and mental health disorders has received increasing attention in the national and international literature and increasing clinical focus in both alcohol and drug and mental health sectors over the past decade. The recognition that co-existing disorders are common, that use of traditional treatments is often associated with poor outcome, that patients with co-existing disorders generally experience severe dysfunction and that these patients sometimes bridge the "cracks" between services and sometimes fall through them, lies behind this increasing attention given to the issue of co-existing disorders.

Although alcohol consumption and cannabis smoking are still the two main addictions common with people with mental illnesses, the availability of cheaper and different drugs has recently been making an impact on the dual diagnosis field. Detailed analysis of the *2001 National Drug Survey* followed by more recent research on the socio-economic impact of Amphetamine Type Stimulants (ATS) in New Zealand¹⁶ (a survey of frequent methamphetamine users in Auckland, key informant surveys of drug enforcement officers and drug treatment workers, analysis of drug treatment statistics related to ATS, and a local pilot study of the drug use of arrestees conducted in police watch-houses) demonstrates that ATS are now serious drugs of abuse in New Zealand. In 2001, one in 10 New Zealanders aged 18-29 had used an ATS drug in the last year. The level of amphetamine use among 15-19 year olds may be higher in New Zealand than in Australia. The illicit trade in ATS drugs in New Zealand is of the equivalent dollar value as the illicit trade in cannabis and may have effectively doubled the dollar value of the illegal trade in drugs in New Zealand in less than 10 years. In the case of methamphetamine, the proceeds are likely to be concentrated among a relatively small number of local organized criminal gangs who were instrumental in the introduction of methamphetamine manufacture to New Zealand.

The secondary analysis of the National Drug Survey findings highlighted the greater risks and harms associated with frequent ATS use and identified the risk that increased ATS use may pose in terms of the spread of intravenous drug use and the enhancement of the demand for other 'hard' drug types. Attention was also drawn to users of crystal methamphetamine as the ATS drug users with the highest levels of daily use, poly drug use, intravenous drug use and opioid use. These findings suggest law enforcement and other agencies should focus on frequent ATS and crystal methamphetamine users as priorities in the effort against ATS.

Many frequent users of methamphetamine reported pre-existing mental health problems including tendencies to self-harm. Use of methamphetamine increased these individuals' levels of psychological problems such as anxiety, mood swings,

¹⁶ The Socio-Economic Impact of Amphetamine Type Stimulants in New Zealand. Dr. Chris Wilkins James Reilly Emily Rose Debashish Roy Dr. Megan Pledger Arier Lee. Massey University. 2004.

short temper, paranoia, and depression and the level of suicidal thoughts and attempts. These findings suggest frequent methamphetamine users should be approached with caution and reassurance to avoid triggering any violent defensive or self-harm response. Methamphetamine users' increased propensity for self-harm should also be taken into account when they are detained in custody.

New antidepressant medication – antidepressants are used to slow the removal of neurotransmitters (such as *serotonin* and *norepinephrine*) from the brain as they are needed for normal brain function and are involved in the control of mood and in other responses and functions, such as eating, sleep, pain, and thinking. Antidepressant drugs help reduce the typical symptoms associated with depression and may be used to treat other conditions, such as obsessive compulsive disorder, premenstrual syndrome, chronic pain, and eating disorders.

Newer antidepressants are thought to have fewer side effects and a wider safety margin than the older tricyclic antidepressants. These newer medications include Fluoxetine (Prozac), Paroxetine (Aropax), Citalopram (Cipramil) and Moclobemide (Aurorix).

The UK's Medicines and Healthcare Products Regulatory Agency (MHRA) however, has tightened warnings on Prozac-type antidepressants following a review of Selective Serotonin Re-uptake Inhibitors (SSRI) sparked by concerns over their safety especially in young adults possible increased risk of suicide compared with other antidepressants. Drugs including GlaxoSmithKline Plc's Seroxat - the most widely prescribed among the drug class in Britain - were banned from use in children last year following evidence that they may increase the risk of suicides.

In late 2004, the New Zealand Medicines Adverse Reactions Committee (MARC), has issued an advice relating to the known risks and benefits associated with prescribing medications to treat depression in young people and in adults including SSRI, Tricyclic Antidepressants (TCAs), and Monoamine Oxidase Inhibitors (MAOIs). In addition to this, MARC has advised that when treating children and adolescents with depression the risk of suicidal thoughts and behaviour with SSRIs generally outweighs the possible benefits from the medication.

New antipsychotic medications – antipsychotics are used to treat psychotic states, working primarily as dopamine receptor antagonists, aimed at producing a state of apathy. These drugs have other properties such as antiemetic and antihistaminic effects, and possess the ability to potentiate analgesics, sedatives and general anaesthetics. An important unwanted effect is Parkinsonian symptoms mediated by antagonism of dopamine in the nigrostriatal system. Examples include Chlorpromazine, Clozapine and Thioridazine. Depot injections (e.g. Flupenthixol and Fluphenazine) are not easily detected in blood due to the low levels obtained.

The traditional antipsychotics available since the 1950s, such as Chlorpromazine (Largactil) cannot 'cure' mental illness, but they are effective for many people in eliminating or reducing psychotic symptoms such as hallucinations, delusions, and thought disorders. They are less useful in the treatment of so called 'negative' symptoms such as social withdrawal and loss of drive and emotional expression. They may also lead to 'extrapyramidal' side effects ie movement disorders such as involuntary trembling and stiff muscles. In recent years a new generation of antipsychotic medications have become available. These new medications include Clozapine (Clozaril), Risperidone (Risperidol), Olanzapine (Zyprexa) and Quetiapine (Seroquel). These new medications have a number of advantages:

- They lead to fewer of the unpleasant side effects such as trembling or stiffening of

muscles associated with traditional medications.

- There may be less risk of developing 'tardive dyskinesia' - a particular movement disorder that develops over the long term in some people, and which does not respond to treatment.
- There is some evidence that they help people feel less withdrawn and more motivated.

Since the introduction of the second generation anti psychotics (SGAs) over the last decade, the use of these medications has soared. The SGAs are of great benefit to a wide variety of people with psychiatric disorders. As with all drugs SGAs are associated with undesirable side effects. One constellation of adverse effects is the increase risk of obesity, diabetes and dyslipidemia. The etiology of the increased risk for metabolic abnormalities is uncertain but their prevalence seems correlated to an increase in body weight often seen in patients taking SGA. Direct drug effects on cell function and insulin action could also be involved. In the general population, being overweight or obese also carries a much higher risk of diabetes and dyslipidemia. These three adverse conditions are closely linked and their prevalence appears to differ depending on the SGA used. Clozapine and Olanzapine are associated with the greatest weight gain and higher occurrence of diabetes and dyslipidemia. Risperidone and Quetiapine appear to have intermediate effects. Aripiprazole and Ziprasidone are associated with little or no significant weight gain, diabetes or dyslipidemia, although they have not been used as extensively as the other agents¹⁷.

Physical health and mental illness - there is a growing body of evidence that life expectancy and general health status of people with mental illness is lower than that of the general population¹⁸. Males' life expectancy (when suicide has been factored out) is 14 years less than the general male population and females' is 6 years less than the general female population. These rates stretch across ethnicity, diagnosis, nationality and gender. Based on the overseas estimates, it is expected that in New Zealand while Māori male's life expectancy is 65 and non-Māori male's life expectancy is 75.7, life expectancy of a person with mental illness is only 61.7.

The most common contributors to the lower life expectancy of people with mental illness are deaths due to heart disease (2.2 times higher), cancer (1.5 times higher), influenza (5 times higher), and diabetes (3 times higher) respiratory illness (2.8 to 4 times higher).

A number of risk factors that contribute to lower health status have been identified including lower socioeconomic status/poverty, smoking and obesity. In addition, lack of clear responsibility for consumers physical health care, discrimination, and iatrogenic illness are also contributing factors.

- **Poverty** - as mentioned earlier, there is a bi-directional link between mental illness and sociodemographic status. Lack of adequate housing may influence a person's mental health, and in turn the presence of mental illness may influence whether or not a person can access adequate housing. Similarly, the relations between determinants of health and mental health are multi-faceted and interactive – employment status may influence whether or not a person with mental illness has adequate income, housing and even social networks and supports. And lastly,

¹⁷ Consensus development conference on antipsychotic drugs and obesity and diabetes. American Diabetes Association, American Psychiatric Association American Association of Clinical Endocrinologists, North American Association for the Study of Obesity. Diabetes care, Volume 27, Number 2, February 2004.

¹⁸ 'Our physical health... who cares?'. Occasional Report no.5. New Zealand Mental Health Commission. 2004.

access to the determinants of health is affected by the economic and social forces locally, nationally and globally.

Nevertheless, it is important to note that not all consumers are poor. The effects of other risk factors may be as important in influencing the person's physical health status.

- **Smoking** - smoking is a significant risk factor contributing to heart disease, cancer and respiratory disease. Consumers smoke far more than the general population and across most diagnoses as do people of higher deprivation or low socioeconomic status. Research shows that smoking is associated with mental illness even after controlling for socio-demographic factors¹⁹. The inpatient environment, both past and current, may be a contributing factor to high levels of smoking. In New Zealand's inpatient past, service users were rewarded or "paid" with a daily quota of cigarettes. Cigarettes are used as prizes during organised games in some supported accommodation. In the current inpatient environment, the room that is warmest and friendliest, a gathering point, is the smoking room, which helps foster addiction.
- **Obesity and diabetes** - obesity is a key risk factor for heart disease, hypertension and diabetes. Research²⁰ indicates that 71% of people who are chronically mentally ill are overweight or obese, compared with 52% of the general New Zealand population, indicating that "neuroleptic and psychotropic drugs play a significant role in the undesirable weight gain in the mental health population"²¹.

It is expected that the weight of people who are prescribed newer SGAs may increase, as weight gain with some SGAs has been significant. Research examining the relationship between SGAs and diabetes indicates that irrespective of obesity, drug-related chemical reactions may disturb glucose levels (see above).

- **Tardive Dyskinesia (TD)** - large doses of older anti-psychotics, such as Haloperidol that are linked to permanent paralysis are comparatively rare in today's clinical environment. However, temporary TD related to medications remains common, including symptoms of jaw lock, twitching and restricted movement. The negative effects TD has on a person's ability to initiate recovery cannot be underestimated.
- **Dental Health** - the dental health of mental health service users is also of concern. Long term use of lithium has been linked with a number of side effects, among them oral complications, caries, periodontal disease and xerostomia.
- **Addiction to prescription medications** - addiction to prescription medications particularly benzodiazapine and possibly some serotonin re-uptake inhibiting medications often result in indirect physical illness such as weight loss, sleeplessness and lowered immunity.

Lack of clear responsibility for service users' physical health care - responsibility for consumers' physical health care is not clearly defined between primary care services, community mental health teams, community AOD services

¹⁹ Smoking and Mental Health. McNeil in 'Our physical health... who cares?'

²⁰ Nutrition and obesity in the chronically mentally ill. Wallace and Tennant in 'Our physical health... who cares?'

²¹ B Wallace, C Tennant. 1998. Nutrition and obesity in the chronically mentally ill. Australian and New Zealand Journal of Psychiatry 32: 82-5, pg.85

and inpatient facilities. Clear responsibilities are considered important to avoid gaps in access and service provision and to improve and monitor the quality of service provision.

The draft Second Mental Health Plan²² places a greater emphasis on the link between mental health and the primary health care system. It acknowledges that primary health services can have the largest impact on reducing mental illness and increasing the health status of people who experience mental illness and that primary health practitioners are best placed to identify potential and existing mental health problems at an early stage. By providing good advice and care, and through referral to specialist services where further assessment is needed, they can reduce the impact of mental illness significantly. However, the recommendations in the plan are mainly in relation to the 17% of the population who are at risk of acquiring a mental illness, not the 3% who are currently seriously mentally ill and are mental health consumers.

Discrimination of Health Care Professionals - access to (physical) health care is often affected by real or perceived discrimination. Research suggests doctors generally share the public's overall stereotypical images of people with mental illness. Consumers' own perception is that doctors do not take them seriously and often ignore requests for specialists' tests.

RESEARCH AND DEVELOPMENT

Good information and a growing knowledge base are required in order to better serve the consumers of health services. There is a link between R & D expenditure to improved health outcomes; to retention of staff (e.g. research is seen as by many staff as assisting in increased job satisfaction and is necessary for any health professional job advancement) and, to recruitment (e.g. through joint appointments and/or joint ventures between health and educational agencies).

The Mental Health Research & Development Strategy is aiming to better understand what we are doing in mental health and alcohol and other drug services, who needs services and "what works" for service users, what influences staff practices and leads to more responsive services, and the wider "system" that impacts upon mental health.

Current research activities include:

- Sector development – activities aimed at improving quality and best practice in the mental health sector, including progress on the national mental health strategy, the Treaty of Waitangi, Pacific development, and the strategic principles of the Mental Health R&D Strategy.
- Epidemiology research that aims at understanding the prevalence of mental health problems in New Zealand, mainly through the NZ Mental Health Epidemiology Study through an extensive household survey.
- Outcomes - an area which covers all activities associated with development and implementation of outcome measures and processes, focusing on the introduction of routine collection of a suite of standard outcome measures (starting with HoNOS) across New Zealand to support recovery by promoting and facilitating the development of an outcomes-focused culture in the mental health sector. This is being done through the MH-SMART (Standard Measures of Assessment and Recovery) Outcomes Initiative. Another activity is the development of a process to identify appropriate standard measures for routine

²² Improving Mental Health. Ministry of Health. 2004.

implementation to complement the HoNOS. This is being developed through a number of research projects. A number of projected were completed including preliminary work towards the development of a self-assessed measure of consumer outcome; child and youth outcome measures; New Zealand mental health classification and outcomes study (CAOS); and "Hua Oranga", a Maori measure of mental health outcome.

WORKFORCE DEVELOPMENT

Mental Health Workforce Development (MHWD) is identified as a priority in the 2004-2005 Midland Regional Mental Health and Addiction Services Plan. It has gained momentum in recent years and is increasingly identified by mental health sector stakeholder groups as an area requiring coordination, communication and information. A workforce that has the wherewithal and ability to respond to service user requirements now and in the future, requires a combination of activities that extends beyond the sole focus on training and development to include other essential elements.

The National Mental Health (Alcohol and Other Drugs) Workforce Development Framework (2002) identified five strategic imperatives to support building capacity and capability within the mental health workforce:

- Infrastructure development
- Training and development
- Retention and recruitment
- Organisational development
- Research and evaluation

The Ministry of Health has funded four national programmes to advance the strategic imperatives and strengthen MHWD infrastructure:

- Mental Health Workforce Development Programme (General)
- Te Rau Matatini (Māori)
- The Werry Centre (Child and Youth)
- National Addiction Centre (Alcohol and Other Drugs)

Additionally MHWD issues are being addressed by the Health Workforce Advisory Committee and DHBs in partnership with District Health Boards New Zealand (DHBNZ). The greatest investment in training nationally is post-entry clinical training purchased via the Clinical Training Agency (CTA).

Nationally and internationally the health sector is experiencing significant skilled labour shortages and there is the added demand of planning for an ageing population and ageing health workforce.

The Mental Health Workforce Development Programme (MHWDP) is currently funding Mental Health Workforce Development services in Midland. The overall goal of the services is to provide a sustained and systemic response to regional mental health workforce development by ensuring alignment between regional projects, national policy and with broader DHB health workforce regional networks and initiatives.

The Mental Health Workforce Development Coordinator role (2004-07) is responsible for the development of the Midland Regional Mental Health Workforce Development Strategic Plan, which will include the foundation work required to establish a Midland Workforce Development - Communication strategy, Planning framework, Information, Expertise, Collaboration, and Implementation framework.

Essential skills training has been identified as a regional priority and MHWD programme funding for 04/05 will be utilised to purchase an initial regional training module as well as analysis, coordination and planning for future essential skills training provision.

The Midland region consultation process (see following sections) identified a number of key workforce issues for the region:

Infrastructural Development

- Backfill of staff when staff attending training
- Develop a planning culture
- Develop regional vision
- Training coordinators required in each DHB district – connect with regional MHWD coordinator
- Regional orientation for overseas staff
- Regional workforce coordination required to reduce duplication and improve efficiency

Organisational Development

- Implementation and follow up within organisation after training attended. Develop learning workplace that engages in new information/training and takes a proactive role in implementation and revision
- Valuing staff – organisational culture, acknowledge feedback, flexibility in hours, terms etc, remuneration, increase access to individually tailored training and development, establish advancement pathways, develop culture of affirmation and success
- Alignment between MH philosophy/policies and directions and staff attitudes and beliefs
- Develop mechanisms for staff led strategic and organisational improvement
- Improve utilisation of IT for maximum benefit
- Improve Performance reviews and mechanisms

Recruitment and Retention

- Develop attractive culture that attracts and retains membership
- Review current practices in DHB and NGO

Training and Development

- Training needs analysis
- Address workforce basic skills
- Training information dissemination in the workplace – how do we ensure that the knowledge stays when a staff member leaves the organisation
- Training to address employed staff and whānau, consumer and voluntary sector
- Improve utilisation of IT
- Develop coordination of training and flexible training options
- Develop Dialectical Behavioural Therapy (DBT) and Cognitive Behavioural Therapy (CBT) workforce
- Develop dual diagnosis workforce skills

Telepsychiatry

The administrative, and to a lesser extent, clinical use of telepsychiatry has been established in New Zealand over the last six to seven years. There is an acknowledgement that recruitment/retention, particularly for rural and remote sites,

could be addressed by better use of video-conferencing. Recent enquiries into high profile mental health cases have raised issues on the level of access to clinical supervision for clinicians working with little or no peer support on site. A national telepsychiatry project that is currently nearing completion, is an initiative of the MHWD programme, was carried out to enhance and encourage the use of videoconferencing within the mental health sector as a workforce development initiative with "The ultimate goal in any Mental Health Workforce Development initiative is to ensure better health outcomes for consumers."

DHBs' input into the national project was co-coordinated regionally through the provider arms. The Midland region project (co-coordinated by Waikato DHB provider arm) was completed in late 2004. The key outputs of the project were:

- Identify communication channels with key stakeholders for project input and updates
- Review / update equipment directory and put process in place to gather information on equipment use, frequency, purpose
- Review / assist in developing policies, protocols against national guidelines
- Identify training needs required for use of videoconferencing
- Provide an annual plan for each DHB outlining current state/usage of equipment, planned activities, needs analysis for new/improved service development taking into account input from key stakeholder groups including consumers, Māori, Pacific and family representation along with clinical and workforce development needs.

SOCIO-DEMOGRAPHIC INDICATORS OF MENTAL HEALTH

GEOGRAPHY OF MIDLAND REGION

The Midland region is made up of five District Health Boards – Bay of Plenty, Lakes, Tairāwhiti, Taranaki and Waikato DHBs. These areas are within the geographical boundaries for Ngāti Awa, Whakatohea, Te Whānau-a-Apanui, Ngai Tai, Tuhoē, Ngāti Rangitīhi, Ngāti Wāhkahemo, Tapuika, Waitaha, Ngaiterangi, Ngāti Pukenga, Ngāti Ranginui, Te Whānau a Te Ehutu, Tuwharetoa (Bay of Plenty); Te Arawa waka and Ngāti Tuwharetoa (Lakes); Turanganui a Kiwa rohe: Te Aitanga a Mahaki, Rongowhakaata, Ngai Tamanuhiri, Te Whānau a Kai, Ngāriki Kaiputahi (Tairāwhiti); Ngāti Tama, Ngāti Maru, Ngāti Mutunga, Te Atiawa, Ngāti Ruanui, Taranaki, Nga Ruahine, Nga Rauru (Taranaki); and Tainui waka: Ko Mokau ki runga, Ko Tamaki ki raro, Ko Mangatoatoa ki waenganui, Pare Hauraki, Pare Waikato (Waikato).

The region covers 56,738.3km², and comprises 21% of the New Zealand land mass. Waikato DHB is the largest in size, covering 37% of the area, while Taranaki is the smallest, covering only 14% of the total region.

The total population of the Midland Region is 738,918. The distribution of the population between the DHBs is not even, with 43% of the region's population residing within the Waikato DHB area while and only 6% within the Tairāwhiti DHB area.

There are a number of main urban areas²³ in the region (Hamilton Zone, Cambridge Zone, Te Awamutu Zone, Tauranga, Rotorua, Gisborne, and New Plymouth) and a few secondary urban areas²⁴ (Tokoroa, Taupo, Whakatane, and Hawera), but a large proportion of the region's population reside in rural and isolated areas (19.2% compared to 12.2% nationally).

Table 2 : Midland Region Land Area and Population (2001)

DHB	Area in km ²	% of Region	Population	% of Region
Bay of Plenty	9,649.5	17%	178,143	24%
Lakes	9,570.4	17%	96,027	13%
Tairāwhiti	8,355.0	15%	43,977	6%
Taranaki	7,944.6	14%	103,020	14%
Waikato	21,218.8	37%	317,751	43%
Midland Region	56,738.3		738,918	

ETHNICITY

Overall, 21.9% of the region's population are Māori, 1.6% Pacific and 2.3% Asian. The percentage of Māori varies across the region, ranging from a high of 44% in Tairāwhiti, to a low of 14% in Taranaki.

The percentage of Pacific people reaches 2.1% in Waikato and Lakes but is as low as 0.6% in Taranaki, while the percentage of Asian reaches 3.3% in Waikato.

Table 3 : Midland Region Population by Ethnicity (2001)

²³ Main urban areas are very large urban areas centred in a city or major urban centre, with a minimum population of 30,000

²⁴ Secondary urban areas are very urban areas centred on large regional centres, with populations between 10,000 and 29,999

	Māori	Pacific People	Asian	Other	Grand Total
Bay of Plenty	42,633	1,815	2,847	130,848	178,143
Lakes	30,363	2,049	2,037	61,578	96,027
Tairāwhiti	19,356	648	477	23,496	43,977
Taranaki	14,592	660	1,368	86,400	103,020
Waikato	64,299	6,672	10,506	236,274	317,751
Midland	171,213	11,844	17,235	538,596	738,918
Bay of Plenty	24%	1%	2%	73%	178,143
Lakes	32%	2%	2%	64%	96,027
Tairāwhiti	44%	1%	1%	53%	43,977
Taranaki	14%	1%	1%	84%	103,020
Waikato	20%	2%	3%	74%	317,751
Midland	21.9%	1.6%	2.3%	72.9%	738,918

AGE STRUCTURE

Overall, 24% of the region's population are under 15, 13% are 15 to 24, 50% are 25 to 64 and 13% are over 65 years of age. This age structure differs between the ethnic groups in the region:

- Māori – while 38% are under 15 years of age, only 4% are over 65.
- Pacific - while 33% are under 15 years of age, only 4% are over 65.
- European/ Other – the percentage of under 15 is lower (20%) as is the percentage of youth and young adults (11%). The percentage of older persons is higher (13%).

Table 4 : Midland Region Population by Ethnicity and age (2001)

	Asian	Māori	Pacific People	Other	Grand Total
<15	4,296	64,416	3,960	107,856	180,528
15 to 24	3,714	28,878	2,124	59,793	94,509
25 to 64	8,547	71,178	5,271	284,088	369,084
65+	678	6,771	489	86,859	94,797
Total	17,235	171,243	11,844	538,596	738,918
<15	25%	38%	33%	20%	24%
15 to 24	22%	17%	18%	11%	13%
25 to 64	50%	42%	45%	53%	50%
65+	4%	4%	4%	16%	13%

POPULATION ESTIMATES AND PROJECTIONS

The region's population is expected to reach 828,210 in 2016 and 855,380 in 2026, an increase of 12.1% from 2001 to 2016 and 15.8% from 2001 to 2026.

The changes in population is not expected to be homogenous across the region, as the increase from 2001 to 2016 is expected to reach 27.3% in the Bay of Plenty, 10.3% in Lakes and 11.2% in Waikato. The population of both Tairāwhiti and Taranaki are expected to decrease over this period by 1.1% and 4.1% respectively.

Table 5 : Midland Region Population Projections (2006 to 2026)

	BOP	Lakes	Tairāwhiti	Taranaki	Waikato	Midland	New Zealand
2006	201,860	102,200	45,030	104,220	339,960	793,270	4,109,340
2011	214,540	104,260	44,330	101,750	346,980	811,860	4,248,260
2016	226,780	105,940	43,500	98,790	353,200	828,210	4,378,640
2021	238,840	107,420	42,570	95,490	359,120	843,440	4,505,880
2026	250,300	108,440	41,310	91,450	363,880	855,380	4,622,130

The ethnic composition of the region's population is expected to change during the same time period, with an expected growth of the Māori population to 27.1% in 2016 and to 29.2% in 2026, and decline in the non-Māori non-Pacific population.

These changes are not expected to be homogenous as well across the region – as Tairāwhiti is expected to experience the largest increase in Māori population (from 47.3% in 2001 to 54.1% in 2016, and Bay of Plenty the smallest increase (from 25.8% to 26.4%).

Table 6 : Midland Region Ethnic Population Projections (2001 to 2026)

	Māori	Other	Pacific	Māori	Other	Pacific
	Total Numbers			Percent of total population		
2006	201,451	581,086	13,779	25.3%	73.0%	1.7%
2011	213,092	588,126	14,566	26.1%	72.1%	1.8%
2016	225,616	592,265	15,322	27.1%	71.1%	1.8%
2021	238,497	594,444	16,055	28.1%	70.0%	1.9%
2026	251,524	593,630	16,760	29.2%	68.9%	1.9%

Statistics New Zealand projections²⁵ indicate that the combined Asian population in Hamilton City, Tauranga District and Rotorua District will double over the next five to ten years. It is expected that the Hamilton Asian population will increase to 18,800 (from the 2001 9,000), the Tauranga Asian population will increase to 5,500 (from the 2001 2,400), and the Rotorua Asian population to 3,100 (from the 2001 2,200),

Age composition projections indicate that by 2016 the percentage of child and youth (<20) will decline from 31.6% in 2001 to 26.1% in 2016, while the percentage of older persons (65+) will increase from 12.8% in 2001 to 17.3% in 2016.

Table 7 : Midland Region Population Projections by Age (2001 to 2026)

	<20	20 to 64	65+	Total	<20	20 to 64	65+
	Total Numbers				Percent of Total Population		
2001	233,151	410,967	94,776	738,894	31.6%	55.6%	12.8%
2006	241,380	443,760	108,130	793,270	30.4%	55.9%	13.6%
2011	228,420	461,270	122,170	811,860	28.1%	56.8%	15.0%
2016	216,370	468,520	143,320	828,210	26.1%	56.6%	17.3%

EDUCATION

Overall, 27% of the Midland population over 15 have no educational qualification, compared with 24% nationally. The proportions of the population with either secondary or tertiary level qualifications are lower in the Midland region compared with the national average.

Within the region, Tairāwhiti and Taranaki DHBs have the highest proportions of residents without any formal qualifications, while Waikato DHB has the highest proportion of residents with either secondary or tertiary qualifications.

There are also consistent differences between males and females – while the proportion of females with secondary qualifications are higher in all geographical areas, the proportion of males is higher in both the “no qualifications” and “tertiary qualifications” categories.

²⁵ Medium projection based on the 2001 census

Table 8 : Midland Region Highest Qualification Achieved²⁶ (2001)

	No Qualifications			Secondary qualifications			Tertiary Qualifications		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
Bay of Plenty	26%	28%	27%	35%	30%	32%	23%	26%	25%
Lakes	25%	27%	26%	34%	30%	32%	24%	26%	25%
Tairāwhiti	29%	31%	30%	32%	28%	30%	22%	23%	22%
Taranaki	29%	32%	31%	32%	27%	30%	23%	26%	24%
Waikato	26%	29%	27%	35%	30%	33%	25%	27%	26%
Midland	27%	29%	28%	34%	30%	32%	24%	26%	25%
New Zealand	23%	24%	24%	36%	33%	34%	27%	29%	28%

Māori educational qualifications are lower than that of the total population in the Midland Region, as it is in nationally and in each of the DHBs in the region. However, unlike the general population, there are no significant differences between the DHBs in the region.

There are differences between Māori males and females – while higher proportions of males have no qualifications, higher proportions of females have either secondary or tertiary qualifications.

Table 9 : Highest Qualification Achieved – Māori population²⁷ (2001)

	No Qualifications			Secondary qualifications			Tertiary Qualifications		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
Bay of Plenty	37%	41%	39%	30%	25%	28%	18%	15%	17%
Lakes	35%	39%	37%	31%	26%	28%	19%	17%	18%
Tairāwhiti	35%	40%	38%	30%	26%	28%	18%	15%	16%
Taranaki	39%	41%	40%	28%	26%	27%	18%	16%	17%
Waikato	38%	42%	40%	30%	25%	28%	18%	16%	17%
Midland	37%	41%	39%	30%	26%	28%	18%	16%	17%
New Zealand	35%	39%	37%	32%	28%	30%	19%	17%	18%

EMPLOYMENT

Unemployment rates²⁸ in the region were higher than the national average (7.5%) and reached 10.4% in Taranaki and 9.7% in Tairāwhiti. The rates for the Māori population were higher than the national average in most DHBs, especially in Tairāwhiti where unemployment rate of Māori reached 22%.

In addition to those in the labour force (either employed or unemployed) there are people who are not in labour force. In the Midland region, for both the total population and the Māori population, the percentage of people who were not in the labour force were higher than the national averages - 33% for the total population and 35% for Māori, compared with 32% nationally. This, again, varied across the region, where Bay of Plenty had the highest rate of population not in the labour force and Lakes the lowest.

²⁶ Secondary Qualifications include: Fifth Form, Sixth Form, Higher School and Other Secondary Qualifications; Tertiary Qualifications include: Vocational, Bachelor Degree and Higher Degree.

²⁷ As above.

²⁸ For the over 15 population.

Table 10 : Midland Region Unemployment Rate for Total Population

	Employed	Unemployed	Employed	Unemployed
	Total Numbers		Percent	
Bay of Plenty	143,889	12,951	92%	8.3%
Lakes	42,378	3,948	91%	8.5%
Tairawhiti	74,172	7,983	90%	9.7%
Taranaki	17,907	2,073	90%	10.4%
Waikato	46,134	3,888	92%	7.8%
Midland	324,480	30,843	91%	8.7%
New Zealand	1,727,268	139,908	93%	7.5%

Table 11 : Midland Region Unemployment Rate for Māori Population

	Employed	Unemployed	Employed	Unemployed
	Total Numbers		Percent	
Bay of Plenty	21,006	5,085	81%	19%
Lakes	10,716	2,190	83%	17%
Tairawhiti	12,993	3,681	78%	22%
Taranaki	6,387	1,413	82%	18%
Waikato	4,647	1,104	81%	19%
Midland	55,749	13,473	81%	19%
New Zealand	185,820	37,497	83%	17%

ACCESS TO TELECOMMUNICATION

Most people in the region (95%) had access to a telephone on census night, while, 24% had access to a fax machine and 32% to the Internet. Rates of access to all types of telecommunication were lowest in Tairawhiti DHB area.

Table 12 : Midland Access to Telecommunication

Area	Access to Telephone	Access to Fax Machine	Access to the Internet
Waikato DHB	95%	25%	33%
Lakes DHB	94%	25%	33%
Bay of Plenty DHB	95%	25%	32%
Tairawhiti DHB	91%	19%	25%
Taranaki DHB	96%	22%	32%
Midland	95%	24%	32%
Total NZ	96%	25%	37%

DEPRIVATION

NZDep01 is an index of socio-economic deprivation developed by the Health Services Research Centre at the Wellington School of Medicine. It is an area-based measure of deprivation combining nine variables from the 2001 Census. Variables included are as follows:

Table 13 : NZDep 2001 Variable Description

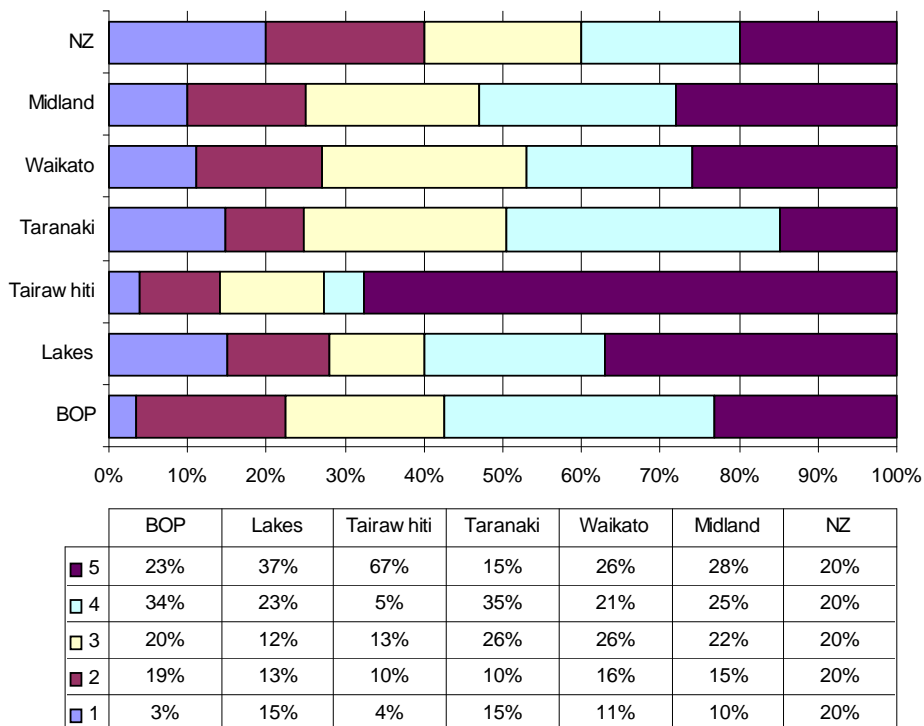
Variable Name	Variable Description
Income	People aged 18-59 receiving a means tested benefit
Employment	People aged 18-59 who are unemployed
Income	People living in households with equivalised income below and income threshold ²⁹
Communication	People with no access to a telephone
Transport	People with no access to a car
Support	People aged less than 60 living in a single parent family
Qualifications	People aged 18-59 without any qualifications
Owned home	People not living in own home
Living Space	People living in equivalised household below a bedroom occupancy threshold

NZDep01 provides a deprivation score for each mesh block in New Zealand and average scores can be calculated at higher levels (Census Area Unit, Territorial Authority, DHB, Etc). The scores can be scaled from 1 to 10, with 10 being the most deprived 10% of the country, to quintiles – 1 to 5.

More than a quarter of the region’s population (28%) reside in the highest quintile of deprivation while only 10% reside in the least deprived quintile. The region deprivation areas are not homogenously distributed:

- High deprivation - Tairawhiti DHB has the highest deprivation scores with two third of the population residing in quintile 5, while Taranaki DHB, on the other hand, has only 15% in quintile 5.
- Low deprivation – only 3% of the Bay of Plenty DHB’s population reside in quintile 1, while 15% of both Taranaki and Lakes are in quintile 1.

Figure 1 : NZDep01 Quintiles Midland Region by DHB

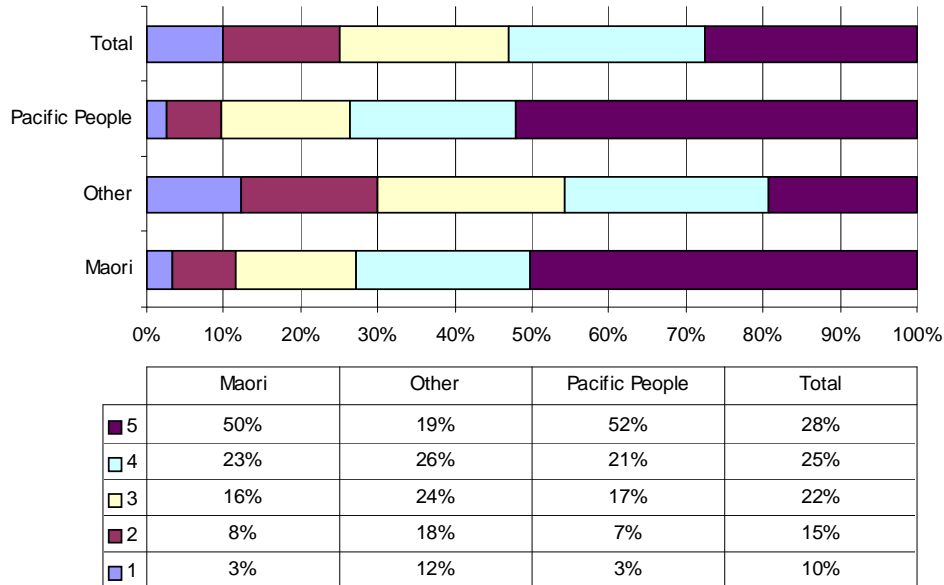


²⁹ Equivalisation is a method to control for household size and composition.

Deprivation patterns in the region differ between Māori and Pacific People and other ethnic groups.

Māori and Pacific people – about half of the population reside in the most deprived quintile in the Midland area, while only 3% reside in the least deprived areas.
 Other (non Māori/non-Pacific) – close to three quarters of the population reside in the medium deprivation areas (quintiles 2, 3 and 4), while only 19% reside in the high deprivation areas.

Figure 2 : NZDep01 Quintiles Midland Region by Ethnicity



PREVALENCE OF MENTAL ILLNESS AND ALCOHOL AND OTHER DRUGS USE

PREVALENCE OF SERIOUS MENTAL DISORDERS

There is currently no direct data on the prevalence of mental health problems in the region. Estimates can only be made from other studies conducted in New Zealand and overseas.

Blueprint Benchmarks

The *Blueprint for Mental Health Services in New Zealand* provided access benchmarks for specialist mental health services estimating that 3% of the population are most severely affected by mental illness. The benchmarks are further expanded, indicating that services should be available for 1.0% of the 0 - 9 age group, 3.9% of the 10 - 14 age group and 5.5% of the 15 - 19 age group. Applying these benchmarks to the current and projected population of the region indicates that currently (2001) there are 22,167 people in the region who need mental health specialist services. This number is expected to increase to 18,355 by 2016.

Table 14 : *Blueprint Access Targets for Midland Region 2001 to 2016*

Year	Total Population (3.0%)	0 to 9 (1.0%)	10 to 14 (3.9%)	15 to 19 (5.5%)	20+ (3.0%)
2001	22,167	1,179	2,443	2,895	15,172
2006	23,798	1,139	2,509	3,473	16,557
2011	24,356	1,060	2,354	3,415	17,503
2016	24,846	1,026	2,171	3,198	18,355

Applying the access targets to each of the DHBs in the region indicates the following:

Table 15 : *Blueprint Access Target (3%) for Midland Region's DHBs 2001 to 2016*

Year	Bay of Plenty	Lakes	Tairāwhiti	Taranaki	Waikato
2001	5,345	2,880	1,319	3,091	9,532
2006	6,056	3,066	1,351	3,127	10,199
2011	6,436	3,128	1,330	3,053	10,409
2016	6,803	3,178	1,305	2,964	10,596

New Zealand Mental Health Epidemiology Study

A major psychiatric epidemiology study is currently underway in New Zealand (NZ Mental Health Epidemiology Study: the NZ Mental Health and Wellbeing Survey, Te Rau Hinengaro³⁰). This survey involves extensive household interviews and will provide information on a range of diagnoses at regional level as well as comparative data across age, gender and ethnicity. The survey is taking place from November 2003 until October 2004 and it is expected that by 2006 a final report will be available.

New Zealand Health Survey

The recently completed New Zealand Health Survey has asked a limited number of questions around mental illness and is the most up-to-date source of local prevalence data. The survey included a self-reported health status utilizing SF-36 Health Status Questionnaire embedded within WHO's Long Form Health Status Questionnaire.

³⁰ Health Research Council of New Zealand (2003) The New Zealand Mental Health and Wellbeing Survey 2003-2004, Information Booklet. Mental Health Research and Development Strategy. Ministry of Health, Health Research Council. <http://www.mhrds.govt.nz/dyn.aspx?ID1=1&ID2=26>

The information currently available³¹ indicates that overall:

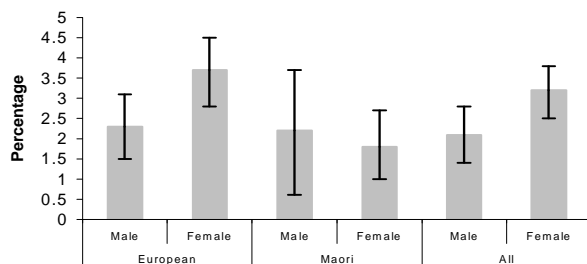
- One in 40 adults (2.5%; 2.1–2.9) had ever been diagnosed with a serious mental disorder (i.e., depressive disorder, bipolar disorder or schizophrenia).
- Depressive disorders were most common (1.9%; 1.6–2.2), followed by bipolar disorder (0.5%; 0.3–0.7) and schizophrenia (0.2%; 0.1–0.4).
- There was no significant difference in the prevalence of serious mental disorders between males (2.1%; 1.4–2.8) and females (3.2%; 2.5–3.8).

Table 16 : Prevalence (Percent) of Serious Mental Disorders, NZHS

	European/Other	Māori	Pacific	Asian	All
Male (Crude)	2.2 (1.5-2.9)	2.3 (0.7-4.0)	-	-	2.0 (1.4-2.6)
Female (Crude)	3.5 (2.8-4.2)	1.9 (1.1-2.8)	1.1 (0.0-2.2)	-	3.0 (2.4-3.6)
Male (AS ³²)	2.3 (1.5-3.1)	2.2 (0.6-3.7)	-	-	2.1 (1.4-2.8)
Female (AS)	3.7 (2.8–4.5)	1.8 (1.0–2.7)	1.8 (1.0–2.7)	-	3.2 (2.5–3.8)

Note – when ethnic groups were not represented in adequate numbers for reliable estimates results are suppressed.

Figure 3 : Prevalence of Severe Mental Illness in New Zealand by Ethnicity



Application to the Midland Region

The New Zealand Health Survey estimates the prevalence of severe mental illness in the population to be:

- 2.5% in total population
- 2.1 % in total male population
- 3.2% in total female population
- 2.2% in Māori male population
- 1.8% in Māori female population
- 1.8% in Pacific female population
- 2.3% in the non-Māori non-Pacific male population
- 3.7% in the non-Māori non-Pacific female population

When these rates are applied to the Midland region population it is estimated that currently (2001) **19,067** people in the region suffer from severe mental illness. This number is expected to increase to **19,905** in 2006, **20,392** in 2011 and **20,827** in 2016 (note that the numbers in the tables don't add up).

³¹ A Portrait of Health: Key results of the 2002/03 New Zealand Health Survey. Public Health Intelligence Occasional Bulletin No 21. Aug 2004.

³² AS- Age Standardised.

Table 17 : Estimated Numbers of People with Severe Mental Illness

		2001	2006	2011	2016
European/Other	Female	10,561	10,953	11,094	11,185
	Male	6,315	6,556	6,631	6,669
Māori	Female	1,730	1,836	1,940	2,051
	Male	2,057	2,187	2,316	2,455
Pacific	Female	114	119	127	134
	Male	-	-	-	-
Total	Female	12,412	12,949	13,269	13,559
	Male	7,870	8,223	8,421	8,597
Total Population		19,067	19,905	20,392	20,827

Table 18 : Estimated Numbers of People with Severe Mental Illness in DHBs

	BOP	Lakes	Tairāwhiti	Taranaki	Waikato	Midland
2001	4,584	2,484	1,137	2,647	8,214	19,067
2006	5,047	2,580	1,126	2,639	8,513	19,905
2011	5,371	2,635	1,108	2,579	8,699	20,392
2016	5,683	2,680	1,089	2,511	8,865	20,827

The New Zealand Health Survey further estimates the prevalence of severe mental illness in the population to be comprised of:

- 1.9% depressive disorders
- 0.5% bipolar disorders
- 0.2 schizophrenia

Applying these rates to the Midland population estimates:

Table 19 : Estimated Number of People with Severe Mental Illness in Midland

Estimated Number of People with Depressive Disorders						
	BOP	Lakes	Tairāwhiti	Taranaki	Waikato	Midland
2001	3,484	1,888	864	2,012	6,242	14,491
2006	3,836	1,961	856	2,006	6,470	15,128
2011	4,082	2,002	842	1,960	6,611	15,498
2016	4,319	2,036	828	1,908	6,737	15,829
Estimated number of people with bipolar disorders						
	BOP	Lakes	Tairāwhiti	Taranaki	Waikato	Midland
2001	917	497	227	529	1,643	3,813
2006	1,009	516	225	528	1,703	3,981
2011	1,074	527	222	516	1,740	4,078
2016	1,137	536	218	502	1,773	4,165
Estimated number of people with schizophrenia						
	BOP	Lakes	Tairāwhiti	Taranaki	Waikato	Midland
2001	367	199	91	212	657	1,525
2006	404	206	90	211	681	1,592
2011	430	211	89	206	696	1,631
2016	455	214	87	201	709	1,666

PREVALENCE OF HAZARDOUS DRINKING

Misuse of alcohol often results in considerable harm to individuals and communities including death, physical and mental health problems, injury and death on the roads, drowning, violence, fetal abnormalities, absenteeism and impaired work performance. In annual terms, the social costs of alcohol misuse in New Zealand have been estimated to be between \$1.5 billion and \$2.4 billion³³.

Ministry of Health figures indicate that from 1988 to 1996 there were between 130 and 150 deaths each year from alcohol-related conditions, including heart and liver damage, high blood pressure, cancer and digestive disorders. It is estimated that alcohol-related conditions account for 3.1% of all male deaths and 1.4% of all female deaths in New Zealand.

Alcohol is a causative factor in a number of mental health conditions, ranging from episodes of alcohol-induced psychosis to alcohol-related dementia. Dependence on alcohol constitutes a diagnosable mental disorder. It is estimated that around half of all costs attributed to alcohol involve people who meet international classifications as alcohol dependent. Alcohol dependence exists along a continuum, from mild to severe. Although problematic alcohol use is known to co-exist with other mental health problems, very little is known about the prevalence of such 'dual diagnoses'. One New Zealand study found that people with alcohol disorders were 1.9 times more likely than other people to have another mental disorder. Studies have shown that the conditions most frequently associated with alcohol use disorders were antisocial personality disorders, abuse of other substances, major depression, schizophrenia and anxiety disorders. A recent New Zealand study identified alcohol and/or drug abuse as one of the factors that predispose young people to suicide (Beautrais et al 1996).

Since the opening of casinos in New Zealand there has also been growing interest in the relationship between alcohol and gambling. Two New Zealand studies have confirmed high rates of hazardous or harmful alcohol use amongst problem gamblers, particularly pathological gamblers. Amongst gamblers identified as pathological, 48% drank in a hazardous or harmful manner, compared with 19% of those whose gambling was considered less serious.

In the NZ health survey, participants were asked questions about their alcohol consumption using the Alcohol Use Disorders Identification Test (AUDIT). The AUDIT is a 10-item questionnaire covering alcohol consumption, alcohol-related problems and abnormal drinking behaviour. It was developed by the World Health Organization as a screening tool for health professionals to identify people at risk of developing alcohol problems (not a measure for AOD secondary or tertiary care). Each question is scored from zero to four, so the questionnaire has a maximum score of 40. Hazardous drinking is defined as an established pattern of drinking that carries a high risk of future damage to physical or mental health, but has not yet resulted in significant adverse effects. Hazardous drinking is most commonly identified from an AUDIT score of eight or more.

- One in six adult drinkers (17.2%; 16.1–18.3) had a potentially hazardous drinking pattern, as indicated by an AUDIT score of eight or more.
- Male drinkers (27.1%; 24.7–29.5) were significantly more likely than female drinkers (11.4%; 10.1–12.7) to have a potentially hazardous drinking pattern.

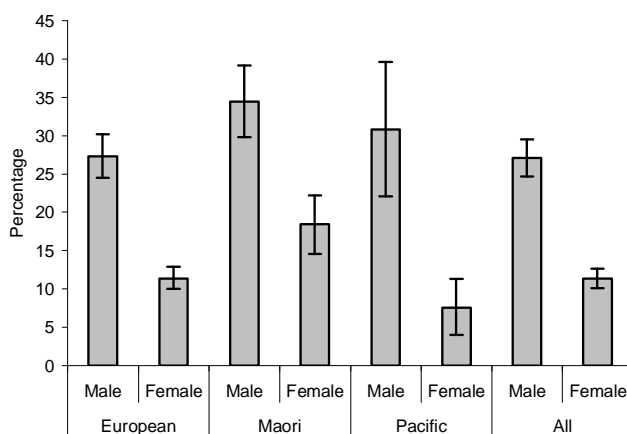
³³ National Alcohol Strategy 2000-2003. Alcohol Advisory Council of New Zealand and Ministry of Health. 2001.

- Māori, Pacific and European/Other males were significantly more likely to have a potentially hazardous drinking pattern than Asian males. Māori females were significantly more likely to have a potentially hazardous drinking pattern than females from all other ethnic groups.
- In both males and females, the proportion of adult drinkers with a potentially hazardous drinking pattern was highest in the 15–24 years age group, and then decreased with age. In both males and females.
- The proportion of adult drinkers with a potentially hazardous drinking pattern was slightly higher in NZDep2001 quintile 5 (most deprived) than in quintile 1 (least deprived), although these differences were not significant.

Table 20 : Prevalence (Percent) Hazardous Drinking Pattern in Drinkers, NZHS

	European/Other	Māori	Pacific	Asian	All
Male (Crude)	24.6 (22.3–26.9)	38.0 (32.7–43.2)	32.5 (23.9–41.1)	7.5 (3.7–11.3)	25.4 (23.4–27.4)
Female (Crude)	8.8 (7.7–9.9)	20.6 (16.3–24.8)	8.7 (4.6–12.8)	-	9.7 (8.6–10.7)
Male (AS)	27.3 (24.5–30.2)	34.5 (29.8–39.2)	30.8 (22.1–39.6)	6.8 (3.5–10.1)	27.1 (24.7–29.5)
Female (AS)	11.4 (10.0–12.9)	18.4 (14.6–22.2)	7.6 (4.0–11.3)	-	11.4 (10.1–12.7)

Figure 4 : Prevalence of Hazardous Drinking in New Zealand by Ethnicity



Application to the Midland Region

The New Zealand Health Survey estimates the prevalence drinking in the population to be:

- 83.5% in total population
- 88.5 % in total male population
- 80.3% in total female population

And the prevalence of hazardous drinking in the drinking population to be:

- 17.2% in total population
- 27.1 % in total male population
- 11.4% in total female population

Applying these rates to the Midland population estimates:

Table 21 : Estimated Number of People with Hazardous Drinking Behaviour

Year	BOP	Lakes	Tairawhiti	Taranaki	Waikato	Midland
Female						
2001	8,603	4,628	2,116	4,919	15,241	35,507
2006	9,459	4,808	2,100	4,907	15,769	37,042
2011	10,065	4,908	2,066	4,802	16,118	37,959
2016	10,649	4,996	2,031	4,679	16,432	38,788
Male						
2001	21,438	11,706	5,368	12,506	38,868	89,886
2006	23,641	12,155	5,303	12,462	40,352	93,913
2011	25,159	12,416	5,218	12,164	41,220	96,178
2016	26,617	12,615	5,128	11,830	41,995	98,185
Total						
2001	30,041	16,335	7,484	17,426	54,108	125,393
2006	33,100	16,963	7,402	17,369	56,121	130,955
2011	35,225	17,325	7,283	16,966	57,338	134,137
2016	37,266	17,612	7,159	16,509	58,427	136,972

PREVALENCE OF DRUG USE

The use of illicit and other drugs results in serious harm to many New Zealanders' health as well as crime and other forms of social disruption. Harm to health includes deaths associated with drug use, illness and disease, and accidents and injuries. Intravenous injection of drugs can result in the transmission of blood-borne viruses, such as hepatitis and HIV, which potentially threatens the whole community through the risk of infectious diseases being spread throughout the population. Crime is also associated with drug use in a number of ways. Illicit drugs involve individuals in criminal activities – users by obtaining the drug and sometimes in criminal activities to support their drug use, and other individuals through involvement in supplying the drug to the user. Drug use affects the life of the family and the community in which the individual lives, as well as the individual user. Excessive use of drugs can lead to reduced social functioning at home, with dysfunctional behaviour affecting the behaviour of other members of the family, at school and in the community generally. It can also lead to accidents as well as reduced productivity at work³⁴.

Information on drug use was obtained from a number of sources. While the New Zealand Health Survey asked respondents to report about their marijuana smoking, additional information was available from surveys conducted by the Alcohol and Public Health Research Unit (APHRU) of the University of Auckland, including the **1998 National Drug Survey** which sampled 5,475 people aged between 15 and 45 years and the **Regional Drug Surveys** which obtained information on alcohol, tobacco, marijuana and other drugs were and conducted in two regions — Auckland and Bay of Plenty — in 1990 and 1998. These sampled approximately 5000 people aged between 15 and 45 years³⁵.

Prevalence of Marijuana Smoking

The New Zealand Health Survey asked respondents to report about their marijuana smoking.

³⁴ National Drug Policy. Ministry of Health. 1998.

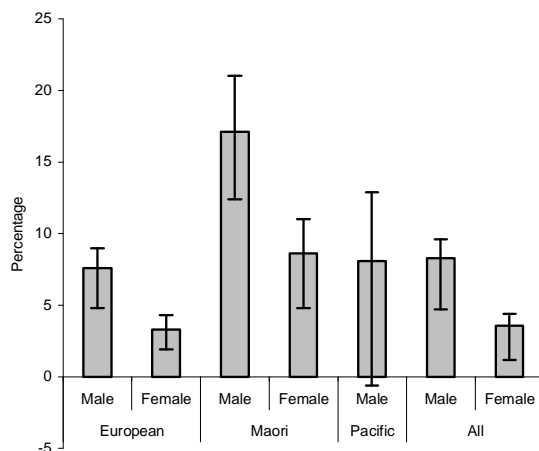
³⁵ New Zealand Drug Statistics. Ministry of Health. 2001.

- Overall, one in seven adults (14.2%; 13.2–15.1) had smoked marijuana in the last year and one in 19 adults (5.3%; 4.6–5.9) smoked marijuana regularly (i.e., daily, weekly or fortnightly).
- Males (8.3%; 6.9–9.6) were significantly more likely than females (3.6%; 2.8–4.4) to smoke marijuana regularly.
- In both males and females who are regular marijuana smokers, Māori were significantly more likely than other ethnic groups to smoke marijuana regularly.
- In both males and females who are regular marijuana smokers, adults aged 15–24 years were most likely to smoke marijuana regularly.
- In both males and females who are regular marijuana smokers, there was no significant difference in the proportion of adults who regularly smoke marijuana between NZDep2001 quintile 1 (least deprived) and quintile 5 (most deprived).

Table 22 : Prevalence (Percent) of Regular Marijuana Use, NZHS

	European/Other	Māori	Pacific	Asian	All
Male (Crude)	6.3 (5.2–7.5)	19.9 (15.2–24.5)	9.7 (4.0–15.4)	-	7.7 (6.5–8.8)
Female (Crude)	2.4 (1.7–3.1)	10.0 (7.3–12.7)	-	-	3.1 (2.5–3.7)
Male (AS)	7.6 (6.1–9.0)	17.1 (13.2–21.0)	8.1 (3.4–12.9)	-	8.3 (6.9–9.6)
Female (AS)	3.3 (2.3–4.3)	8.6 (6.3–11.0)	-	-	3.6 (2.8–4.4)

Figure 5 : Prevalence of Regular Marijuana Use in New Zealand by Ethnicity



Application to the Midland Region

The New Zealand Health Survey estimates the prevalence or regular marijuana smoking in the population to be:

- 5.3% of total population
- 8.3% of males
- 3.6% of females

Applying these rates to the Midland population estimates:

Table 23 : Estimated Number of People who Smoke Marijuana Regularly

Year	BOP	Lakes	Tairāwhiti	Taranaki	Waikato	Midland
Female						
2001	3,383	1,820	832	1,935	5,994	13,964
2006	3,720	1,891	826	1,930	6,201	14,567
2011	3,958	1,930	812	1,888	6,339	14,928
2016	4,188	1,965	799	1,840	6,462	15,254
Male						
2001	7,419	4,051	1,858	4,328	13,451	31,107
2006	8,181	4,206	1,835	4,313	13,965	32,500
2011	8,707	4,297	1,806	4,210	14,265	33,284
2016	9,211	4,366	1,775	4,094	14,533	33,979
Total						
2001	10,802	5,871	2,690	6,263	19,445	45,071
2006	11,901	6,097	2,661	6,242	20,166	47,068
2011	12,665	6,227	2,618	6,098	20,604	48,212
2016	13,399	6,331	2,573	5,934	20,995	49,233

Other Illicit Drugs

Other illicit drug include stimulants (amphetamines and methamphetamines), cocaine and or crack cocaine, designer drugs (ecstasy, amyl nitrate and butyl nitrite/rush/poppers, ketamine/K /special K, GHB/fantasy, and 1,4 butanediol), hallucinogens (LSD, mushrooms) and opioids (heroin, morphine and opium). The patterns of use and the consequences of each drug vary and change over time,

The National Drug Survey (1998) and the Regional Drug Surveys (1990 and 1998) of the population 15 to 45 indicate that:

- Opium and its derivatives had been tried by 4% while 1% had used the drug in the previous year.
- Hallucinogens were tried by 13% at some time and 5% had used these drugs in the past year.
- The use of LSD by 18-24-year olds in the previous year grew from 5% in 1990 to 11% in 1998.
- Nine percent (11% of men, 7% of women) had tried stimulants at some time while three percent had used stimulants in the last year.
- There were 2,012 apprehensions in 2000 for offences related to illicit drugs other than cannabis. The number of prosecutions in 1998 was 1,829, resulting in 1,049 convictions nationally.
- Between 1990 and 1996 there were 156 opiate-related deaths and 2 hallucinogen related deaths nationally.
- Between 1996 and 1998 there were 3,955 opiate-related publicly funded hospitalisations, 343 hallucinogen-related publicly funded hospitalisations and 109 stimulant-related. Twenty-three of these were due to cocaine, and the rest due to amphetamines.

Recent statistics indicate increase in use of designer drugs³⁶. A 2001 survey noted:

- Last year use of ketamine for 20-24-year-olds reached 1.8%.
- Last year use of GHB was most common for men aged 18-19 years (4.4%) and 20-24 years (2.7%), and women 20-24 years old (1.7%).

³⁶ New Zealand Drug Foundation Website (www.nzdf.org.nz)

- The use of stimulants amyl nitrite and butyl nitrate, commonly called rush or poppers: 4.7% ever tried in 2001; 0.9% used last year in 2001; and 0.5% current user in 2001. Last year use of rush was most common for men (5.9%) and women (2.5%) aged 18-19 years.

PREVALENCE OF SUICIDE AND SELF-HARM

The consequences of suicide and suicide attempts include premature loss of life, medical, surgical, mental health and rehabilitative services to those attempting suicide, bereavement and other psychological impacts on family and others closely involved with individuals making fatal or non-fatal suicide attempts and loss of productivity for those involved in the suicidal behaviour and those affected by it³⁷.

Suicide is rarely the response to a single stress but rather the outcome of a culmination of stressors and adverse life-course sequences in a person with few protective factors to draw upon and whose resilience may be compromised. Socioeconomically disadvantaged background, childhood physical or sexual abuse, poor parent-child relationships, loss of a parent through separation or divorce, and suicide or violence in the family are common risk factors.

Mental disorders and Suicide

Evidence on the linkage between mental illness and suicide/ self harm derived mainly from research on youth suicide. Most suicidal behaviour occurs in the context of mental illness and mental illness is the strongest risk factor for suicidal behaviour. The clear majority of those who die by suicide or make serious suicide attempts have at least one diagnosable psychiatric disorder at the time of their attempt. The most common disorders are mood or affective disorders (including depression and bipolar disorder). Other disorders include alcohol and other substance use disorders, antisocial behaviours (including conduct disorder and antisocial personality disorder) and, much less commonly, anxiety disorders. While psychotic disorders (including schizophrenia) occur infrequently in the general population, amongst the small group with these disorders the risk of suicide is high.

Frequently, those with serious suicidal behaviour have co-morbid (or co-occurring) mental disorders. Most commonly, the disorders that co-occur are depression and substance use disorder. Those with more than one disorder, compared with those with a single disorder, tend to have markedly increased risks of suicidal behaviour. Those with serious suicidal behaviour often have a history of previous suicide attempts, and of inpatient or outpatient care for mental health problems. Young males who have made a prior suicide attempt are at particularly high risk of suicide. Other suggested risk factors are discrimination and negative attitudes towards people with mental illness and a lack of awareness of available services. These factors may cause isolation, loneliness and delays in seeking help.

Suicide in the Midland Region

The number of suicides in the region fluctuated over the last 14 years between a low of 73 (1989) and a high of 129 (1998). The latest mortality statistics show that in 2001 there were 106 recorded suicides in the region. Similarly the rates fluctuated between a low of 10.6 per 100,000 population (1989) to a high of 17.1 per a 100,000 population (1998). The rate for 2001 was 12.7. If a trend-line is applied to the rate, a small gradual increase can be seen.

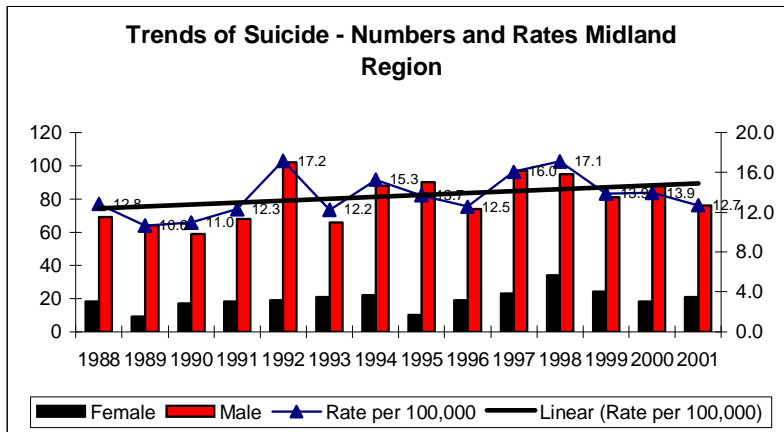
There is a large difference between male and female suicide trends. On an average, more than 4 times as much suicides are completed by males than females.

³⁷ Suicide Tool Kit. Ministry of Health. 2001.

Table 24 : Suicide Numbers and Rates per 100,000 population

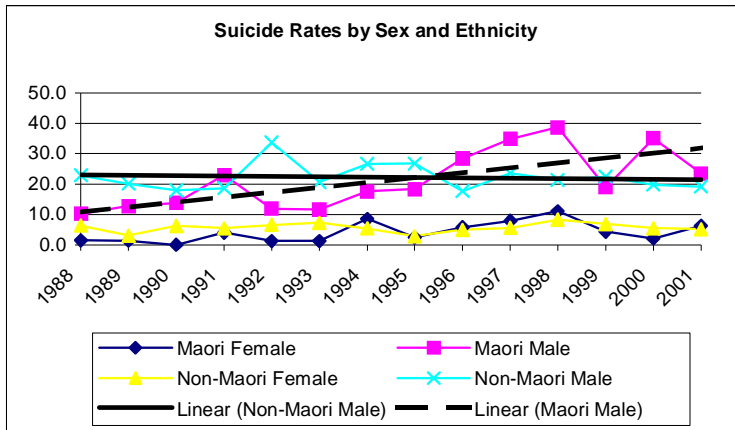
Year	Female	Male	Total	Rate per 100,000
1988	18	69	87	12.8
1989	9	64	73	10.6
1990	17	59	76	11.0
1991	18	68	86	12.3
1992	19	102	121	17.2
1993	21	66	87	12.2
1994	22	88	110	15.3
1995	10	90	100	13.7
1996	19	74	93	12.5
1997	23	97	120	16.0
1998	34	95	129	17.1
1999	24	81	105	13.9
2000	18	88	106	13.9
2001	21	76	97	12.7

Figure 6 : Trend in suicide numbers and rates



The rates of suicide differ between male and female and between Māori and non-Māori. While the rates among female (Māori and non-Māori) are low and steady, the rates for Māori male are increasing and the rates for non-Māori male are steady but higher than that of other groups.

Figure 7 : Trend in suicide rates by sex and ethnicity



CONSULTATION WITH KEY STAKEHOLDERS

During August to October 2004 planning sessions were held with each of the Midland region stakeholders groups. Some sessions were facilitated by external facilitators while other were aided by staff. In the last meeting, the Midland Region Mental Health and Addiction Planning Day, delegates from each of the regional forums engaged in a facilitated strategic planning workshop. During the day, participants discussed the mental health and addiction issues, gaps and needs of the Midland Region, and identified priorities for the next five to 10 years.

The following is a summary of the issues raised during the meetings. The full minutes of all stakeholders meetings are in Appendix A.

OVERALL SUMMARY

Vision

Mental health system that is flexible and responsive and builds on Partnership, participation/protection -

1. Focused on the consumer
2. Whānau ora, Tapa Wha
3. Accessible service system across primary, secondary, tertiary levels
4. Supporting workforce development
5. Building on collaboration

To do so we need to go through positive evolution and develop informed leadership and overcome -

- o Disconnected funding system – public health, DSS, mental health, primary care
- o Rigid service specifications
- o Funding that is not aligned to needs
- o Inequity of funding
- o Mind set changes from medical to non-medical, from social disability to ability
- o Provide options and choices including cultural assessment tools

MIDLAND REGION CONSUMER ADVISORY GROUP

Where is the Mental Health Service Development going?

- Consumer for consumer/ by tangata whaiora for tangata whaiora services
- More collaboration/ communication & interface with: primary care and intersectorial
- Needs tangata whaiora to input into development
- Use a health promotion approach
- More holistic approach with regards to support, community involvement, the range of services available, housing
- Po te Atatu Māori Mental Health services
- Packages of care plan – Holistic wrap around service

Where is Workforce Development going?

- Holistic Māori models of practice – how best we work with Māori
- Develop the tangata whaiora to do the work!
- Holistic core, Core competencies, Recovery workshops
- The medical model is NOT the only way!

- Seen tangata whaiora disempowered by mainstream training. Steps and a continuum of support needed for training within mental health

Prioritise consumer needs for the 05-06 Plan

- Midland mental health consumer network is a HIGH PRIORITY!
- Mental health staff and consumers need to be recovery-focused
- Much more ownership of client support plans
- Parents to be peer supported
- More collaboration, power, resources, tangata whaiora help, tangata whaiora peer support services to be encouraged/ created
- More possibilities, tangata whaiora upskilling and training interested in for employed tangata whaiora
- Maternity services gaps, child services gaps, adolescent services gaps
- Wellness Recovery Action Plan (WRAP)
- Independent policy involvement

MIDLAND REGIONAL MĀORI ADVISORY GROUP

Regional Priorities

- Workforce Development
- Wananga I te reo me ona tikanga - Recover
- Economic Business Development
- Participation of Māori at every DHB level that influence Māori mental health
- Tino rangitiratanga reflected in policy
- Development of Māori owned research by Māori for Māori – Evidence based practice
- Māori Leadership
- Alliances with other indigenous peoples/non Māori
- Information
 - Government strategic direction
 - What does the Māori workforce look like
 - Data relevant to inform decision making

Priorities for 2009

- Service Specs need to be reviewed
- Effective Māori participation/control in every area that influences Māori mental health
- Leadership – Growing, consolidating, mentorship, tino rangatiratanga reflected
- Information (scope, status quo, across specific spectrum e.g. workforce)
- Māori owned research and evidence
- Māori quality monitoring framework to be developed and implemented

Priorities for 2014

- Be in my own home, close to my whānau with access to good health services when I need them
- Economic business development
- Leadership – growing, consolidating, mentorship
- Wananga I te reo me ona tikanga - Recovery
- Alliances with other indigenous peoples

Vision - Kia tu pakari, tu maea te tangata I roto I tona ao ma te ora o te hinengaro, te wairua te whānau me te hapu, ka ora te tangata

First Steps:

1. Become informed re: Policy and other documents
2. Adjust business/strategic plans to reflect moemoea
3. Wananga – Personal and professional development
4. Promote the vision – Know it!
5. From hui – stakeholder workshop in October – support good membership on local advisory groups

MIDLAND REGION PACIFIC NETWORK

Planning

- 2002/03 and 2003/04 regional plans objectives for Pacific People were not implemented.
- The 2004/05 objectives are similar but worded differently:
 - Resource Regional Co-coordinator
 - Commitment that the Pacific portion of the RMH&A plan will be actioned.

Regional Priorities

- Develop a framework for providing services that are culturally appropriate and responsive to the needs of Pacific peoples.
- Identify appropriate Models of Care
- Develop a regional Pacific workforce plan
- Recruitment, retention and training for Pacific people workforce and other working with Pacific peoples
- Long-term: 'Pacific for Pacific'
- Link Pacific mental health development between DHBs
- Create sustainable capacity building for Pacific People
- Link with Regional Advisory Group and provide advice and direction to Midland DHBs

Major Issues

- Recruitment and retention of Pacific mental health workforce
- Improve mental health responsiveness to Pacific
- Increase capacity of Pacific AOD especially for child & youth (8 to 18)
- Overall mental health services for child & youth, especially the 8 to 18
- Specific Pacific cultural competency form main stream child & youth sector
- Mental health services by Pacific for Pacific
- Urgent need to educate the Pacific community about mental health
- Community development
- Networking
- De-stigmatisation
- "Selling" mental health to the Pacific community
- Encourage young Pacific people to train in the mental health field
- **Pacific consumers' perspectives**
 - o Need Pacific providers
 - o Prefer traditional healing
 - o On-going support not just treatment
 - o Support families with information
 - o Support individuals around their own cultural needs
 - o Education

- Recruitment and retention
- Providers capacity
- Intersectoral involvement (corrections)

MIDLAND REGION GROUP ADVISING FAMILIES

What do we want from the stakeholder planning workshop?

- Recovery approach requires a combination of service user leadership and the engagement of families, whānau and communities
- Services in the midland region that are more holistic, flexible, and culturally sensitive, inclusive of families and the community

Our Vision

- Family input at all levels of the DHB to ensure immediate support needs of families are met so that families can play a constructive role in the treatment options for their family member
- That the family voice is heard in service development and captured in policy and planning
- Family is included in quality improvement and involved in complaints and audits
- All health professionals have an opportunity to learn what it is like to be a family member
- NGOs continue to provide independent individual advocacy
- Ongoing support for families when consumers have moved on from the acute phase

What needs to happen?

- Families and whānau need services, information, education and /or counseling so that they can support their family member's recovery
- Families differ according to the life stage of their family member:
 - Families of up to 18 on first presentation – need information about the disorder/s that is delivered in a way that is sensitive and helpful to them, need help to manage their own emotional distress and learn how to cope with difficult and/or challenging behaviour, help in understanding the services and the various roles of the health professionals, know who to contact with questions or for help, Know where to go to become upskilled in areas where they may be expected to play a role in the care of their family member, Guidance on when to pull back
 - Families of adults, 18-plus may need education or information about new treatment options, engagement, have their knowledge recognised and valued, respite options and counselling
 - Families of older people 65-plus may need education/information about the various disorders, support, information on how to deal with a physically and mentally frail person, practical support, support in balancing the needs of children, grandchildren and partners with the needs of an elderly frail person
- A key issue is lack of appropriate respite options
- DHBs that make up Midland region need to recognise that NGO services are providing more than what they are funded for and fund them more appropriately
- Family support services for the DHBs are already at breaking point
- Facing increased reporting and data collection requirements from the DHBs without funding to assist

MIDLAND REGION ALCOHOL AND OTHER DRUGS FORUM

Issues

- Links with mental health
- Residential services – access, geographical
- Workforce development, upskilling, retention, recruitment
- Dual diagnosis/multiple diagnosis/head injuries ID
- A need to be careful with disciplines setting up against each other
- Services for people returning home to family/community after treatment need continuous support
- Involving families in treatment and planning they need to believe and support the treatment and able to access
- Are assessment criteria for residential appropriate

Issues prioritised

1. Residential
2. Workforce development
3. Provision of service across the continuum
4. What does “recovery focus” mean for AOD? Consumer participation

Residential

- What does the consumer want?
- Recovery in a safe environment
- Limited intervention in a community setting
- Timely access
- Local options close to family and children
- Choice of treatment/therapies
- What do providers want?
- One criteria for access
- Dual diagnosis criteria
- Family access, involvement in treatment
- Good coordination of access to services
- Continuum of care – entry and exit
- Additional services
- Taha Māori
- Sub acute services
- Credentialing of services
- Standardised assessment tool for entry
- Strengthen communication between providers referring to treatment and back again

Workforce Development

- Increasing professionalism of sector – drive philosophical shift
- Intersectoral and inter organisational collaboration
- Career pathway for workforce
- Minimum entry level
- Integration of NGO and provider arm of DHBs
- Need for shift in attitude of management – employ generic counselors

Mental Health and AOD

- Workforce development and cross training (every door is the right door)
- Adequate funding
- Outcome measures – what is it
- Integration and collaboration – respecting each other

MIDLAND REGION CHILD AND ADOLESCENT TAMARIKI RANGATAHI FORUM

Priority issues

1. Workforce development
2. Integration and intersectoral development inclusive of primary health developments
3. Adequate Resourcing and service development at least at Blueprint level

Workforce Development

- Minimise clinicians time used in administration roles
- Retention of clinical staff a problem
- Improved (local) access to training \$\$ CTA
- Recruitment – costly, minimal pool of skilled clinicians for 40-50% turnover
- Need to stake a claim – Mental Health adult services dominate
- Managers/team leaders also need support, training and recognition of their key roles

Integration and Intersectoral Development

- No dedicated resource to enable it to happen although all the documents outline it as a strategy for service development
- Time consuming and pivotal to outcomes, is this adequately recognised in the way services are funded/expected number of clients seen?

Resources – Service Development

- Services should be adequately funded to deliver core business
- Consistent core business investment throughout region as a baseline – building blocks
- Clients with an Intellectual Disability
- Forensic Services for youth – needs consistent funding through region not just 2FTE in Waikato
- Maternal mental health services need to integrate/have a close working relationship with CAMHS and the development of a service for infant mental health
- Kids with parents with mental health issues – need services
- Significant health issues with related mental health issues. diabetes, cancer, serious accidents
- Consumer inclusiveness – development required throughout region
- Regional service – Inpatient beds in Midland may include general admissions for eating disorders, forensic, a regional consultancy service for eating disorders and some serious forensic cases may be useful.

MIDLAND REGION GENERAL MANAGERS AND CLINICAL DIRECTORS

Workforce development

- A “non-poaching” approach between DHBs
- Involvement of mental health workforce
- Take leadership in researching and providing evidence for changes in the system
- Upskilling of staff with potential who usually not accessing development opportunities

Current constraints of mental health system

- Theory vs. Practical reality
- Loss of expertise due to policies

- Competing demands on clinicians

What progress have we seen locally and regionally over the last five to 10 years?

- We are working regionally and appreciate the benefits of regional collaboration
- Regional network is beneficial but sometimes more difficult for smaller DHBs to keep up due to added MoH pressures, intersectoral activities and overall lack of resources
- Clinical governance is working well within provider arms and there are systems to deal with clinical risk. There is no similar mechanism within NGOs as they don't have clinical governance but have the risk
- Regional capacity increased but not sufficient to fulfill all the requirements of the 2nd mental health plan

What are the gaps we have in the system?

- Specific dilemmas regarding building collaborations because of the number of contracts in the area
- Research and evaluation – how to create more effective contribution from NGOs
- System is currently fragmented
- Use of technology – can expand the use of telemedicine/ telepsychiatry
- Mental health funding is treated in isolation
- Lack of regional specialist services i.e. eating disorders, personality/ borderline, maternity mental health
- Haven't resolved yet the residential for high and complex needs
- Service schedule framework is very ambiguous
- No re-integration / transitional planning for patients
- Training and education for staff of general mental health services on special needs
- Shortage of resource at all levels including the funder level, mental health management level
- Gaps in access to ID/mental health services
- Gaps in access to A&D services
- Gaps in services to Pacific people or Asian
- Fix up the system not just add more \$\$ to a system that might not be working well

Principles for the future (Key themes, overarching concerns around funding)

- Funding for integration not for fragmentation
- Progress on the issue of mental health service delivery by primary health care sector
- Give high priority to the implementation of MHSMART
- Workforce – use more innovative approaches to workforce planning
- Use generic training across the sector so NGOs can also benefit
- Review the outcomes of the 0800 initiative for reassessment and screening
- Review what should an integrated system look like?

MIDLAND REGION MENTAL HEALTH AND ADDICTION PLANNING DAY

Focus on the consumer

- o Recovery
- o Build consumers' resiliency through de-stig, peer support, advocacy
- o Consumers' responsibility to be recognised and acknowledged
- o Participation and empowerment of consumers to drive their recovery, e.g. Input into all decision making levels including planning, funding, management

and governance, and the development of individual treatment plans, advance directives, family therapy and cultural activities

Whānau ora, Tapa Wha

- Inclusive system – whānaungatanga³⁸ / kotahitanga³⁹
- Holistic mental health care for the whole family – physical, mental, social and family
- Model of the person “ko au”⁴⁰
- Continuity of care including practical support (i.e. housing, social, income, employment)

Accessible service system

- Focus of the needs of service users and whānau rather than focus on organisations needs
- Limit or remove barriers
 - “Every door is the right door” – access not just through one way, variety of locations and hours of service
 - Social inclusion
 - Information
- Alternative systems

Supporting workforce development

- Training and retention
- Attitude change
- Essential skills
- Psycho education
- Interventions that are goal oriented
- Primary health care settings as the first contact
- Sustained training in evidence based community holistic intersectorial consumer orientated interventions

Building on intra and inter sectoral collaboration, integration and human kindness to foster strong networks and combine resources when possible

- Health – provider arm, NGOs, primary health, public health, DSS
- WINZ
- Corrections
- Justice
- Education / schools
- CYFS
- Police
- Housing Corp
- Whānau, hapu and iwi

What happened over the last ten years?

- Consumer voice grow
- Legislation changed
- Broader range of services
- Health system changed
- Recovery model

³⁸ Family relationships

³⁹ Coming together as one

⁴⁰ Ko Au - it is I

What do we want to have in 2014?

→Focus on the Consumer

Employment

- Consumer run services especially support area; equal recognition in employment as mental health service employer; extra support for employers with mental health needs; pay parity

Empowerment

- Choice in basics of life – a stable job, food, living arrangements
- Consumer involvement in all levels of advice, advocacy, decision making, leadership, governance, and management, from grassroots to government, and within all mental health services including C&Y, A&D
- Effective independent consumer network working collaboratively with other mental health services will facilitate reduction in isolation, information sharing and increase activity within services
- Increased self-responsibility
- Increasing life span for consumers e.g. physical well being, healthy diet, decreased smoking
- Mentals mentoring (role modeling)

Society

- Acceptance, normalisation, de-stigmatisation and recovery

System

- Consumers are well supported in ways they need to in order to led rich and full lives
- Every door is the right door
- Focusing on supporting the consumer whose mental illness is part of life not life
- Identity of individual will be determined by persons potential rather than illness
- Integrated service providers (NGO)
- Multi-system involvement – case management approach
- Responsive services – acknowledge everyone does it differently – service users see ‘holistic’ in their own paradigm
- Services designed around the needs of consumers (including demographics) to ensure the right supports are provided
- Strengths based approach to service provision
- Supports, including respite for children of parents with mental illness and for parents of children with mental illness

→Whānau Ora, Tapa Wha

Basic skills

- Families need to have skill base, need to be valued, wider whānau do have skills and can bring family together - family are naturally involved and groups are connected better
- Education – innovation ways of interaction/having conversations e.g. email, phone

Whānau involvement

- Families often don't deal with mental health issues because of stigma/whakama. Māori like to deal with unwellness within their own families. Need connectedness within their whānau
- Family communication important
- Family process is parallel to that of client
- Training and education to support the family not just the clients
- Family/whānau intrinsically part of recovery – listened to, valued
- Full family inclusion within mental health services - whānaungatanga/kotahitanga
- Helping by being
- Family needs to have Information on how to access services in the most appropriate ways
- Family not necessarily blood ties, family is who ever the service user chooses

Community development

- Community information
- House, job and connected to communities

Options

- Issues urban/rural Māori – connectedness – options for Māori also for mainstream. Not all Māori want Māori delivered services. Want Māori services in mainstream
- Mental health continuum

Leadership

- Mana motuhake
- Rangatiratanga (self determination)
- Manaakitanga (respect)
- People family centered

Holistic approach

- Physical, mental, social, family
- Whole of health approach - Te Whare Tapa Wha – and connection across other sectors - Housing, Education, WINZ, MSD, Justice
- Aroha (love)

→ Accessible Service System

Service availability

- Providers should not be gate keepers
- Access to services should be through a variety of ways – any door is the right door
- Services to be available at the time of day and place that suits the consumer e.g. after hours for those who work, use technology (e-mail, telepsychiatry)
- Rural communities – one stop shop – provides linkages across services and sectors

Continuum of services

- Focusing on recovery in the community
- Access a continuum of mental health care easily
- We need to know what the continuum looks like and be able to articulate it – monitor and audit
- Provide holistic/ healing centres for first time consumers
- Respect for diversity and ‘social inclusiveness’ – provide access to diverse models of diverse treatments
- Educate the community about mental illness
- Early intervention – teaching skills for coping before needing specialist services
- Health promotion needs to be standard procedure

Funding

- Build new services then phase out the old
- Ensure capacity to be aligned with expectations
- Outcome based funding rather than number
- Put the ‘health’ back in mental health
- Redefinition of what sits in primary and secondary services
- Service cultures –align with policy/philosophy

Quality

- Evidence based services, including ongoing evaluating and reflective practice development
- Information gathering and distribution (for providers and for communities) - right information at the right time
- Move away from economic decision re innovations, best practice, and latest medications to consumer need driven decisions. Look at individual outcomes

A& D

- Clarity around spectrum of care for A&D

- Collaboration with other A&D providers, other mental health areas, and other health and non-health sectors
- More supports in community can reduce the need for medical intervention
- Increased social responsibility will result in decreased need for mental health and addiction services – what are the contributing factors for addiction?
- More community services to enable rapid exits back to community
- Lack of other interventions e.g. respite, consumer driven services that are supported by mainstream providers
- Lack of general dual diagnosis (A&D and mental health) services

C&A

- Children of parents with mental illness often function as caregivers and need support
- Need for respite options for parents of children with mental illness
- Increasing numbers of young people who need more “youth-friendly” services
- Less case load for C&A workers as include families in therapy – need to factor the intersect oral ramifications on workload
- Less fragmentation, improved continuity of care
- Support for children of clients
- More resources to support families of children with mental illness so families themselves do not become users of adult system

Specific groups

- Aged population
- ID needs
- Māori
- PI
- Specialist services

Families

- Connectedness for consumer into a family or group is left to individual
- Look at family as whole unit
- Respite care for families
- Resourcing and educating families

Primary health care

Stronger linkages with the primary health care system –

- Mental health professionals / community specialist services can be based in PHOs
- Screening of general population for mental health problems in primary health care settings

→Supporting Workforce Development

Clinical vs. non-clinical

- Basic skills are needed, not just clinical based practice
- Clinical cross over
- Clinical governance
- Common sense rather than robotic
- Counseling i.e. Social work, Talking therapy
- Improved pharmacology
- Less focus on medical - include more holistic therapies
- Meeting basic needs of consumers –not just technicalities (medial qualifications) to treat
- Reduce medication

Development

- Each discipline should have input into their workforce development with a common framework

Family

- Basic skills should be recognised within family unit including children

Recruitment

- Ground level recruitment to address aging workforce

Retention

- High turnover in mental health especially C&Y

Training

- Academic training of nursing and social work and allied health to include mental health component including recovery, relationships and structured psycho education
- Meet regularly to discuss training opportunities coming up
- Current training is too technical for A&D workforce
- Training needs analysis, evaluation and reflective practice
- Training of people with A&D experience to work in the field
- Workforce should be Well trained and responsive who want to work in mental health
- Workforce with excellence in clinical skills and recovery focused

Work environment

- Healthy work environment
- Incentives to stay in clinical vs. managerial roles
- Staff well trained and wanting to work in mental health environment that is safe and enjoyable

Infrastructural Development

- Backfill of staff when staff attending training.
- Develop a Planning culture
- Develop Regional vision
- Training Coordinators required in each DHB district – connect with Regional WDC
- Regional orientation for overseas staff
- Regional workforce coordination required to reduce duplication and improve efficiency

Organisational Development

- Implementation and follow up within organisation after training attended. Develop learning workplace that engages in new information/training and takes a proactive role in implementation and revision
- Valuing staff – organisational culture, acknowledge feedback, flexibility in hours, terms etc, remuneration, increase access to individually tailored training and development, establish advancement pathways, develop culture of affirmation and success
- Alignment between MH philosophy/policies and directions and staff attitudes and beliefs
- Develop mechanisms for staff led strategic and organisational improvement
- Improve utilisation of IT for maximum benefit
- Improve Performance reviews and mechanisms

Recruitment and Retention

- Develop attractive culture that attracts and retains membership
- Review current practices in DHB and NGO

Training and Development

- Training Needs Analysis
- Address workforce basic skills
- Training information dissemination in the workplace – how do we ensure that the knowledge stays when a staff member leaves the organisation
- Training to address employed staff and whānau, consumer and voluntary sector
- Improve utilisation of IT
- Develop coordination of training and flexible training options
- Develop DBT and CBT workforce
- Develop Dual diagnosis workforce skills

Research and Evaluation

- Evaluate organisations with good staff retention – estimate benchmark and best practice.
- Match service design to skill base required to achieve service delivery – creation of new roles
- Explore systems developments and the relationship between national services frameworks and the workforce
- Measure health of workforce
- Track workforce movement and trends i.e. inter agency movement, aging etc
- Understand and further develop Career pathways
- Promote Indigenous research and solutions
- Promote Kaupapa Māori research and workforce solutions
- Do generic competencies detract specialised workforce from working in MH services – how will professional identity be maintained

Building on Collaboration

- Strong networks
- Less fragmentation between services
- Formalise external stakeholders' relationships outside to enhance support to consumers
- Integration of provider arm services with NGOs and PHOs
- PHO development needs to be inclusive of other government and non-government agencies and services –joint governance
- Closer interaction and collaboration with families to support clients move to recovery

MENTAL HEALTH SERVICE IN THE MIDLAND REGION

COMPONENTS OF SERVICE

Specialist mental health services in the Midland region include local and regional services and services provided to residents of the region in DHBs outside of the Midland region. For a complete list please refer to the appendix.

There are currently inpatient units in each of the five DHBs provider arm:

- Bay of Plenty DHB - 24 beds in Tauranga
- Lakes DHB - 14 beds in Rotorua
- Tairāwhiti DHB - 11 beds in Gisborne
- Taranaki DHB - 30 beds in New Plymouth
- Waikato DHB - 108 beds in Hamilton
- In addition, a kaupapa Māori inpatient facility is located in Hamilton (Hauora Waikato).

Each of the five DHBs provider arm provides community mental health services in the main centres and in rural communities:

- Bay of Plenty DHB - Tauranga and Whakatane
- Lakes DHB – Rotorua and Taupo
- Tairāwhiti DHB - Gisborne
- Taranaki DHB - New Plymouth, Stratford, Hawera; smaller clinics in Patea and Waitara
- Waikato DHB – Hamilton; rural services in Thames, Te Kuiti, Tokoroa and Te Awamutu; smaller clinics in Waihi, Whangamata, Te Aroha, Paeroa, Whitianga and Coromandel.

Inpatient regional forensic services are delivered in Hamilton by Waikato DHB and Hauora Waikato, while regional community forensic services are delivered by these two providers across the region. Additional forensic services are currently also purchased from other DHBs.

As well as the provider arm mental health services there are a large number of NGOs that are contracted by the five DHBs to provide a range of mental health services in the region.

Regional specialist services, highly specialised services that are usually provided regionally or nationally, are accessed by the region's population either within the region or more often in other DHBs. Although some specialist maternal mental health services and respite maternal services are available in the region, access to other specialist services (ie eating disorders, mother and babies services, services for people with disabling personalities, services for people with traumatic brain injuries) are available only at DHBs out of the region. Similarly, child and youth beds and residential services for people with alcohol and other drugs addictions, are accessed from other DHBs

Services provided in most of the Blueprint service lines and include services for the following needs groups:

- Adults
- Children and youth
- Older people
- Families

- People using forensic services
- Māori
- Pacific people

The following section looks the special characteristics of each of these groups:

○ **Adults**

Many adults need support and education in order to assist them in their recovery. The scope of this will depend on their life circumstances and the nature of their mental illness. Adults with serious mental illness have a range of differing needs including people with short term but significant illness, people who are acutely unwell or in crisis, people with severe ongoing or recurring illness, people with severe illness and disability, who have support needs, people with needs for long term structured support in a safe environment, people with other special mental health needs, and people with alcohol and drug problems.

○ **Children and youth**

New Futures (Ministry of Health 1998b) provided a strategic framework that focused on the role and functions of child and adolescent mental health services (CAMHS). Since 1995 CAMHS have increased in number from 16 to 21, and now provide the whole range of services identified in *New Futures*. The environment for working with children and young people has also improved considerably. The key agencies of Health, Education, and Child, Youth and Family now work collaboratively in a range of settings; in the area of youth justice, this collaboration extends to Police, Justice and Corrections.

The challenge now is to provide services for children and young people and their families/whānau that reflect current knowledge and fit the intersectoral model of working that acknowledges the whole environment of the child or young person and provides appropriate services at the right time. This approach is consistent with government strategic documents such as the *Youth Development Strategy* (Ministry of Youth Affairs 2002).

○ **Older people**

There is a high prevalence of mental illnesses in older people. Especially common are depression and anxiety disorders, which are found particularly in people with severe and chronic health problems and conditions more commonly associated with older age. Both primary and specialist mental health services need to work well together and with other specialist services for older people in order to address all the health needs of older people and to integrate their care well.

○ **Families/ whānau**

People with serious mental illness are not ill in isolation. Their families, extended whānau, and significant others, are also affected. Family-inclusive mental health services should pay attention to the emotional, educational, social, and clinical needs of the whole family, involve them in the treatment plan, and provide the person with a mental illness and key family members with information about the illness and its treatment. Family/whānau need to be involved and supported in all levels.

○ **People using forensic services**

Forensic mental health services in New Zealand form a specialist component of a continuum of services covering assessment, treatment and rehabilitation. Forensic

services arose as a consequence of the first Mason report⁴¹. Since then, a national network of comprehensive mental health services has been developed for people in prisons and courts, including a range of secure inpatient services and community follow-up.

Regionally, a plan for forensic services is currently nearing completion as well as ongoing planning for community-based services for those with high and complex needs who do not require forensic services but require more intense supports.

○ **Māori**

Despite improvements in Māori health over the past four decades, social and economic disparities, particularly health disparities, still exist between Māori and non-Māori, and health status levels for Māori remain lower than for non-Māori across a range of health indicators.

Addressing disparities in mental health status for Māori remains a key national and local priority. The need to improve our knowledge of existing and new data related to Māori mental health needs is paramount. Research to examine the existing data from the Mental Health Information National Collection (MHINC) data set will add to the growing pool of information on access data for Māori.

The past seven years have seen the growth and development of a diverse range of mental health services for Māori. These services have been supported by Māori workforce development initiatives and a continually evolving research and evaluation evidence base.

Te Puawaitanga: Māori Mental Health National Strategic Framework (2002) aims to provide DHBs with a nationally consistent framework for planning and delivery of services for tangata whaiora. Te Puawaitanga aligns with He Korowai Oranga: The Māori Health Strategy (Minister of Health and Associate Minister of Health 2002a) and Whakatātaka: The Māori Health Action Plan 2002–2005 (2002).

○ **Pacific people**

Pacific peoples overall have lower levels of health than the general population, and the Government has placed a priority on reducing these inequalities. Improving responsiveness to Pacific mental health and addiction needs has to be set in the context of reducing inequalities and encouraging Pacific-preferred approaches to service delivery. Achieving these goals involves acknowledging that Pacific approaches to mental illness differ from traditional medical-based approaches; they are holistic, family based, and centred on beliefs that recognise all aspects of a person's life – spiritual, physical, emotional and family. This holistic view of health is based on the Fonofale model (2004).

SERVICE UTILISATION

This section covers primarily hospitalisations for Mental Health related conditions, based on the Mental Health Information National Collection (MHINC).⁴²

Hospitalisation and community based provision of Mental Health Services does not necessarily represent prevalence in a population, but it is the only empirical data that can cautiously be treated as an indicator at a DHB, regional and national level. Furthermore, while all provider arm mental health services are reporting, not all

⁴¹ Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admissions, Discharge or Release on Leave of Certain Classes of Patients. 1988.

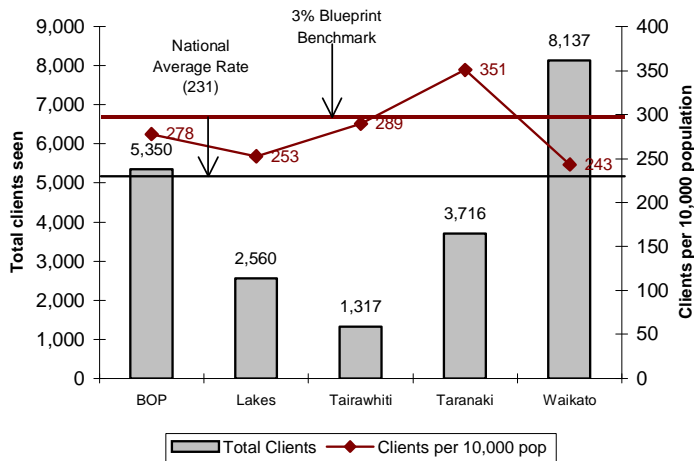
⁴² Source: Central TAS Mental Health Fact Sheet. Nov 2004.

mental health providers are currently reporting to MHINC. In the Midland region, only 26 NGOs out of total of 400 are reporting, and among those who are not reporting are a number of community mental health providers who provide clinical services. The largest kaupapa Māori mental health provider in the region, Hauora Waikato, is among those who do not report to MHINC. This means that per capita or any other comparative analysis is highly likely to be misleading.

MHINC - 3 years of event-based data was provided by NZHIS, covering calendar years 2001 to 2003. The data elements included: Team Type (Type of Healthcare team consisting of a person or functionally discrete grouping of people providing mental health care to a client or group of clients); Service Setting (Identifies the location of the clinician at the time the mental health service is provided to the healthcare user); Service (Describes the type of Mental Health Service the healthcare user receives); Agency Type (enables selection of Hospital and / or NGO providers); Ethnic Group (Māori, Pacific, Other); Age (5 year age bands); Gender; Domicile (Mapped to Territorial Authority and DHB region); Encrypted NHI, Bed Nights, Contacts, Event Date (grouped to calendar reporting period). In addition, data extracted from DHBs Mental Health Service Profile (2003), was also used to supplement TAS analysis.

Ministry of Health has set access benchmarks for the population at 3%, or 300 per 10,000 population. The national average (2003) was 231 clients seen per 10,000 population, while the Midland DHBs ranged between a high of 351 (Taranaki) to a low of 243 (Waikato). A total of 21,080 clients were seen in 2003 in the Midland region, comprised of 5,350 (Bay of Plenty), 2,560 (Lakes), 1,317 (Tairāwhiti), 3,716 (Taranaki) and 8,137 (Waikato).

Figure 8 : Total Clients Seen by Mental Health Services and Rates



The following section provides more detailed information regarding mental health services provided by the provider arm of the Midland DHBs for 2003.

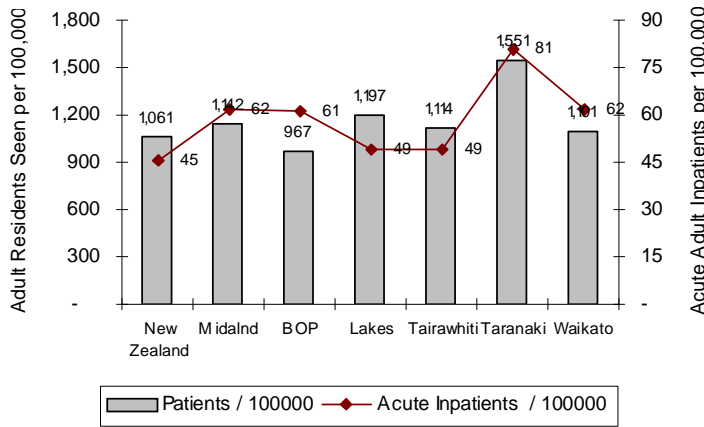
MENTAL HEALTH FUNDED SERVICES (2002/03)

Adult Services (20 to 64)

Nationally, 1,061 adults per 100,000 were seen by mental health providers, and 45 per 100,000 were acute inpatients. Midland region overall averaged 1,142 per 100,000 patients and 62 acute inpatients. Within the region, Taranaki had the highest

rate of patients (1,551) as well as acute inpatients (81 per 100,000), while BOP had the lowest rate of patients (967) and Lakes and Tairarwhiti the lowest rate of acute inpatients (49 per 100,000).

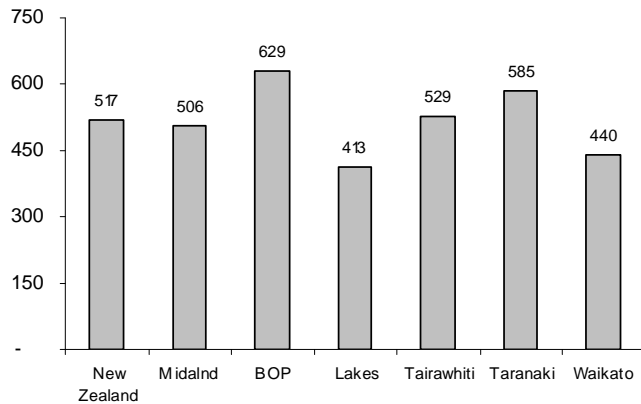
Figure 9 : Adult Patients Seen in Mental Health Services (2002/03)



Child and Youth Services (under 20)

Nationally 517 children and youth under 20 per 100,000 were seen by mental health services, while in the Midland region only 506. The rates varied between the DHBs with BOP rate reaching 629 per 100,000 and Lakes only seeing 413. It is important to note that the target benchmark set by the Ministry of Health for children and youth is 5% of the population, or 500 per 100,000 compared to 3% for the adult population (or 300 per 100,000) as above.

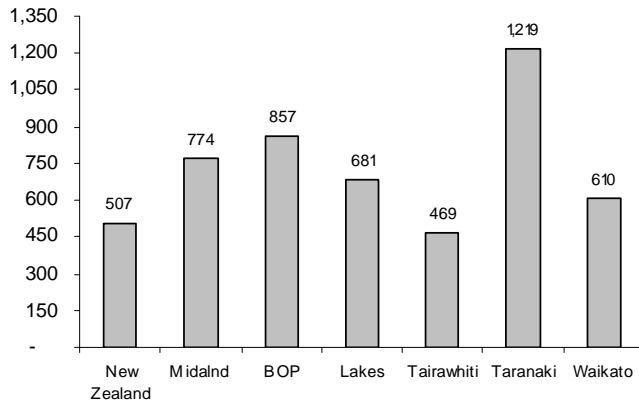
Figure 10 : Children and Youth Seen by Mental Health Services (2002/03)



Older Persons Services (65+)

Nationally 507 people over 65 per 100,000 were seen by mental health services, while in the Midland region 774. The rates varied between the DHBs with Taranaki's rate reaching 1,219 per 100,000 and Tairawhiti only 469.

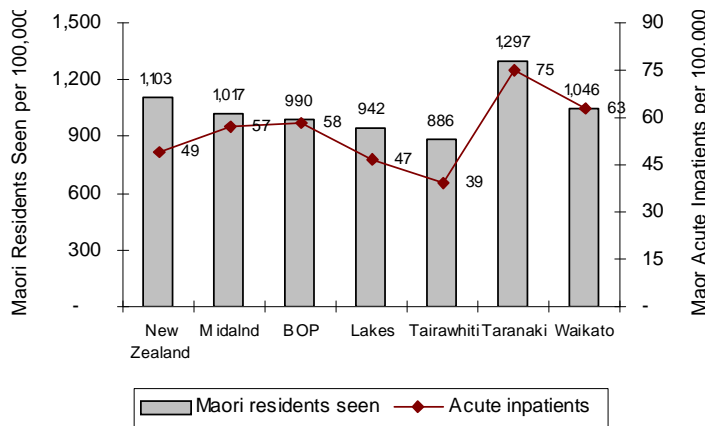
Figure 11 : Older Persons Seen by Mental Health Services (2002/03)



Māori Mental Health Service Use

Nationally, 1,103 Māori per 100,000 were seen by mental health providers, and 49 per 100,000 were acute inpatients. Midland region overall averaged 1,017 per 100,000 patients and 57 acute inpatients. Within the region, Taranaki had the highest rate of patients (1,297) as well as acute inpatients (75 per 100,000), while Tairawhiti had the lowest rate of patients (886) and as well as acute inpatients (39 per 100,000).

Figure 12 : Māori Patients Seen by Mental Health Services (2002/03)



FUNDING OF MENTAL HEALTH SERVICES

Nationally, all funded mental health services received \$773M in 2003/04, averaging \$207 per capita. Midland region received \$149.4M, averaging \$202 per capita. This included \$146.5M of Midland DHBs mental health contracts and additional \$2.9M

regional and national contracts that Midland residents had access to throughout 2003/04⁴³.

Maori mental health and addictions services in the region amounted to \$8,384,882 in 2003/04 and included Kaupapa Maori Alcohol & Drug Services (Non-Clinical FTEs), Kaupapa Maori Alcohol & Drug Services (Other Clinical FTEs), Kaupapa Maori Day Programmes, Kaupapa Maori Mental Health Services - Adult Community Teams (Clinical FTEs), Kaupapa Maori Mental Health Services - Crisis Intervention, Kaupapa Maori Mental Health Services - Dual Diagnosis with Alcohol and Drug problems, Kaupapa Maori Mental Health Services - Early Intervention, Kaupapa Maori Mental Health Services - Tamariki and Rangatahi, Kaupapa Maori Mental Health Services - Tamariki and Rangatahi, and Maori Advisory Services. In addition, a number of Maori providers are funded to provide generic/ non-kaupapa Maori mental health and addictions services (ie forensic, community mental health teams, community residential beds) which are not included in the above total.

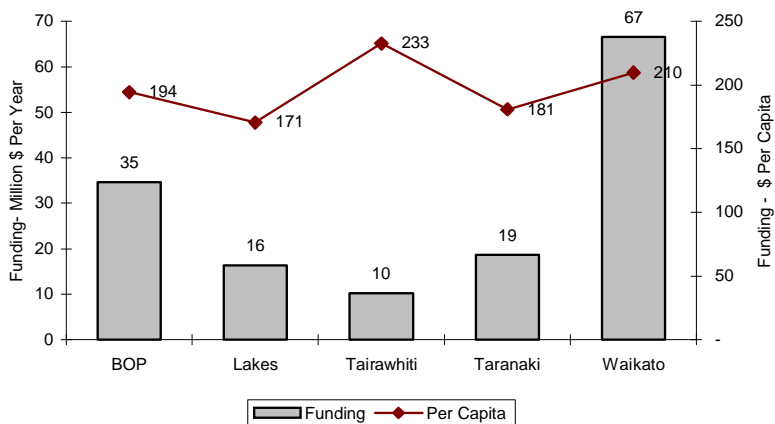
Non provider arm mental health and addictions services funded in the region amounted to \$55,514,995 in 2003/04, or 36.6% of the total funding. A number of the NGOs are centrally funded through the Ministry of Health and are available for the region's residents in other DHBs (ie Auckland, Wellington) or are contracted through other DHBs but are accessed locally.

The following graphs are based only on the actual DHBs' contracts and exclude in the calculation the national/regional contracts mentioned above.

Total Funding (by DHB)

Excluding the national/ regional contracts, Midland per capita funding averaged \$198 in 2003/04. Per capita funding differed between the DHBs, with Tairarwhiti receiving the highest allocation (\$233 per capita) and Lakes the lowest (\$171).

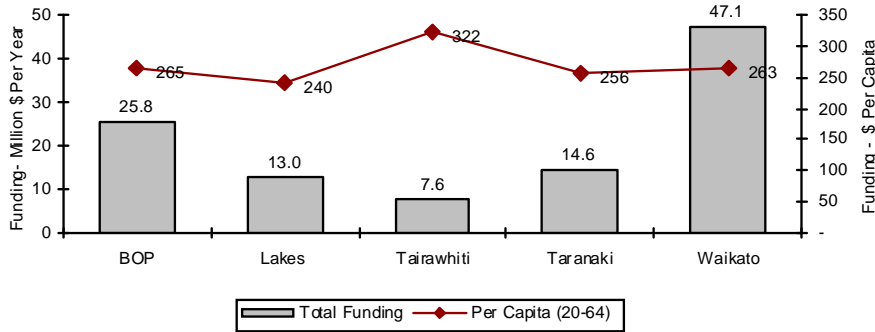
Figure 13 : Total Funding for Mental Health Services (2003/04)



⁴³ Ashburn Hall (Acute Inpatient), Hauora Waikato Māori Mental Health Services (Forensic Minimum secure beds), The Youth Horizons Trust (Regional Co-ordination Service), Framework Trust (Home based support services), GROW New Zealand Incorporated (Consumer advisory and consumer run initiatives), The Salvation Army New Zealand Trust (A&D Residential treatment), Auckland DHB (Acute inpatient - child and youth), Schizophrenia Fellowship NZ Inc (Regional Co-ordination Service), and Care NZ Limited (A&D Community assessment and treatment).

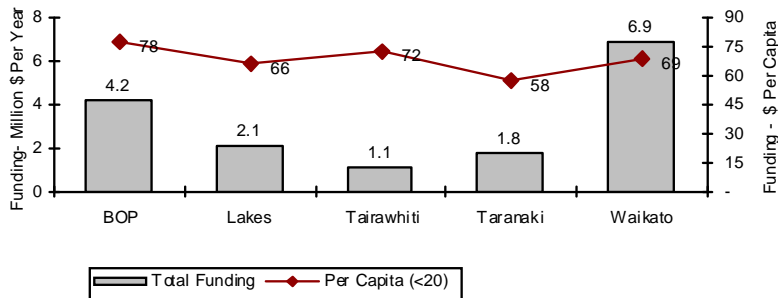
Adult mental health services show a somewhat similar trend. Midland region DHBs held mental health adult contracts to the value of \$108.1M in 2003/04, averaging \$263 per capita (adult 20 to 64). Per capita funding differed between the DHBs, with Tairawhiti reaching the highest per capita (\$322) and Lakes the lowest (\$240).

Figure 14 : Adult Mental Health Services Funding (2003/04)



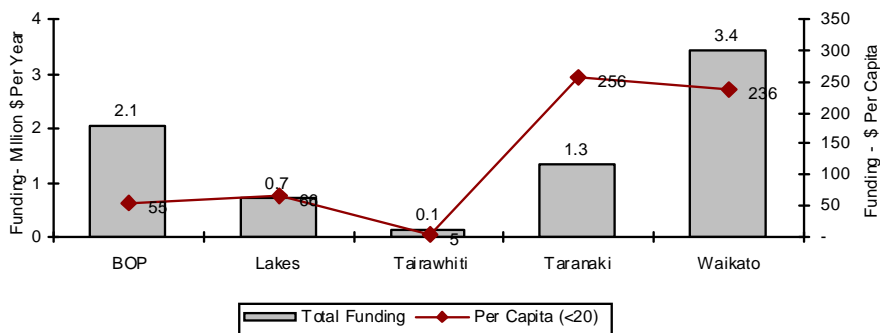
Child & Youth mental health services show a different trend. Midland region DHBs held mental health adult contracts to the value of \$16.1M in 2003/04, averaging \$69 per capita (Under 20 population). Per capita funding differed between the DHBs, with Bay of Plenty reaching the highest per capita (\$78) and Taranaki the lowest (\$58).

Figure 15 : Child and Young People Mental Health Services Funding (2002/03)



Midland region DHBs held mental health older persons contracts to the value of \$7.7M in 2003/04, averaging \$81 per capita (65+ population). Per capita funding differed between the DHBs, with Taranaki and Waikato reaching over \$200 per capita (256 and 238 respectively) while Tairawhiti, with only \$145,490 averaging \$5 per capita.

Figure 16 : Older People Mental Health Services Funding (2002/03)



Funding of Mental Health Services in Relation to Blueprint Benchmarks

The Blueprint benchmarks are access benchmarks set by the Ministry of Health. In 1998 the Mental Health Commission⁴⁴ developed resource guidelines for services to provide access to mental health services, including alcohol and drug services for 3% of the total population over any six months period, based on the Commission's view of the HFA funded services and estimates of need based on international epidemiological studies. The guidelines are the Commission's view of what services are necessary to provide a comprehensive service which meets the needs, including local and regional level services.

Although the Government requires DHBs to implement the Blueprint and much attention has centred on the Blueprint's resource guidelines for planning, it is now recognized that the Blueprint was written as a tool for national and regional planning purposes, prior to the establishment of DHBs with their individual accountabilities and funding teams. The Commission intended to update the Blueprint guidelines as services and access increased, but neither the Blueprint guidelines nor the population targets of the national mental health strategy have changed. These are good reasons for cautious application of the guidelines based on careful needs analysis at the district, regional and national levels.

The Commission is currently reviewing the applicability of the guidelines to the current environment and suggesting that in applying the Blueprint guidelines the funder should

- understand local demand and the features of the district that reduce or increase demand and, within the constraints of available funding:
 - ensure that the number of funded community clinical positions are sufficient in each service area: pre-schoolers, children, adolescents, youth, adults, older persons; resources should be (roughly) available according to population size and access benchmarks
- ensure that the number of funded clinical positions is sufficient for clinically sound services in the main population centres with outreach to rural areas
- ensure sufficient capacity for 24 hour coverage
- ensure inpatient capacity is sufficient; fewer beds may be needed if community and inpatient staff have access to planned and crisis respite facilities or respite budgets
- where there are concentrations of people with identifiable needs, ensure that services are contracted that reflect those differences; this would apply particularly

⁴⁴ Blueprint for Mental Health Services in New Zealand – How Things Need to be. Mental Health Commission. 1998.

in Auckland in relation to refugees and Asian peoples, South Auckland and some other areas in relation to Pacific peoples, and many areas in relation to Māori.

Notwithstanding the current review, the Ministry of Health, DHBs and many stakeholders are still very much interested to understand the national, regional and local position in relation to the benchmarks. The following therefore, is an analysis of the current position of the region, and estimates for the near future. This analysis should not be perceived as a recommendation for the region, but only as a statistical representation of current funding allocations.

The following table provides an analysis of the Blueprint benchmarks

- Description of Blueprint service lines
- Blueprint benchmark - rate per 100,000 total population
- 2003
 - Target – based on the Blueprint benchmark and the 2001 population, volume of services that is expected
 - Actual - Current services funded in the Midland region (FTEs or beds/care packages)
 - Variance – difference between the target and the actual
 - % of BP – percentage of the actual compared with the Blueprint target
- 2006 / 2011
 - Target – based on the Blueprint benchmark and the 2006 & 2011 population projections, volume of services that is expected
 - Variance – difference between the target and the 2003 actual

Table 25 : Blueprint Analysis - 2003, 2006 & 2011 Blueprint Benchmarks per 100,000

Blueprint Line	Blueprint Benchmark	2003 (2001 population 738,918)				2006 (projected population 796,316)		2011 (projected population 815,784)	
		Target	Actual	Variance	% of BP	Target	Variance	Target	Variance
Adult Services									
A1 - Acute Inpatient - beds/care pkgs	15.0	110.8	136.1	-25.27	123%	119.4	-16.7	122.4	-13.7
A2 - Community mental health teams - adult - FTE's	41.7	308.1	374.7	-66.59	122%	332.1	-42.7	340.2	-34.5
A3 - Community residential beds level I & II - beds/care pkgs	30.0	221.7	38.4	183.26	17%	238.9	200.5	244.7	206.3
A4 - Community residential beds level III+ - beds/care pkgs	40.0	295.6	347.7	-52.18	118%	318.5	-29.2	326.3	-21.4
A6 - Home based support services - FTE's	15.0	110.8	198.6	-87.80	179%	119.4	-79.2	122.4	-76.3
A7 - Residential intensive long-term - beds & care pkgs	1.6	11.8	-	11.82	0%	12.7	12.7	13.1	13.1
A8 - Medium term & extended inpatient services - beds/care pkgs	12.0	88.7	15.7	72.99	18%	95.6	79.9	97.9	82.2
A9 - Employment & educational support - FTE's	10.0	73.9	15.1	58.76	20%	79.6	64.5	81.6	66.4
A10 - Support & education for recovery - FTE's	9.0	66.5	28.2	38.34	42%	71.7	43.5	73.4	45.3
A11 - Outreach (rural) - FTE's	1.5	11.1	8.5	2.55	77%	11.9	3.4	12.2	3.7
A12 - Consumer advisory & consumer run initiatives - FTEs	4.0	29.6	50.7	-21.15	172%	31.9	-18.9	32.6	-18.1
A13 - Family advisory & family run initiatives - FTEs	2.5	18.5	30.9	-12.38	167%	19.9	-10.9	20.4	-10.5
A14 - General hospital liaison - FTEs	2.0	14.8	6.8	8.03	46%	15.9	9.2	16.3	9.6
A15 - Primary service liaison - FTEs	2.5	18.5	-	18.47	0%	19.9	19.9	20.4	20.4
A16 - Early intervention programme - FTEs	4.5	33.3	10.0	23.29	30%	35.8	25.9	36.7	26.7
A17 - A&D - Community assessment & treatment - FTEs	15.5	114.5	122.9	-8.36	107%	123.4	0.5	126.4	3.6
A18 - A&D - Methadone specialist - treatment places	90.0	665.0	501.0	164.03	75%	716.7	215.7	734.2	233.2
A19 - A&D - Methadone GP - treatment places	60.0	443.4	179.8	263.55	41%	477.8	298.0	489.5	309.7
A20 - A&D - Residential treatment - beds/care pkgs	5.5	40.6	60.1	-19.48	148%	43.8	-16.3	44.9	-15.2
A21 - A&D - Supported living services - beds/care pkgs	2.0	14.8	4.1	10.68	28%	15.9	11.8	16.3	12.2
A22 - A&D - Home & community detox - FTEs	0.8	5.5	1.6	3.95	29%	6.0	4.4	6.1	4.5
A23 - A&D - Social, medical & dedicated inpatient detoxification - beds & care pkgs	3.0	22.2	-	22.17	0%	23.9	23.9	24.5	24.5
A24 - Mental health & alcohol & drug services - Specialist expertise - FTEs	2.0	14.8	36.4	-21.59	246%	15.9	-20.4	16.3	-20.1
A25 - MH & A&D - Community residential rehabilitation	2.5	18.5	-	18.47	0%	19.9	19.9	20.4	20.4

	Blueprint Benchmark	2003 (2001 population 738,918)				2006 (projected population 796,316)		2011 (projected population 815,784)	
A26 - Mental health & alcohol & drug services - Community teams - FTEs	1.5	11.1	-	11.08	0%	11.9	11.9	12.2	12.2
A27 - Mental health & intellectual disability - Specialist expertise - FTEs	1.0	7.4	4.0	3.36	55%	8.0	3.9	8.2	4.1
Services for Children & Young Peoples									
B1 - Acute inpatient - child & youth - beds/care pkgs	2.0	14.8	3.3	11.50	22%	15.9	12.7	16.3	13.0
B2 - Secure inpatient - child & youth - beds/care pkgs	0.4	3.0	-	2.96	0%	3.2	3.2	3.3	3.3
B3 - Community mental health teams - child & youth - FTEs	28.6	211.3	182.1	29.19	86%	227.7	45.6	233.3	51.2
B4 - Respite services - child & youth - care pkgs	0.8	5.9	11.7	-5.79	198%	6.4	-5.3	6.5	-5.2
B5 - Day programmes - child & youth - care pkgs	4.0	29.6	0.2	29.39	1%	31.9	31.7	32.6	32.5
B6 - Community residential services - child & youth - beds & care pkgs	2.0	14.8	-	14.78	0%	15.9	15.9	16.3	16.3
Services for Older People									
C1 - Older people - assessment, treatment & rehabilitation - beds/care pkgs	4.0	29.6	19.3	10.24	65%	31.9	12.5	32.6	13.3
C2 - Older people daytime support services - care pkgs	4.0	29.6	8.5	21.06	29%	31.9	23.4	32.6	24.1
C3 - Older people - community teams - FTEs	8.5	62.8	36.9	25.95	59%	67.7	30.8	69.3	32.5
							0.0		0.0
Forensic Services									
D1 - Forensic - Acute medium secure inpatient - beds	3.8	27.7	21.3	6.38	77%	29.9	8.5	30.6	9.3
D2 - Forensic - Long stay, maximum secure, inpatient - beds	1.3	9.2	-	9.24	0%	10.0	10.0	10.2	10.2
D3 - Forensic - Minimum secure - beds	1.3	9.2	25.0	-15.78	271%	10.0	-15.1	10.2	-14.8
D4 - Forensic - Community residential recovery support & education - beds & care pkgs	0.8	5.5	-	5.54	0%	6.0	6.0	6.1	6.1
D7 - Forensic - Total liaison Services - FTEs	2.0	14.6	30.3	-15.72	208%	15.7	-14.6	16.1	-14.2
D8 - Mental illness & alcohol & drug disorders - Specialist expertise - FTEs	0.2	1.5	-	1.48	0%	1.6	1.6	1.6	1.6
Specialist Services									

	Blueprint Benchmark	2003 (2001 population 738,918)				2006 (projected population 796,316)		2011 (projected population 815,784)	
E1 - Mothers & babies - beds & care pkgs	0.5	3.7	-	3.69	0%	4.0	4.0	4.1	4.1
E2 - Mothers & babies - Community staff - FTEs	1.8	12.9	7.2	5.76	55%	13.9	6.8	14.3	7.1
E3 - Mothers & babies - Respite services/intensive home support - beds/care pkgs	0.8	5.5	0.1	5.41	2%	6.0	5.8	6.1	6.0
E4 - Head injury/neurological disorder with behavioural problems - beds/care pkgs	2.0	14.8	-	14.78	0%	15.9	15.9	16.3	16.3
E5 - Head injury/neurological disorder with behavioural problems - Community teams - FTEs	0.2	1.5	-	1.48	0%	1.6	1.6	1.6	1.6
E6 - Eating disorders - Community teams - FTEs	2.4	17.7	0.5	17.23	3%	19.1	18.6	19.6	19.1
E7 - Eating disorders - beds/care pkgs	0.5	3.7	-	3.69	0%	4.0	4.0	4.1	4.1
E8 - Services for the profoundly deaf who have a mental illness - Community consultation/liaison - FTEs	0.1	0.9	-	0.89	0%	1.0	1.0	1.0	1.0
E9 - Services for refugees who have a mental illness - Community staff - FTEs	0.2	1.5	-	1.48	0%	1.6	1.6	1.6	1.6
E10 - Services for people with disabling personality disorders - Community teams - FTEs	0.3	2.2	0.2	2.06	7%	2.4	2.2	2.4	2.3
E11 - Services for people with severe anxiety disorders - Community teams - FTEs	0.3	2.2	-	2.22	0%	2.4	2.4	2.4	2.4
E12 - Mental illness prevention services - Community staff - FTEs	10.0	73.9	-	73.89	0%	79.6	79.6	81.6	81.6
Non Blueprint Programmes									
F1 - Regional Co-ordination Service			472.5						

A complete stock of all mental health services in the Midland region (and those purchased for Midland regions' residents outside of the region) is available in Appendix B.

APPENDIX A

The following meetings were held with the Midland Regional key stakeholders network:

Group	Date	Facilitated by
Midland Regional Consumers Advisory Group (MR CAG)	11 August 2004	Lina Samu
Nga Purei Whakataa Ruamano (Midland Regional Māori Advisory Group (MR MAG)	12-13 August 2004	Moe Milne
Midland Regional Pacific Network (MR PN)	26 August 2004	Staff
Midland Regional Group Advising Families (MR GAF)	27 August 2004	Maxine Gay
Midland Regional Alcohol and Other Drugs Forum (MR AOD)	29 September 2004	Paula Parsonage
Midland Regional Child Adolescents Tamariki Rangatahi Forum (MR CATR)	4 October 2004	Staff
General Managers & Clinical Directors (MR GMs & CDs)	20 October 2004	Staff
Midland Region Mental Health and Addiction Planning Day	27 October 2004	Anne Patillo

Minutes of each on the meetings are enclosed.

**Midland Regional Consumer Advisory Group (MRCAG) meeting minutes
Held on Wednesday 11 August 2004**

Present: Noeline Kuru, Barbara Hart, Gavin Pike, John Barker, Lila Baker, Annette Casey, Char Turei, Carolyn Swanson, Tiaki Tume, Janet Chapman, Florence Lihou-Emery, Sue Harkin & Cate Light, Linda Penny, Leigh Worsnop, David Baker, Rhona Hyndman, John Harvey, Tarja Walter, Kevin Macken, Materoa Pikai, Tania Tokona, Tupana Osborne, Paula Jessep, Wi Huata, Ken Whyte, Frank Turnwald, Tina Lane, John Harvey, Tupana Osborne and Adele Winikerei. (Facilitator's note: my apologies if I've missed anyone out, they did not sign the register. I am aware of two people unaccounted for – one female who may have come with Noeline and one male who joined us late in the afternoon)

John Barker welcomed Lina Samu as the Facilitator of the day
Centre 401 was acknowledged and thanked for providing the venue and the food for today's hui/ meeting.
Formal business conducted by the Facilitator. Minutes were taken by Sue Harkin.
Acknowledgment and respects were paid to the memory and the work of Olive Lewis.

Election of your MRCAG officers:

In this voting process only delegates from the Midland areas could vote for the Co-Chairs. This meant that votes were cast by the following elected area delegates:

For Waikato – Florence Lihou-Emery, Frank, (Laura not present)
For Lakes: Noeline Kuru, Barbara Hart, Gavin Pike, (David not present)
For Taranaki: Janet, Tiaki, Carolyn Swanson, (Graham not present)
For Bay of Plenty: for Western – Tarja Walter & John Barker; for Eastern – Ken Whyte
For Tairāwhiti: Char Turei, Annette Casey, (third delegate space vacant at this meeting)

Each delegate had two votes to vote for two Co-Chairs for MRCAG and one back-up co-chair. This means that thirteen delegates cast a total of twenty-six votes. The Co-chairs were selected according to who got the most votes. Lina Samu as the Facilitator was the scrutineer.

The following people stood for the Co-Chair positions

- Gavin Pike, Char Turei, John Barker and Carolyn Swanson

Thank you very much to these delegates who put themselves forward for the MRCAG Co-chair positions

Result: The delegates voted Gavin Pike & Carolyn Swanson as your MRCAG Co-Chairs with John Barker as the Back- up Co-chair

1. Where is the Mental Health Service Development going?

- Coming back to the place where it belongs (David Baker)
- By consumer for consumer/ by tangata whaiora for tangata whaiora services – there is movement happening!
- Respite - participants in own care

- Take things down to 4-5 bed by consumer for consumer
- Wrap around services (Carolyn)
- Recovery workshops are happening (Noeline)
- More collaboration/ communication & interface with: primary care; intersectorial with Work and Income NZ (WINZ) & NZ Police
- There's a strengths focus happening
- Exciting time! Force to drive mental health development
- Hope that we're moving on from diagnosis as we might miss opportunities (Wi)
- Needs tangata whaiora to input into development (Cate)
- Patient-focused yet don't have power or no efficient means to empowerment (Tina)
- We've come a long way in the right direction (Char)
- Packages of care
- By consumer for consumer doing training around participation (Florence)
- This needs acknowledgment
- Serious Fun n Mind Trust (John)
- We are running recovery workshops
- We are doing training and consumer participation
- Use a health promotion approach (Linda)
- The Health Promotion approach is: *Build healthy public policy; Create supportive environments; Strengthen community action; Develop Personal Skills; Reorient health services
- The importance of citizenship
- Build skills
- Looking at our own stigma issues and keeping balanced attitudes
- Big shift meds is not "IT" now there is a more holistic approach with regards to support, community involvement, the range of services available, housing (Barbara)
- That is where we want to go – Holisticism (John H)
- Po Te Atatu Māori Mental Health services (Ngaire)
- Packages of care plan – Holistic wrap around service – tangata whaiora is at the centre and the kaumatua, the whaanau, the support team and others are around the person
- Learn from the past! (Kevin)
- Work is becoming an issue – Ministry of Social Development
- How best can we work in the community
- Mental health services in mainstream – we need to be guarded to not step into the services of the past
- Preventative & Recovery (Lila)
- Whaanau involvement
- Non- government organisations – NGOs have worked with consumer groups
- Moving in a positive direction
- There needs to be accessible workforce development for consumers (Rona)

- We have support workers and the National Mental Health Certificate but need more
- Can still challenge at policy & procedure level
- Lots of work done to change community attitudes (Noeline)
- Change is happening BUT we need to be responsible for workplans, WRAP plans, care plans, strategic plans and direction (Carolyn)
- We are choosing priorities and direction BUT is it where the \$\$\$ is going (John Barker)

2. Where is Workforce Development going?

- What does “workforce development” mean? (Janet)
- How is it developing? Where is it going (Kevin)?
- Holistic Māori models of practice – how best we work with Māori (Wi)?
- Mental Health Certificate
- Essential skills (Carolyn)
- Tangata whaiora are next step to looking after tangata whaiora
- Hope achievement – get in and do something
- Develop the tangata whaiora to do the work! (Sue)
- More training, more \$\$
- There is a huge gap between getting contracts and delivery of services
- What about people outside? (Tina)
- We’re referring to people in the mental health sector (Sue)
- Holistic core, Core competencies, Recovery workshops (Tina)
- The medical model is NOT the only way!
- Tertiary education needs to know
- There is a lot of training. Workforce development newsletter (Florence)
- Want to be professional! Want to get it right (Cate)
- Need professional training in: Governance, Business, Roles of responsibility
- The development of the Diploma of Mental Health going out for consultation
- Community training is available e.g. community enterprise
- Psychiatric survivors have said we should only use services with “mental health” in it. This is internalised stigma (Kevin)
- Seen tangata whaiora disempowered by mainstream training. Steps and a continuum of support needed for training within mental health (Sue)
- We need training at all levels (John Harvey)
- Personal choice-> grass roots-> strengths model
- We need quality managers, support workers, team leaders – we need to look right across the board don’t box consumers in to one role (Rona)
- A lot of foreigners with English as a second language now working in mental health. There is not a lot of support for these people with special language needs
- There are no true guidelines to help the vast numbers of foreign people to work in mental health – this impacts hugely on consumers

- A service is only as “recovery-focused” or “consumer-led/ driven” as the leader/ manager is (Barbara)
- Role modeling and mentoring is needed (Wi)
- Often a very lonely place and need to enhance strengths (Noeline)
- Role modeling and mentoring happening in Māori mental health (Lila)
- Personal development first for ourselves! (Sue)

3. Prioritise consumer needs for the 05-06 Plan

- Discharge Planning at the point of entry - less forced entry (Kevin)
- If force is needed let it be because it's necessary NOT because it's convention
- Forward planning
- Message to inpatient services: Do what you do do well; keep your noses out of things not done well
- High and complex needs work
- Midland mental health consumer network is a HIGH PRIORITY!
- Mental health staff and consumers need to be recovery-focused (Ngaire)
- Start to focusing on what tangata whaiora needs NOT what services need! (Barbara)
- Much more ownership of client support plans (Rona)
- Understand that everyone's role is important even to the consumer who is unpaid doing the garbage (John Harvey)
- Parents to be peer supported -> support for children and involvement with children (Cate)
- Education first and foremost offers opportunity (Tiaki)
- Accessing quality services
- A lot of poor people in rural areas
- Transport to services is an issue
- Clinicians need to see where consumers come from – attitudes of health professionals are often very unhelpful (Tina)
- What about the whaanau? (Florence)
- Whaanau help is a big gap (Noeline)
- Mothers need help to look after their children while they get better
- Commitment to clinicians working from a strengths model (Paula)
- Psychiatrists are NEVER at recovery training or strengths training (Carolyn)
- More collaboration, power, resources, tangata whaiora help, tangata whaiora peer support services to be encouraged/ created (David)
- Better quality life for whaanau ora (Wi)
- More possibilities, tangata whaiora upskilling and training interested in for employed tangata whaiora
- Maternity services gaps, child services gaps, and adolescent services gaps
- Make it happen NOT gaps that exist! (Lila)
- Education workshops on cultural aspects
- Freedom of choice
- Whaanau involvement in processes e.g. PDM (*Facilitator's note – Lila what is this please?)
- Wellness Recovery Action Plan (WRAP)

- Everyone who goes into the acute unit needs to do one as it can be a legal document and it is all about tangata whaiora ownership
- Independent policy involvement (Kevin)
- Involvement and representation on panels
- Services especially support services to have less control on psychiatric survivors' lives!
- Treatment orders are used as a weapon against psychiatric survivors
- For non-custodial parents
- Where is the help to put the whaanau back together?
- Where is the room for the child if a parent is in residential/ rehabilitation services

4. Identify consumer representatives who will attend the wider Stakeholders' Regional Planning Day on October 20th 2004

REASON FOR ELECTION: MRCAG has been given 5 places to attend the upcoming Midland Regional Planning Day on the 20th October 2004. There was good debate about whether to a. select one person from each area (Taranaki, Waikato, Bay of Plenty, Lakes, Tairāwhiti), or b. Select the best five people with the best skills and capability. It was decided that people should be elected based on those who had the best skills, experience and capability to have the mandate to represent the MRCAG at that October meeting.

OBJECTIVE: To pick 7 people mandated by MRCAG to attend the Midland Regional Planning Day on 20th October 2004. Five to actually attend the meeting. Two to be selected as back-up people in case one of the five could not attend.

PROCESS OF ELECTION: Thirteen people indicated interest in standing for the five places. They were: John Barker, Sue Harkin, Annette Casey, Florence Lihou-Emery, Paula Jessep, Carolyn Swanson, David Baker, Barbara Hart, John Harvey, Lila Baker, Gavin Pike, Tarja Walter and Kevin Macken. Thank you to these 13 people who willingly put themselves forward! All 13 people had the opportunity to speak for one minute each, stating why they would be the best person to be a mandated MRCAG representative at the Midland Regional Planning Day. Secret ballot voting was done on cards.

METHOD OF ELECTION: Each person voted by secret ballot. Each person was allowed to vote for a maximum of five of the 13 people standing. These votes were done by voters writing their choices on one card. The names of those standing were written up on chart paper to help those voting.

RESULTS: The results have been tabulated today by Lina Samu (facilitator of the meeting and scrutineer of this election process)

- A total of 29 people voted in this election process:
- 24 voters voted for five people, 4 voters voted for four people, 1 voter voted for three people = 139 single votes
- Sue Harkin (23), Carolyn Swanson (20), John Barker (16), Kevin Macken (16), Gavin Pike (14), Florence Lihou-Emery (9), Paula Jessep (9), Tarja Walter (8), Lila Baker (7), David Baker (6), Barbara Hart (4), John Harvey (4), Annette Casey (3)

The five mandated MRCAG representatives to attend the Midland Regional Planning Day 20th October:

Sue Harkin, Carolyn Swanson, John Barker, Kevin Macken and Gavin Pike

The two mandated MRCAG representatives to attend the Midland Regional Planning Day 20th October in the event of one of the above five not being able to attend: Florence Lihou-Emery and Paula Jessep

This is a true and correct record of the election process as scrutinised by me as an independent person. Lina Samu

5. Clearly identify the strategies that representatives will take to the Planning Day

Based on the information from this meeting – Strategies will be agreed upon at the next meeting on September 20th

6. Where to from here?

Need to sit down at another meeting – September 23rd to discuss the network

All are urged to read the document prepared by Sue Harkin and Helen Gilbert called Weaving a new net. This document is a scoping report for the creation of a Midland Region Consumer Network

There is a strong feeling that the setting up of the Midland Region Consumer network is an A+ priority and that the MRCAG work will be a workstream and flow out of the proposed Midland consumer network once it's established

Another important workstream for the proposed Midland Regional Consumer network would be to establish an Advocacy & Policy Council

Kevin had an appointment to meet with Rachel P about “have we delivered appropriately on the contract”. He invited others to be at that meeting to be held the next day on 12 August.

Louisa Erickson gave assurance that all those who were chosen by MRCAG to attend the 20th of October regional planning meeting – costs will be paid for their attendance.

Need to select representatives on the New Zealand consumer/ tangata whaiora/ psychiatric survivor network. This should be an agenda item for 23rd September

Congratulations to all in attendance for the efforts done and the work achieved.

Wi closed our hui/ meeting with a karakia.

**Midland Regional Pacific Network Meeting Minutes
Held on Thursday 26 August 2004**

Present: Tangaroa Whitiara, Ned Cook, Tiso Fiaolo, Sameli Tongalea, Louisa Erickson, Rachel Dekel, Rachel Poaneki

Venue: Sky City, Hamilton

Minute Taker: Louisa Erickson

Draft Minutes

Items	Discussion	Action/Outcome
Introduction – Welcome Apologies	Meeting Chaired By Tangaroa Edwina Dalziel	
Planning RMHAAN Plan 04/05	<p>Waikato DHB has the lead responsibility for the Pacific Peoples' section of the RMHAAN Plan. This means leading not doing. The 2002/03 and 2003/04 regional plans objectives for Pacific People were not implemented. The 2004/05 objectives are similar but worded differently. We need now to focus on the actual needs of Pacific People, as mental health services regionally are not seen as responsive to the needs of Pacific people. Provider arm in all DHBs are not resourced for Pacific cultural advisors - instead they often call on Pacific providers to provide support (but they are not funded for this service).</p> <p>Resource Regional Co-coordinator The group wanted commitment that the Pacific portion of the RMH&A plan will be actioned. A regional co-coordinator was clearly identified in 2003/04 and the new 2004/05 plan to deliver the objectives from the plan (pg 62).</p> <p>Although the role is in the plan the task need to be clearly articulated to identify what resources are required (e.g. 10 hours?).</p> <p>Rachel Poaneki suggested that the forum send a letter to the Planning & Funding GMs:</p> <ul style="list-style-type: none"> ⇒ Referencing the '02-'03, '03-'04, '04-'05 regional mental health plans. ⇒ Link to MoH documents including the 2nd Mental Health Plan ⇒ Seek regional coordination to action all plans <p>Provide a timeframe for response</p>	Louisa to draft up letter

<p>Regional Priorities</p>	<ul style="list-style-type: none"> • Develop a framework for providing services that are culturally appropriate and responsive to the needs of pacific peoples. <p>Mental health sector standards - providers are expected to comply with NMHSS: 2 Pacific Peoples but there are no specific frameworks currently in use.</p> <ul style="list-style-type: none"> • Identify Appropriate Models of Care <p>Discussion. What was the intent of this objective and how is it intended to improve services for Pacific Peoples? Group unsure – suspected was to ensure culturally appropriate and responsive services to Pacific</p> <p>A list of current research from Auckland University was circulated.</p>	<ul style="list-style-type: none"> • (Rachel P) to check with the Ministry of Health and Mental Health Commission what national initiatives are in place to action this so do not duplicate work. • Check with Carmel Peru from MoH who is writing a report on cultural competency. • Louisa will check also with Wellington if there are other activities and HRC. • Louisa to send updated schedule to the group.
	<ul style="list-style-type: none"> • Develop a regional pacific workforce plan <p>The regional co-coordinator will start 22/9/04. Work will include the development of a regional workforce plan.</p> <p>Two areas of concern to the group regarding recruitment, retention and training are:</p> <ul style="list-style-type: none"> • Pacific people workforce • Others working with pacific peoples • Essential skills • Long-term: 'Pacific for Pacific' <p>Link pacific mental health care development between DHBs - Develop the ability to share pacific focus between DHB provider arms and NGOs. The intent to improve access for pacific peoples.</p> <p>Create sustainable capacity building for Pacific People - This includes: Provider capacity; Pacific for Pacific; Providers delivering services to Pacific peoples; Community capacity</p> <p>Link with Regional Advisory Group and provide advice and direction to Midland DHBs - This is redundant, as the RAG no longer exists in the new structure.</p>	

Resource Regional Coordination	<ul style="list-style-type: none"> ⇒ To action last three regional mental health plans ⇒ Link into national projects ⇒ Implement planning strategies at a locality level ⇒ Develop frameworks for best practice in Midland or link with national projects for best practice framework development ⇒ Coordinate implementation of best practice at locality level ⇒ Develop Pacific models of care for the Midland region or link with national projects for Pacific models of care ⇒ Coordinate training of models of care at locality level 	
Regional Strategic Planning Process	<p>Rachel Dekel – Midland Regional Strategic Planner</p> <ul style="list-style-type: none"> ⇒ There is no robust mechanism in Midland to input into the Pacific section of the regional strategic planning process ⇒ Even if a dedicated regional coordination process/position is approved by GM's, this resource will not be in position in time to assist Rachel with the Pacific portion of the planning. An alternative process is required. ⇒ There is adequate qualitative data available for analysis, but to collect quantitative data community input is needed. 	
Some of the major issues that should be reflected in the strategic plan:	<ul style="list-style-type: none"> • Recruitment and retention of Pacific mental health workforce for all levels and areas of mental health • Improve mental health responsiveness to Pacific - integrate service delivery against framework using models of care into mainstream practice • Increase capacity of Pacific AOD especially for child & youth (8 to 18) • Overall mental health services for child & youth, especially the 8 to 18 • Specific Pacific cultural competency form main stream child & youth sector • Co-coordinator to ensure Pacific models of care are included in the essential skill core competency training for all providers • Mental health services by Pacific for Pacific. 	

	<p>One of the main barriers is that mental health issues are not discussed openly in the Pacific community rather it is hidden. There is an urgent need to educate the Pacific community about mental health:</p> <ul style="list-style-type: none"> • Community development • Networking • De-stigmatisation • "Selling" mental health to the Pacific community • Encourage young Pacific people to train in the mental health field • Providers development - talk to high school students, encourage them to train in mental health and return to work in Pacific communities <p>Pacific consumers perspectives</p> <ul style="list-style-type: none"> • Need Pacific providers • Prefer traditional healing • Use of prayers • Use appropriate language • On-going support not just treatment (currently only funding for treatment and Pacific people often attend Māori mental health services, but no resources for on-going support) • Consumers need choice -they might not want to return home after acute treatment • Support families with information • Support individuals around their own cultural needs <p>Raising awareness of Pacific communities Prevention of mental illness - go beyond the 3% Early intervention especially AOD users who might become mentally ill eventually Early intervention in the context of primary health cares - training of GPs Gambling becoming a big problems in Pacific communities AOD - educate youth, parents, communities, churches - to identify early symptoms</p> <p><u>Overall</u></p> <ul style="list-style-type: none"> • Education • Recruitment and retention • Providers capacity • Intersectoral involvement (corrections) 	
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October Stakeholder Planning Workshop	Tiso, Tangaroa and Sameli will attend on behalf of MRPN. Meeting scheduled for 20 October at Kingsgate Hotel, Hamilton. MRPN, Rachel P and Rachel D and Louisa Erickson will teleconference prior to October meeting to agree regional priorities in preparation for the planning workshop.	Teleconference to be scheduled (Louisa) for 4.30pm Wednesday 22 September 2004. Please diary.
Meeting ended 3pm		

Regional Māori Advisory Group Meeting Minutes
Held on Thursday 12, Friday 13 August 2004.

Present: Akaira Te Moana, Libby Kerr, Heather Campbell, Rubyanne Te Ahomio, Ramari Porter, Rukuwai Rangitauira, Louisa Erickson, Rachel Dekel, Phyllis Tangitu, Vicki Greeks, Barbara Anderson, Rob Beckett, Pue Whakaruru, Hori Kingi, Makarita Hall, Rangitamata Kinita, Pam Asher, Norah Puketapu Collins, Jo Van Leeuwen, Linda McCulloch, Karaki Nan Hoani, Dickie Farrar, Tina Bointon, Fiona Rewiri, Claire Pye, Huia Haunui, Jaycob Brown, Merie Matoe-Bendixa, Ngarongo Ormsby, Shayne Tuhere, Maisie Whakaruru, Keri Limmer, Don & Anne Lemieux, Sheena Merino, Sandy Carroll, Brent William Hyde, Kim Richards, Rutu Maxwell-Swinton, Denise Whata, Pauline Hapi, Trudy Hineturawa Tapsell, Natalie Johnston, Maraea Johns Turuwheua, Cheryl Collier, Cindy Mokokoko, Toni McCallion, Joss Kiernan, Linida Wilkinson, Huka Williams, Jimmy Morrison, Arama Pirikia, Whariki Gardiner

Apologies: Johnny Coleman, Marlene Matehuirua, Selina Robinson, Aunty Makere,

DRAFT MINUTES

Agenda Items	Discussion Points	Planned Action	Responsibility of
Powhiri (Day One)			
Karakia/	Matua Barry Whakaruru		
Whānaungatanga	The Hui introduced themselves.		
Forensic Review	Materoa Marr presented the review of the Waikato Forensic Service Provision in the Midland Region. An opportunity was given for the Hui to consider questions from Materoa and Wayne Blissett that would contribute to the review that they were conducting.	Need to track progress of the review and feedback to NPWR	Phyllis
Strategic Planning Whakatauaki	Phyllis welcomed and introduced Moe Milne to the Hui. Moe is responsible for the strategic planning session. Moe began the session with a update and korero on some of the historical developments within Te Ao Māori, that have contributed significantly to		Moe Milne

Agenda Items	Discussion Points	Planned Action	Responsibility of
	<p>the developments of Māori health and in particular Māori mental health. Moe also acknowledged the Whakatauaki, and pepeha that our Tupuna have left for us. We need to reclaim these as whānau and hapu and take the guidance and advice that these give.</p> <p>Moe began the session with visioning – He aha re te moemoea What do will we look like, be like in 2039, 2014, 2009</p>		
Waikato MAG	<p>Taking a break from visioning, Hori addressed the group re: Māori representation on MRNOG. Hori advised the Hui that he was informed last week that the Co-chair of the Waikato Māori advisory group had advised the people present at the roadshow presentation that the Waikato Māori advisory group were considering leaving Nga Purei Whakataa Ruamano. This came from their concern that during the process of the review, their voice and the collective voice of the Regional Māori group was not being heard, in ensuring Māori participation within MR NOG. He came to seek clarification from Nga Purei Whakataa Ruamano on our position with regards Māori participation. He provided background on the Hui that we had that reiterated Māori participation in all levels of the RMHN infrastructure.</p>	<p>Reps to discuss again with their individual MAGs</p>	

Agenda Items	Discussion Points	Planned Action	Responsibility of
	<p>Phyllis provided an update on this development and advised that yes Hori korero was correct, that Nga Purei had requested Māori participation at all levels, and that other local Māori advisory groups were concentrating on maintaining and influencing developments at a local DHB level. Rachel Dekel advised that this structure is going to be reviewed and evaluated in February 2005; this is an opportunity to ensure the view of Māori is considered.</p> <p>The whakaaro of Waikato was acknowledged by NPWR. This whakaaro is to be acknowledged in the evaluation of the RMHN structure in January 2005. Group to consider overnight, - view the structure tomorrow and make a definitive statement then. Also need to report back to local DHB Māori advisory groups.</p>		
Visioning continues	Moemoea for individual areas – Notes attached to minutes		

Day Two

Regional Priorities	2014	2009
❖ Workforce Development	❖ I want to be in my own home, close to my whānau with access to good health services when I need them	❖ Service Specs need to be reviewed

❖ Wananga I te reo me ona tikanga - Recover	❖ Economic Business Development	❖ Effective Māori participation/control in every area that influences Māori mental health
❖ Economic Business Development	❖ Leadership – Growing, Consolidating, Mentorship	❖ Leadership – Growing, consolidating, mentorship, tinorangatiratanga reflected
❖ Participation of Māori at every DHB level that influence Māori mental health	❖ Wananga I te reo ona tikanga - Recovery	❖ Information (scope, status quo, across specific spectrum e.g. workforce)
❖ Tinorangitiratanga reflected in policy	❖ Alliances with other indigenous peoples	❖ Māori owned research and evidence
❖ Development of Māori owned research by Māori for Māori – Evidence based practice		❖ Māori quality monitoring framework to be developed and implemented
❖ Māori Leadership		
❖ Alliances with other indigenous peoples/non Māori		
❖ Information <ul style="list-style-type: none"> ○ Government strategic direction ○ What does Māori workforce look like ○ Data relevant to inform decision making 		

Vision

Kia tu pakari, tu maea te tangata I roto I tona ao ma te ora o te hinengaro, te wairua te whānau me te hapu, ka ora te tangata

Enroll	Blocks	Keeping Strong
❖ Planners & Funders	❖ Lip Service	❖ Whānau ora
❖ GMs Māori Health – Tumu Whakarae	❖ Ourselves, Attitudes, Staff, Kaumatua, Whānau	❖ Develop tangata whaiora skills
❖ Iwi/Runanga Health Board	❖ DHB GM turnover, stupid decisions, lack of continuity	❖ Regional hui – Bi annual NPWR
❖ Tangata Whaiora/ Whānau	❖ Lack of career pathways – visibility of mental health as a career option needs good marketing	❖ Visits to traditional healers
❖ Policy Makers	❖ Workforce recruitment and retention	❖ Organisation CEOs stay connected to front line
❖ Midland Regional Planning & Coordination Team	❖ Discrimination and stigma attached to development tangata whaiora as mental health workers	❖ Good communication
❖ Intersectoral Forums	❖ Dominance of clinical medical models of service	❖ Leadership – positive action

❖ Yourselves	❖ Non equitable sharing of services/specialists/funding	❖ Focus and acknowledge as a region – creativity in service
❖ Offshore Allies (Info sharing)	❖ GP Services/PHO	❖ Tikanga – added value
❖ Information - Researchers	❖ Implementation of Blueprint – focus on 3% seriously mentally ill, undervalues the other end of the continuum – need continuums of care – whānau ora	❖ Whakanuia nga hapu/iwi ❖ Our knowledge base

First Steps:

6. Become informed re: Policy and other documents
7. Adjust business/strategic plans to reflect moemoea
8. Wananga – Personal and professional development
9. Promote the vision – Know it!
10. From hui – stakeholder workshop in October – support good membership on local advisory groups

Attending Regional Stakeholder workshop in October 2004

Barbara Anderson – Ngati Ranginui
 Jo Van Leeuwan – Tui Ora
 Dickie Farrar – Raukawa Trust
 Phyllis Tangitu – Lakes DHB
 Libby Kerr – Tairāwhiti

Agenda Items	Discussion Points	Planned Action	Responsibility of
Regional Mental Health Network Structure	Louisa presented restructure on OHP Phyllis facilitated the session on considering Hori whakaaro at yesterdays meeting.	NPWR still support Māori participation on MRNOG will take whakaaro back to local DHB MAGs to support. And ensure that this is presented in the review and evaluation of the RMHN	All NPWR members
Te Rau Matatini	Phyllis provided some latest publications by Te Rau Matatini, and advised that the strategic plan was being reviewed currently. Phyllis was hoping to have copies of the plan but these did not arrive before the Hui.	Phyllis to send out the Regional draft strategic plans when they arrive.	
Meeting closed	Karakia – Uncle Barry		

	2009	2014	2039
Te Arawa Ngongotaha	<ul style="list-style-type: none"> ⇒ Whānau/hapu kainga - Tinana, hinengaro, whānau, wairua. ⇒ Strengthening Te Arawa kawa/tikanga ⇒ Strengths based recovery ⇒ Representation/control/leadership ⇒ Whānaungatanga, relationships ⇒ Begin to build economic development ⇒ First trials of Rongoa Māori Health services shows staggering results ⇒ Database of traditional natural healers for mentoring ⇒ Career guidance and pathways that are easily accessible ⇒ Vocational education catering to needs of the taurira 	<ul style="list-style-type: none"> ⇒ Oranga tangata ⇒ Integrated PH Care ⇒ Wananga – te reo, Te Arawa kawa, tikanga ⇒ Work with Iwi to change perceptions and focus on ownership of health and social services ⇒ All Māori tamariki attend kohanga reo ⇒ Mainstream integrated into Kaupapa philosophy ⇒ Looking at health from a wellness perspective ⇒ Capacity built in workforce ⇒ Starting to see movements in health gain areas <ul style="list-style-type: none"> ○ Mental Health ○ Diabetes ○ Teenage pregnancy ○ Cancer 	<ul style="list-style-type: none"> ⇒ Sustainability ⇒ Thriving Economic development ⇒ Capacity/capability ⇒ Own hospital and all amenities ⇒ Integration ⇒ Residential homes closed due to Whaiora living in place of their choice with easy access to health and social services
Turanga Nui a Kiwa me Ngati Porou	<ul style="list-style-type: none"> ⇒ Strengthen relationships between NPH and Turanga Health ⇒ Strength in numbers, sharing of resources, tangible and non tangible ⇒ Begin to develop long term research goals and strategic planning ⇒ Strengthen whānau, tangata whaiora position within mental health services leadership roles – develop organisational policies to reflect this 	<ul style="list-style-type: none"> ⇒ TRONP and TROTAK collaborate ⇒ Pathways – whānau ora ⇒ Better housing ⇒ Better access to services ⇒ More employment and education opportunities available ⇒ Māori Mayor 	<ul style="list-style-type: none"> ⇒ TRONP and TROTAK under same umbrella ⇒ TDH – 95% Māori ⇒ Heart disease, cancer, obesity, mental illness, diabetes – major reductions ⇒ Kohanga reo, kura Kaupapa, Wananga increased growth ⇒ No more pollution

	<ul style="list-style-type: none"> ⇒ More Māori staff employed at TDH ⇒ Lower admission rates to Ward 11 ⇒ Health improvements across age span for Māori ⇒ Māori workforce development – whānau returning home to work ⇒ Improvement in recruitment and retention of workforce ⇒ Establish more kura kaupapa and kohanga ⇒ Increase in Māori graduates with qualifications 		
Not labeled		<ul style="list-style-type: none"> ⇒ Qualified workforce ⇒ Kaupapa Māori services up 200% ⇒ Noticeable changes in Māori demographics ⇒ Midland health– hapu owned ⇒ Health services – marae, whānau, hapu ⇒ Strong whānau 	
Whakatohea - Tuhoe	<ul style="list-style-type: none"> ⇒ Service specs reviewed ⇒ Kaupapa Māori service specs ⇒ Māori men will have more leadership – community organisations ⇒ Māori men will take more responsibility for their whānau ⇒ Whānau, hapu workforce development – inclusive of tikanga ⇒ Whānau ora services ⇒ Flexible funding ⇒ Services for parents with children with mental illness ⇒ Māori DAOs in community orgs 	<ul style="list-style-type: none"> ⇒ No more residential services ⇒ Time with whānau – whānau more functional ⇒ Education – healthier whānau – Wananga, tikanga – strong ⇒ Hapu and Iwi Development will increase ⇒ Te Whare Maire will be up and running – Tuhoe model of practice 	

	<ul style="list-style-type: none"> ⇒ external to DHBs ⇒ Consumer advocacy services outside DHBs ⇒ Richmond Fellowship now home based support ⇒ Viable alternative services ⇒ More Māori clinicians 		
Taranaki	<ul style="list-style-type: none"> ⇒ Kaupapa Matauranga te ao Māori ⇒ Kai Pouako – leadership, mentoring, tautoko and awahi ⇒ Political awareness, locally and nationally ⇒ Participation in policy making ⇒ Increased effective participation at all levels ⇒ Information to make informed choices 	<ul style="list-style-type: none"> ⇒ Kaupapa kimikimi ⇒ Rongoa ⇒ Ringaringa Awhi ⇒ Whakatauaki ⇒ Effective use of resources more sustaining growth ⇒ Strengthening relationships ⇒ Whānau ora – more evidence supported by kaupapa Māori structures and systems 	<ul style="list-style-type: none"> ⇒ Capturing the essence of Kaupapa tuturu ⇒ Whakatauaki
Tauranga Moana	<ul style="list-style-type: none"> ⇒ Te reo ona tikanga ⇒ Leadership workforce development – take ownership of our future ⇒ Smoke free Tauranga ⇒ Tangata whaiora, whānau empowerment in regards to self healing and wellbeing ⇒ Home support – intervention employment ⇒ Traditional Healing centres – primary, secondary ⇒ Training facilities ⇒ Access to Māori professionals i.e. psychologists, tohunga, psychiatrists ⇒ Economic development towards self sufficiency, independence i.e. tino rangatiratanga 	<ul style="list-style-type: none"> ⇒ Repealed legislation that has been harmful to Māori growth i.e. guardianship – foreshores, adoptions, health and disability Act ⇒ Now have wrap around services for Māori needs – Multi disciplinary teams – Māori ⇒ Reclaimed Māori land I roto I te rohe o Tauranga Moana ⇒ Healing centre accommodation for Māori health ⇒ Leading Māori business funding Māori health (tourism, fisheries) ⇒ Environmentally friendly transport ⇒ Māori living in better 	<ul style="list-style-type: none"> ⇒ More Māori ⇒ Māori own CBD ⇒ Numerous healing centres ⇒ Māori know identity/culture ⇒ 1st language – Māori ⇒ Warm houses ⇒ Kai Kapa – clean water, land beaches ⇒ Abundant kai moana, Rongoa ⇒ Regional defense, life skills, te reo, tikanga, high tech education training centre ⇒ Māori universities – no fees kohanga to university ⇒ Education systems are developed around Māori

		housing ⇒ Māori leaders leading business ⇒ Māori banking system ⇒ Smoke free city ⇒ Māori leading health research ⇒ Own our own TV/radio station and media networks	learning styles ⇒ Healthier living extending life span for Māori ⇒ Support for first home owners ⇒ Employment friendly environment for families i.e. single parents, couples ⇒ A cure for diabetes, cancer ⇒ Māori police force ⇒ Fees paid to Māori from overseas visitors
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**Midland Regional Alcohol & Other Drugs Forum
Minutes of Meeting Held on 29 September 2004**

Present: Paul Clifford, Steve Scott, David Benton, Ned Cook, Marlene Matehuria, Sue Fielding, Stephen King, Andrea Rowe, Peter Doorbar, Matiu Kiwara, Hester Hattingh, Tio Sewell, Minoaka Kapuaahiwalani, Tini Te Rangiita, Larry Clarke, Rachel Poaneki, Rachel Dekel, Graeme Judson, Ruth Smithers, Alana Ruakere Mack, Louisa Erickson, Paula Parsonage (Facilitator)

Venue: Kingsgate Hotel, Te Rapa, Hamilton

Minute Taker: Rachel Dekel

Final Minutes

Items	Discussion	Action/Outcome
	Meeting opened at 10.15, Karakia – Tio Sewell	
Apologies	Heather Campbell, Teina Mita, Dick Johnstone, Vicki Crarer. Mihaka Hohua	
Minutes of previous meeting	<ul style="list-style-type: none"> ⇒ The AOD Forum does not include any reps of other sectors – only AOD key stakeholders ⇒ Representation dominated by Waikato people ⇒ Links need to be back to LAGs ⇒ Network members must be committed to feeding back to their own stakeholder groups ⇒ Not all LAGs receive information from people who sit on regional forums ⇒ LAGs should all have AOD representation 	
Discussion around membership	<ul style="list-style-type: none"> ⇒ Keep membership open but only some have voting rights ⇒ Delegates to 27 October forum not necessarily one per DHB but rather people who are articulate and able to best represent the AOD forum views in the larger meeting. ⇒ Review membership on a yearly basis ⇒ Representation of all views not only like minded views ⇒ Ruth would like to see equitable representation from all DHBs ⇒ Most of important discussions and decisions are made at local level ⇒ Need to make final decision – if not closed group issues (i.e. membership) get discussed again and the group never settles ⇒ Not always possible to get four reps from each DHB – a question of availability and capacity to engage for the smaller DHBs ⇒ Debate re: Regional drives local planning and development or Local drives regional planning and development Option discussed – members might bring another person only as an observer not as a 	<p>Agreement: Meetings will be closed to members only. Visitors may be bought if approved by Chair prior to meeting.</p> <p>List of nominated members attached as appendix to minutes.</p> <p>Membership now includes: Alana Ruakere Mack (Regional WFD Coordinator) Rachel Dekel (Regional Strategic Planner)</p>

	proxy. Bringing visitors needs to be approved by Chair prior to the meeting	DHB Portfolio Managers. Louisa Erickson (RMHN Manager)
Terms of Reference	<ul style="list-style-type: none"> ⇒ Will remain in draft until further discussion can lead to them being ratified ⇒ Louisa suggests removing “Develop quality framework etc” – group not resourced to do this work. Will discuss further ⇒ Update the TOR and circulate ⇒ Add Portfolio Managers and Regional positions to membership 	
Regional Strategic Plan	<p>Snapshot of Services</p> <p>Regional:</p> <ul style="list-style-type: none"> ⇒ Kahunui – Residential adult, situated in BOP available to Midland ⇒ Rongo Atea – Residential 13 years – 17 years. Kaupapa Māori <p>Out of Region:</p> <ul style="list-style-type: none"> ⇒ Higher Ground – Waikato access ⇒ Spring Hill – Waikato Taranaki access ⇒ Odyssey – Waikato Taranaki access ⇒ Bridge Auckland – Waikato Taranaki BOP access ⇒ Bridge Wellington – Taranaki access ⇒ Nova Trust – Waikato contract, Taranaki access is based on historical use <p>Rongo Atea</p> <p>Referrals are not coming from within the AOD sector but from justice and CYFS. Although its Kaupapa Māori service this relates to the model of service but not to the people in the service. There are no youth AOD services in the region that can make referrals but there are CAMHS services that can. Rongo Atea serves the whole community. Referrals can be made by families, NGO and statutory sectors. Issue identified – lack of Rangatahi AOD services</p> <p>Young People</p> <ul style="list-style-type: none"> ⇒ Whai Marama Youth Connex – TROC ⇒ The Hub ⇒ Waahi Whanui ⇒ Care NZ – AOD Counselling in De. 1-5 Schools in WDHB ⇒ Te Aroha a Rangatahi – Hamilton ⇒ Hauora Waikato Tamariki Rangatahi ⇒ Tairawhiti – Turanga Health, Ngati Porou ⇒ BOP – Youth outreach in schools 	Louisa to follow up: MOH investigation of new AOD residential youth service in Midland. Approach Sue Allies

	<ul style="list-style-type: none"> ⇒ Taranaki – AOD Education ⇒ CAMHS each of DHB's – youth services are core business 	
Issues	<ul style="list-style-type: none"> ⇒ Detox ⇒ Links with Mental Health ⇒ Residential services – access, geographical ⇒ Workforce Development, Upskilling, retention, recruitment ⇒ Dual Diagnosis/multiple diagnosis/head injuries-ID ⇒ Young people ⇒ Family services ⇒ A need to be careful with disciplines setting up against each other e.g. nurses vs. counsellors ⇒ People returning home to family/community with AOD – aftercare ⇒ Sending people to residential treatment outside of region is like going to prison ⇒ Involving families in treatment and planning they need to believe and support the treatment and able to access. ⇒ Are assessment criteria for residential appropriate. Often motivation to move into residential is external (need for safe environment) not clinical assessment ⇒ Residential treatment can wither be for treatment or crisis/short term before ready for treatment ⇒ Worse for youth who return home ⇒ Philosophical problems between providers who don't use the 12 step programme ⇒ Confusion about what residential care actually means ⇒ MH Vs AOD; Youth Vs Adult 	
	<p>Issues prioritised:</p> <ol style="list-style-type: none"> 1. Residential 2. Workforce Development 3. Provision of Service across the continuum 4. What does “recovery focus” mean for AOD? Consumer participation <p>Feedback from Groups on Prioritised Issues:</p> <ul style="list-style-type: none"> ⇒ Residential <ul style="list-style-type: none"> ○ What does the consumer want? <ul style="list-style-type: none"> ▪ Recovery in a safe environment ▪ Limited intervention in a community setting 	

	<ul style="list-style-type: none"> ▪ Timely access ▪ Local options close to family and children ▪ Choice of treatments/therapies ○ What do Providers want <ul style="list-style-type: none"> ▪ 1 Criteria for access ▪ Dual diagnosis criteria ▪ Family access, involvement in treatment ▪ Good coordination of access to services ▪ Continuum of care – entry and exit ▪ Additional services ▪ Taha Māori ▪ Sub acute services ▪ Credentialing of services ▪ Standardised assessment tool for entry ▪ Strengthen communication between providers referring to treatment and back again 	
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	<p>⇒ Workforce Development</p> <ul style="list-style-type: none"> ○ Attrition ○ Qualifications – generic or specific ○ BA – accessibility and availability ○ Time takes university to develop new qualifications ○ Benchmarking of qualifications ○ Increasing professionalism of sector – drive philosophical shift ○ Intersectoral and inter organisational collaboration ○ Career pathway for workforce ○ Minimum entry level ○ Integration of NGO and Provider Arm of DHB's ○ Need for shift in attitude of management – employ generic counsellors and them in AOD ○ DHBs don't have specific funds for training it is embedded in the FTE price. Some funds are available through national workforce centres NAC is one of these – WFD Coordinator to link <p>⇒ MH & AOD</p> <ul style="list-style-type: none"> ○ Workforce Development and cross training (every door is the right door) ○ Adequate funding ○ Outcome measures – what is it ○ Integration & Collaboration – respecting each other 	
Select reps for Stakeholder Workshop in October	Select reps for Stakeholder Workshop in October	Graeme Judson to talk to Tairawhiti about linking to this process.
Meeting ended Next Meeting	Meeting ended Next Meeting	

Andrea Rowe	Taranaki DHB	andrea.rowe@tdhb.org.nz
David Benton	Hamner Tauranga	dbenton-hct@xtra.co.nz
Dick Johnstone	Tairawhiti DHB	dickj@tdh.org.nz
Graeme Judson	Taranaki DHB	graeme.judson@tdhb.org.nz
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Marlene Matehuirua	Te Ngaru O Maniapoto, Waikato	Te-Ngaru@xtra.co.nz
Matiu Kiwara	Bay of Plenty	the.kiwaras@clear.net.nz
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Stephen King	Care NZ Waikato	stephen.k@carenz.co.nz
Steve Scott	Waikato Bridge	waikatobridge.scott@xtra.co.nz
Sue Fielding	Whanui AOD Huntly	fieldings@whanui.org.nz
Teina Mita	Ngati Porou Hauora, Tairawhiti	counsellors@ruatorianph.co.nz
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Tini Te Rangiita	Tuwharetoa Health, Lakes	
Louisa Erickson	Midland RMHN	Louisa.erickson@lakesdhb.govt.nz
Rachel Dekel	RMHN Strategic Planner	Rachel.Dekel@lakesdhb.govt.nz
Alana Ruakere Mack	Midland WFD Coordinator	Alana.Ruakeremack@lakesdhb.govt.nz
Larry Clarke	DHB Portfolio Manager, Waikato	Clarkela@waikatodhb.govt.nz
Ruth Smithers	DHB Portfolio Manager, Taranaki	ruth.smithers@tdhb.org.nz

**Midland Regional CATR Forum
Minutes of Meeting Held on 4 October 2004**

Present: Huia Haunui, Kay Montgomery, Kim Skinner, Barbara Anderson, Rahera Biddle, Margaret Baxter, Frances King, Cheryl Collier, Cindy Mokokoko, Margie Robinson, Ginni Cashell, Margaret Vick, Rachel Poaneke, Grant Aitken, Carol Clarke, Te Uta Rolleston, Laurie Hakiwai, Bev Huttley, Dennis Lihou, David Ngatai-Mokotua, Debbie Cairns, Debbie Goodwin, Louisa Erickson, Rachel Dekel

Venue: BEC, Waikato DHB, Hamilton

Minute Taker: Louisa Erickson

[Final Minutes](#)

Items	Discussion	Action/Outcome
Meeting opened at 10.15 Karakia – Huia Haunui	Introductions Apologies: Heather Campbell	
Terms of Reference	Presented to group. Agreed to keep in draft for further discussion around membership – Significant others - Consumers? Family? Youth employed by MH services?	To be put on agenda at next meeting
Snapshot of services within region	Lakes: ⇒ 4.5FTE – Taupo - 12FTE – Rotorua ⇒ 2FTE Early Intervention ⇒ NGO – Field officer ⇒ CAFS/CYFS collaboration ⇒ 1FTE Youth Dual Diagnosis ⇒ High & Complex Needs – access ⇒ Research – Intersectoral collaboration focus ⇒ Core services Bay of Plenty: This is a mix between Kaupapa and Mainstream at Western BOP ⇒ Kaupapa Māori CAMHS ?5FTEs ⇒ CYFS/Social Service collaboration ⇒ Youth counseling ⇒ Family planning/mentoring	

	<ul style="list-style-type: none"> ⇒ Specialist care (shared between Kaipapa and Mainstream) ⇒ Collaboration with CYFS/Justice – acute respite ⇒ Whānau support/Incredible Years Parenting programme ⇒ Full care – Packages of Care/ High and Complex needs ⇒ Vocational/employment services ⇒ Consultant liaison MH/CYFS/GSE/YHT/Paed/Youth Offending/PHO ADHD initiative/NGO's ⇒ Psychology – psychometric testing ⇒ Early Intervention – 13-25 years ⇒ (Western) DHB 15.7 FTE – Core services (0 to 18 yrs) – Dual-diagnosis - Early Intervention; Strengthening Families Local Management Group <p>Waikato</p> <ul style="list-style-type: none"> ⇒ Hauora Waikato – core CAMHS services and early intervention first time psychosis contract ⇒ Parentline – C&A MH up to 13 years ⇒ Youth Horizons – Planned respite (W.E. only); early intervention first time psychosis ⇒ Whai Marama – JV DHB & NGO – youth advocacy; youth specific services; alcohol & drug counseling, general counseling ⇒ Richmond Fellowship – Residential (2 traditional beds); crisis and planned respite ⇒ Waikato DHB – Generic core services; 2 FTE youth forensic; clinics through out the whole region ⇒ Te Runanga o Kirikiriroa – Rongo Atea –Youth A&D Residential and kaupapa mental health services including residential support services, day program services, dual diagnosis, A&D, whānau support and education, crisis and early intervention and youth specialty services <p>Taranaki</p> <ul style="list-style-type: none"> ⇒ In 1997 – 3FTE - In 2004 15FTE ⇒ 1FTE GSC/CYFS Community based ⇒ CAMHS ⇒ Youth carers coordinator – JV DHB & SF ⇒ 0.6 CYFS & GSE project for one yr. ⇒ Dual diagnosis & A&D workers x2 FTES ⇒ Eating disorders ⇒ ADHD specific position ⇒ Young Carers co-ordinator 0.5 fte 1 year. ⇒ 1 vacant Psychiatrist position. ⇒ All staff do consult liaison 9 have school portfolio each) ⇒ Core CAMHS business 	
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<p>Out of Services</p>	<p>Region</p> <p>Tairawhiti</p> <ul style="list-style-type: none"> ⇒ In 1997 – 1FTE – In 2004 9FTE ⇒ Assessment/treatment ⇒ Eating disorders ⇒ Dual Diagnosis ⇒ GSE/CYFS ⇒ 0.1FTE GP setting ⇒ Adolescents at risk KIWI ACE ⇒ A&D Education ⇒ Early intervention ⇒ Community A&DCAYAD community action youth alcohol & drugs <p>Eating Disorders</p> <p>Auckland DHB – Auckland Eating Disorder Clinic – monthly supervision Tairawhiti access services Auckland/ Wellington Ashburn Hall access through Midland Regional Clinical directors – mainly adult</p> <p>Starship services</p> <p>3 Beds for region – historic use Tairawhiti access inpatient beds in Porirua</p>	
<p>Issues</p>	<ul style="list-style-type: none"> ⇒ Intellectual Disability (lack of services for this client group and clients not being diagnosed until they present at C&A services with behaviour issues) ⇒ Conduct disorder ⇒ Primary mental health ⇒ Integration and Collaboration ⇒ Intersectoral development ⇒ Outcome measures ⇒ Workforce development ⇒ Funding and resources ⇒ More services 	

Issues (cont)	<ul style="list-style-type: none"> ⇒ Alcohol and drug ⇒ Fragmentation of contracts/services <p>Priority issues</p> <ul style="list-style-type: none"> ⇒ Workforce development ⇒ Integration and intersectoral development inclusive of primary health developments ⇒ Adequate Resourcing and service development at least at Blueprint level <p>Feedback from groups on priority issues</p> <p>1. Workforce Development</p> <ul style="list-style-type: none"> ⇒ Clinicians time used in administration roles – admin not funded separately ⇒ Retention of clinical staff a problem – high turnover ⇒ Specialist training – psychotherapy ⇒ Improved (local) access to training \$\$ CTA for fees, travel, accommodation ⇒ Backfill issues ⇒ Werry Centre – better links to training – maybe satellite training ⇒ Multi skilled staff – need for trained experienced staff ⇒ Recruitment – costly, minimal pool of skilled clinicians for CAMHS to recruit from ⇒ Managing stress in workplace ⇒ 40-50% turnover ⇒ Sharing of subcontracted specialist workers (should we?) ⇒ Need to stake a claim – Mental Health adult services dominate ⇒ Staff are generically trained – training needs to be structured to attract workforce to mental health ⇒ Psychologists workforce tends to be more stable, less itinerant while extremely difficult to recruit nursing workforce especially with mental health experience ⇒ Managers/team leaders also need support, training and recognition of their key roles <p>2. Integration and Intersectoral Development</p> <ul style="list-style-type: none"> ⇒ No dedicated resource to enable it to happen although all the documents outline it as a strategy for service development ⇒ Time consuming and pivotal to outcomes, is this adequately recognised in the way services are funded/expected number of clients seen? Is this understood by C&A Service Managers ⇒ Relationship consistency with groups e.g. education, justice, corrections, CYFS critical ⇒ Needs recognition as vital to good service 	⇒
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	<p>3. Resources – Service Development</p> <ul style="list-style-type: none"> ⇒ CAMHS needs to be adequately funded to deliver core business – no waiting lists ⇒ Significant inconsistencies in what’s funded across the region ⇒ Consistent core business investment throughout region as a baseline – building blocks ⇒ Clients with an Intellectual Disability – and clients with severe learning disabilities plus specific learning difficulties presenting with behavioural issues – early diagnosis missed and falling through gaps in education system and health e.g. paediatrics/child development centres ⇒ Forensic Services for youth – needs consistent funding through region not just 2FTE in Waikato ⇒ Maternal mental health services need to integrate/have a close working relationship with CAMHS and the development of a service for infant mental health ⇒ Kids with parents with mental health issues – need services ⇒ Significant health issues with related mental health issues – huge gap – priority area e.g. diabetes, cancer, serious accidents ⇒ Consumer inclusiveness – development required throughout region ⇒ Regional service – Inpatient beds in Midland may include general admissions for eating disorders, forensic, regional consultancy service for eating disorders and some serious forensic cases may be useful. 	⇒
Reps selected to attend Oct 27th workshop	Cheryl Collier, Carol Clarke, Ginni Cashell, Huia Haunui, Margaret Vick Back up – Margie Robinson	⇒
Next Meeting	February 2005	⇒

Midland Region GMs and CDs Strategic Planning Meeting
Notes of Meeting Held on October 20, 2004

Objective of the day – to agree on strategic priorities for the mental health sector in Midland Region from the Provider Arm perspective to be presented to the Midland Regional Stakeholders Planning Workshop on 27 October 2004.

Attendance: Mark Fisher (BOP), Clive Bensemman (Waikato), Shahid Mehmood (Taranaki), Shailesh Kumar (Lakes), John Marks (Tairāwhiti), Graham Mellsop (Clinical School), Chris Harris (Waikato), Dianne Irwin (Tairāwhiti), Sue Keppel (Lakes), Jenny Wolfe (BOP), Joy Farley (Taranaki), Johnny Pulman (Taranaki), Rachel Poaneki (Waikato), Anne Davys (BOP), Alana Ruakere-Mack (MR), Rachel Dekel (MR).

Workforce Development

- Consider a “non-poaching” approach between DHBs
- Involvement of mental health workforce – bring expertise from people in the field to ensure continuous interactions (nursing, psychologists, psychiatrists, etc)
- Use of innovation – tele-psychiatry
- 2nd mental health plan has no vision around workforce development – role of nurse practitioner in mental health aging workforce, impact of student loans,
 - Midland region can take leadership in researching and providing evidence for changes in the system to help MoH move the sector forward.
- Who usually get the upskilling? Those who are already have the skills, often not those who have potential but are not accessing development opportunities. We need to pay more attention to the latter → avoid the “rich get richer” phenomenon
- Mental health workforce information system – common data collection to enable us to know where we stand as a region/DHB.

Reality check – where are we today and where do we want to be?

Group 1

Our mental health system can be likened to a Christmas tree with many decorations but no roots- we focus on the flashy decorations but do not support the core that has to maintain the system.

Tension between MoH and the DHBs

Tension between management and clinicians.

In 2014 – we want a flourishing tree with decorations – a system that is supported!

Group 2

Current constraints:

- Theory vs. practical reality
- Potential loss of staff, loss of expertise due to policies
- Outcomes vs. outputs

- Evidence-based vs. practical solution
- Competing demands on clinicians – clinical work, management, etc

What progress have we seen locally and regionally over the last five to ten years?

Three years ago we were thinking and working individually – regional work was enforced by MoH – but now we are working regionally because we appreciate the benefits.

- The regional network is beneficial but it is sometimes more difficult for the smaller DHBs to keep up especially with added MoH pressures, intersectoral activities and overall lack of resources.

In the region, relationships are working better with other DHBs in and outside of the region.

- Easier access to services in Hamilton
- Better understanding of each other
- Sharing of equipment when own is broken
- Sharing information regarding recruitment
- Collaboration around planning for the PSA nurses strike
- Transfer of patients
- Sharing of procedures and documentation
- Considering positions that have regional responsibilities (i.e. professor of mental health)
- Increase in IT capacity – often only when it's MoH driven it get done, but if locally driven harder to accomplish
- Waikato and Lakes share the Industrial Relationships GM position
- Waikato, Lakes and BOP share training positions
- Out of region – access to Ashburn Hall – effective access to national resources
- HMSMART – we can think about a regional approach to sharing IT/ tele-psychiatry

A different view from Tairāwhiti perspective – often happy to maintain its provincial and isolation characteristics. The transition to regional relationships had been slow with a long learning curve. They have relationships with Midland DHBs but also with Central and Northern regions for access to specialty services. The cost, however, is huge especially in terms of travel.

Mental health sector has specific dilemmas in building collaborations because of the number of contracts in the area – although money was invested in the sector it is hard to see the actual progress and the benefits, especially with the escalating costs of compliance.

Research and evaluation – how to create more effective contribution from eh NGOs? What is the value added to the system?

The system is currently fragmented – a large number of providers and now we need to counter-react and create collaboration among providers. The system itself encourages fragmentation – there is an assumption that each DHB is different and each region is different and each has different needs.

Clinical governance is working well within provider arms and there are systems to deal with clinical risk. There is no similar mechanism within NGOs as they don't have clinical governance but have the risk (especially those who employ a psychiatrist).

Regional capacity- although increased to 3 (Louisa, Alana and Rachel), it is not sufficient to fulfill all the requirements of the 2nd mental health plan.

Quality initiatives – smaller DHBs have more catching up to do (specs, monitoring, sector standards, accreditation)

The progress over the last ten years –

- HFA invested money
- DHBs invested money + shifted forward on accountability and reporting, attempting to be more open and utilize transparent and inclusive process

What are the gaps we have in the system?

- Use of technology – telemedicine/ telepsychiatry is a great tool that needs to be expanded
- Mental health funding is treated in isolation – ring fence has benefits as the \$\$ is protected, but also some negative implications as it is keeping the sector isolated from the rest of health
- Lack of regional specialist services – the information coming from recent MHINC analysis can support the need for:
 - o Eating disorders
 - o Personality/ borderline personality disorders
 - o Maternity mental health
 - o Residential for high and complex needs
- Many sub-specialty services (tertiary and quaternary) are located in Waitemata and Otago who are in close proximity to academic centers
- Smaller DHBs have small numbers of patients who require specialty services and are happy to concentrate on general mental health services
- Service schedule (MoH) framework is very ambiguous
- There is no re-integration / transitional planning for patients returning from out of region/DHB services
- Need more training and education for staff of general mental health services to manage patients with special needs
- The region has shortage of resources at all levels including the funder level, mental health management level, especially for the implementation of the 2nd mental health plan.
- Sometimes upskilling actually results in loss of staff for the organization – if a person is trained but there is no infrastructure to apply the new skills, they move to another position or another DHB
- Gaps in access to ID/mental health services, although Tairāwhiti has good access to Takahānui and Wellington.
- Gaps in access to A&D services
- Gaps in services to Pacific people or Asian, and providers are unable to adhere to the service specs around Pacific people.

→ Need to fix up the system to just add more \$\$ to a system that might not be working well now.

Principles

(Key themes, overarching concerns around funding)

- Funding for integration not for fragmentation
- Progress on the issue of mental health service delivery by primary health care sector – provide better opportunities for both the mental health and the physical health
- Work out the role of mental health nurse practitioner – how can we maximize the gain from this role?
- Give high priority to the implementation of MHSMART
- Review specialty services
- Workforce – use more innovative approaches to workforce planning (take an lead) – estimate the needs of the region in ten years taking into consideration
 - o Changing life/work balance expectations
 - o Length of training
 - o Changing population
 - o Retirement age
- Use generic training across the sector so NGOs can also benefit
- Review the outcomes of the 0800 initiative for reassessment and screening
- Review of what is an integrated system (Blueprint \$ sometimes is allocated to new services irrespective of what the system needs) – what should an integrated system look like??
 - In each DHB, what is the local contribution to such as system?
 - Philosophical
 - Information sharing/ information technology
 - Management
 - Providers

Representation to the Midland Regional Stakeholders Planning Workshop on 27 October 2004

- Shailesh Kumar (Lakes)
- Johnny Pulman (Taranaki)
- Jenny Wolfe (BOP)
- Clive Bensemman (Waikato)
- Chris Harris (Waikato)

The Way Ahead

Whānau Ora

- Inclusion – whānaungatanga/Kotahitanga
- Recovery Approach
- Tika
- Pono
- Aroha
- Manaakitanga
- Rangatiratanga
- Intersectoral collaboration: Housing, Education, WINZ, MSD, Justice
- Mental health continuum
- People family centered
- Access in most appropriate way
- Employment
- Oranga Tangata
- Physical, mental, social, family
- Te Karere who is the messenger
- Community information
- Information on self accessible
- Community Development
- Leadership
- Education – innovation ways of interaction/having conversations e.g. email, phone

Key Elements

- Workforce development
 - o Training co-coordinator in each DHB
 - o Meet regularly to discuss training opportunities coming up
 - o Co-ordinate local training
 - o Training needs analysis, evaluation and reflective practice
- Whānau Ora
- Integration with primary mental health
 - o Education – Police, schools, Winz, Housing Corp, Whānau, Hapu and Iwi
- Early Intervention
 - o COPMI
 - o Psychosis
 - o Schools
 - o Whānau
 - o Consumers
- Participation and empowerment of consumers to drive their recovery, e.g. treatment plans, advance directives
- Employing for attitude

- Integration & Collaboration
 - o Build strong networks
 - o Education, combine resources – housing, welfare
- Shift bulk of funding to community
 - o Alternative systems
 - o Once stop shop – more accessible
 - o Location
 - o Varied hours of service
- Consumer/Involvement at
 - o Family and cultural
 - o Planning and funding level
 - o Family therapy
- Medical – holistic

- Needs of service user and whānau focus rather than focus on organisations needs
- Supporting families/Whānau ora
 - o Consumer involvement and development at all levels
 - o Valuing recovery and strengths
 - o Further development of specialist service
 - o Workforce development
- Māori/consumer
- Responsiveness
- Continuum
- Infrastructure (robust)
 - o Capability/capacity
 - o Staff
 - o Policy – active
 - o Standard of service
- Systems and processes
 - o Co-coordinated
 - o Continuous improvement
 - o Synergies
 - o Focus towards the vision
 - o Quality
- Integration
 - o Co-ordination
 - o Collaboration
 - o Early/effective intervention
 - o Sector knowledge within the sector
- Workforce Development
 - o Co-ordination
 - o Ongoing
- Consumer responsiveness
 - o Consumer responsibility
 - o Access – limit or remove barriers
 - o The three P's (Partnership, participation/protection)

- From Taranaki with love
- Sustained training in evidence based community holistic intersectorial consumer orientated interventions
- Flexible responsive timely accessible system works across primary, secondary, tertiary
- Attitudinal change to incorporate health approach as opposed to illness. Acceptance

Workforce Development

- Organisational/structure/development
- Supporting worker to do training – culture
 - o Backfilling
 - o Follow-up in organisation to utilise training
- Mentoring towards independence
- Training “needs” analysis
- Organisation equip individual
- Existing training incorporates basic mental health requirements e.g. recovery
- Trainers talking to each other
- Retention – who do we have and why are they leaving? How do we get them back
- Research e.g. Good organisation retention
- Matching contract requirements to skill base and identifying gaps
- Fill – gaps
- Valuing staff
 - o Feedback recognised
 - o Participation/involvement
 - o \$\$
 - o Flexibility – hours, holidays, part-time, work roles
 - o Access to individually tailored education
 - o Needs validated
 - o Opportunity for promotion, advancement

- Culture Shift
 - o Attitudes and beliefs aligned with mental health philosophy/policy/direction
 - o Get rid of 'blame' between services
 - o Attention to issues that block implementation
 - o Transfer of ideas from individual level to systematic. How to do this? How to influence and implant. Good ideas – transference to higher level change/policy/implementation
- Systems Development
 - o Move from emphasis on funding/transaction to planning and implementing. This is systems/structure shift.
 - o Complex system currently
 - o Involves all levels and everybody from MoH – services user
 - o Tail wagging the dog. Reluctance to change at national level – e.g. nationwide service framework constraints
 - o Across health sector/government level working together
- As a region
 - o What key things to move on evolve/develop now – vision
- Capacity and leadership and infrastructure
 - o Across funders/GM's/sector wide
 - o NGO often has longest leadership continuity
 - o Alignment of all sectors, NGO's/Prov Amrs/DHB CEO's/GM's etc
 - o Interpretation across all groups need to be consistent/same message – all aligned
 - o Longevity of philosophy. Issue with people coming and going. Culture can stay the same at times
 - o CEO's play critical role
 - o Shift to recovery
- Measured sensible approach to implementation of long term strategy/visions
 - o Move from 1 year planning cycle to longer term
- Shared service agency in Midland to have enduring capacity etc especially analysis
- Inclusion – attitudinal shift
- Resilient, flexible, emotional intelligence
- Affirming management, value our workforce
- Measure 'health' of work force
- Retention/upskilling – agency shifting
- Mental health attractive workplace

- Commitment – people who like to work with people
- Make a difference
- Education – career pathway
- New grad (moldable)
- Mentoring
- Opportunities get narrow
- Workforce information
- Healthy culture/organisations
- Ageing workforce
- Nurse practitioners mental health and primary
- Good managers, good leaders - complimentary
- Management pathway being clearly defined
- Early access

- Need highly skilled workforce to work with those meeting need at “serious end”
- Attitudes review per annum per worker – develop screening performance tool for workers
- Need higher performance at entry and during management, targeted
- Weed out those not prepared to change – change HR legislation
- Change or move on
 - o Challenging extent of mental health training in core courses. Needs to be more robust e.g. docs/nurses etc /police
 - o Create new work roles to meet needs arising from continuum of care e.g. support workers in A&D do not exist at present
- All clinicians basic training personality disorders, MoH support
- Specialists in personality disorders
- Sub acute vs. after care in AOD
- Support workers – huge need for training – especially in residential'
- Training coordinators in each DHB – connect with regional approach to WD
- Whole region aware of what each DHB up to
- Whole sector NGO Prov Arm etc
- Gaps – who's responsibility to identify
- Where does the worker fit?
- Reliance on workforce to move organisation forward
- Self, organisation

- Accountability
- Responsibility
- Sharing new knowledge within teams
- Organisation is clear about training and development needs
- Backfill vs. I've still got to do my work when I get back to work
- Staff retention – training knowledge goes when a staff member leaves
- Identifying problems and choosing solutions
- Level of organisational and vs. personal motivation
- Access – GP, NGO's, Hauora, employability of consumers, PHOs
- Multi-skilling
- Educating community about services
- Politics controlling funding
- Mental health and addiction – career pathways
- Who are the experts
- Workforce retention

- Workforce development
 - o Passion
 - o Clinical skills
 - o Experience
 - o Human – family/Whānau
 - o Connectedness
 - o Recruitment
 - o Retention – training
 - o Alignment of above
- Organisational development
 - o Structure
 - o Systems
 - o Culture/environment
- Family/Whānau
 - o Involvement
 - o De-stig

- Information – awareness raising
- Education
- Ongoing consumer capacity building through continuum
- Every door is the right door

- Parallel development of workforce and consumers/families
- Adequate resourcing for services across the spectrum
 - To improve access
 - Allow for flexibility of approach
- Working smarter – using technology to the max
- Using people

- Leadership
 - Consumer
 - Māori
 - Pacific
 - Whānau
- National Directions
 - Using system to effect change
- Clinical/management
 - Clinicians know how to manage
- All workforce initiatives –
 - Have a recovery philosophy/approach as a given Whānau ora
 - Competency based/performance reviews
- Home grown research
 - Value Māori development and other New Zealand innovations
- Reduce barriers to people trained in New Zealand health professionals
- Value support worker roles – career pathway development
- Equity for remuneration- - NGO same as mental health secondary service
- Value staff
- Inter-disciplinary
- Value skills – culture, life experiences

- How do we support our staff to go and train?
- Training needs to be accessible
- Onsite training

Workforce Culture

- Culture in mental health that attracts and retains staff
- Employers that value and look after staff
- Adequate funding/commitment to workforce wellbeing
- Training passes into practice – ongoing supervision/monitoring
- Reflective training- revisit in 6 months
- Training is a 'daily living ' thing
- Mentorship – preceptor ship
- Human kindness – helping by being
- Internal culture, supporting each other
- Demystify professionalism
- People focused services. Balance risk with humane approaches
- Responsiveness to needs that really is client centered
- Employ consumers as consumers in services
- Openness of clinicians with clients about own weaknesses/exp mental illness

- Translation of structures changes
- Education of wider community
- Training stock take of long term workforce
- Ask consumers what sort of worker do they want looking after them
- Does having a mental illness/addiction experience mean that is enough to work in the sector
- Broaden training/career pathways for consumers
- Cannot be in management role if not trained in skill base other than consumer

Vision

- Workforce
 - o Demolish funder
 - o De-colonise
 - o Institutional
 - o Vision
- Whānau Ora
 - o Mental health care whole family
 - o Family counseling
 - o COMPI
- Intersectoral
 - o Winz
 - o Corrections
 - o Justice
 - o Education
 - o CYFS
 - o Addiction
- Consumer
 - o Management
 - o Funding
 - o Governance
- Tapa Wha
 - o Continuum of care
 - o Holistic
 - o Early intervention
- Education
- Consumers
- Police, WINZ, Housing Corp
- Schools
- Community
- Families/Whānau SOP

- Human kindness
- Service specifications
- Translation to delivery \$ equity
- Informed leadership
- Disconnected funding – public health – MH/DSS

- How do you evolve something ‘collectively’
- What has evolved?
- Fusion or fission
- Holistic ‘or’ whole-istic
- Training and retention
- Family
- Holistic community based support
- Inter sectorial collaboration
- Consumer responsibility to be recognised and acknowledged
- Model of the person “ko au”
- Whānau ora
- Workforce
- Develop leadership to take vision
- What is recovery
- Social ability/disability
- Medical/non medical
- Mind set
- Family based
- Intervention
- Trained workforce

- Workforce that understands that supporting S/U and families to maintain social abilities or overcome social disabilities is their key function
- Stress vulnerability model
- Psycho education
- Problem/goals orientation to all interventions

- Done in primary care setting
- IMHC
- Integrated mental health care
- Need a workforce trained in stress
- Vulnerability that understands that for service users and family/Whānau overcoming social disability or maintaining social ability is their key function
- Redistribute the funding to match the service
- Consolidate vision
- Delivery different – Whānau ora
- Consumer input at planning funding level
- Decision making
- Align funding to community service
- Shift doctors/psychiatrist to community
- Services should employ consumers – value and reimburse accordingly experience of mental illness as a qualification
- Support consumer advisory groups
- No one kaupapa – supporting consumer voice
- Continual forums for voice
- Narrative evidence
- Every door is the right door
 - o Access as a means of referral to the appropriate service
- Consumer driven service i.e. responsive to family, individual needs
- Holistic, inclusive model (whare tapa wha)
 - o Communities communicating and collaborating
 - o Recognition of cultural assessment tools – options (not just ‘medical’ model)
- Trained workforce which includes tangat whai ora
- Education and promotion in wider communities
- Positive evolution
- Collaboration – various ways, PHO, pop, rural

- Intersectorial approach
- Workforce development
 - o Training – now and future
 - o Recruitment
 - o Retention – in clinical service providers
 - o Why leaving?
- Family involvement
- Consumer focus/involvement
- Early intervention/treatment/education
- Access/responsive service
- Adequate resources to meet demand
- Clarity of services required/available on spectrum of care

- 5 themes
- Consumer growth/development/support
- Whole-family context/holistic approach/involvement/children of parents with mental illness/Whānau ora
- Workforce development
 - o Social work/counseling courses need mental health component
 - o Include consumer issues/employment
- Access
 - o Every door being the right door
 - o Social inclusion
 - o Connection – everyone’s business and know where to
 - o Welcome and attended to in any environment
- Primary sector opportunities
 - o First point of assessment
 - o Shifting systems/structures to primary setting
- Appendix
 - o Considerations
 - o Health in mental health
 - o Strengths based focus
 - o Public health

- Global picture
- Expectations aligned with capacity
- Implement strategy/policy
- Vision keeps changing – need debate
- Second mental health plan more appendix than vision
- Like social inclusion – make this priority one

- Workforce is trained, thinks and acts differently (all the buggers)
- Workforce retention
- Family inclusion – part of recovery – education
- Less hospitalisation, more community based support – holistic – one stop shop – primary services
- Build consumer resilience
 - Recovery model
 - De-stig
 - Peer support
 - Advocacy

- Consumer run services
- Focusing on potential strengths focused
- Youth services
- Family/Whānau – consumer together can't separate
- Medical – holistic model
- Continuum of choice
- Working together
- Integration collaboration between services
- Change thinking within workforce/changing attitudes
- More opportunity of hared vision
- Core competencies – monitoring \
- Implement polices that are driven MoH
- Leadership – understanding of policy
- Consumers and family have voice
- Strengthen networks to get a guide voice

- Strengthen minority groups in community to may be form one body
- Value diversity
- More practical support –housing, income, social, employment
- Action the vision
- Redevelopment of service
- Recreate
- Engage people working in field – information dissemination
- More clinicians at planning days

1994 Themes

- Consumer – little voice
- Legislation/changes
- Broader range
- Stigma/discrimination
- Health system changes
- Come out of recovery before accessing service

2014

- In recovery/relationships work
- Consumer workers
- Parity
- Options
- Part of life/not life
- Consumer the focus
- ID needs
- Every door is the right door
- Right decision, right place at the right time

- Aged population
- Youth
- PHO

- Workforce – well trained, responsive, want to work in mental health
- Promote
- Safe/successful/enjoyable
- Consumers in management and leadership
- Mental health strong component of training
- Service cultures –align with policy/philosophy
- Capacity aligned with expectations
- Healthy work environment
- Holistic model – less emphasis medical model
- Talking therapy
- Consumer run services especially support area
- Medical/mental health nursing - post grad
- Improved physical health for consumers
- Stronger network – reduced isolation
- Identity, meaning and potential of an individual – no longer identified by mental illness
- Choices – living arrangements
- Healing centres

2014

- More consumers are involved in governance, decision making
- Consumers: more voice, decisions, being empowered 10 years on
- Recovery part of the community
- Capacity to be aligned with expectations
- Consumers are equal recognition in employment as mental health service employers
- Extra support for employers with needs
- Staff well trained and wanting to work in mental health employment to be safe and enjoyable
- Academia include mental health component in to content. Nursing/counseling i.e. social work
- Less focus on medical
- Clinical treatments: include more holistic therapies
- Increased consumer run services
- Holistic centres for first time consumers

- Total health promotion is standard procedure
- Strong networks
- Identity of individual will be determined by persons potential rather than illness
- Minority groups within community have merged to form one core group of representation

- Compliance requirements
- Mental health service
- Elderly
- NGO's
- PI
- Spec services
- A&D
- Māori

2014

- Consumers well supported in ways they need to led rich and full lives
- Services designed around the needs of consumers to ensure we provide the right support
- Youth and young people – increase numbers - need more “youth-friendly”
- Range of services – choices to suit demographic
- Right information at the right time
- Strengths based approach to service provision
- All the providers stop gate keeping
- Integrated service providers (NGO)
- Primary mental health (Screening pop) – PHO
- Multi-system involvement – case management approach

- Same title across Midland “Mental health and addiction services”
- COPMI services
- Consumer network – active within services – Information sharing in and out
- Evidence based services – evaluating constantly, reflective practice devt
- Whole health approach – holistic care – Te Whare Tapa Wha

- Respect for diversity 'social inclusiveness'
- Acceptance and more de-stig normalisation
- Shared care
- Consumer advice/advocacy within CAMHS
- Increased social responsibility – decreased need for mental health and addiction services
- Increasing life span for consumers e.g. physical well being, healthy diet, decreased smoking
- Family are naturally involved and GPs are connected better
- Ready access “every door’s the right door” less exclusion
- Early intervention – teaching skills for coping before needing specialist services
- Strengths focused
- Increased self-responsibility and advocacy. Consumer identifying what they need and service being willing and able to respond flexibly
- Advanced directives
- Workforce development
- Mental mentoring (role modeling)
- Common sense rather than robotic
- Helping by being
- Human kindness
- Improved pharmacology

- Build new services then phase out the old
- Change the way we ‘think’
- We need to know what the continuum looks like and be able to articulate it – monitor and audit
- Put the ‘health’ back in mental health
- Available at the time of day and place that suits the consumer e.g. for those who work and so on and use technology e.g. e-mail etc.
- Importance of services for addiction needs priority
- House, job and connected to communities
 - o Living at home
 - o With family
 - o Access continuum of mental health care easily
 - o Resourcing families

- Any door is the right door
- Access
 - o AOD and mental health
- Primary care – PHO –community specialist services occur in PHO/primary environment
- Redefinition of what sits in primary and secondary services
- PHO development needs to be inclusive of other government and non-government agencies and services –joint governance.
- Rural communities – one stop shop – provides linkages across services and sectors
- Workforce trained in and believe in this vision – structured psycho education available
- Vision's and strategies exist its now about implementation of policy and leadership

- Education of wider community and specifically for families
- So they understand what is delivered/how people are supported – not operating in isolation
- Families have skill base – needs to be valued wider Whānau do have skills e.g. bringing family together
- Have we let go of basic skills in preference for clinical based practice
- Family communication important
- Training and education for families not just clients
- Youth need support of families
- Train families
- People do not necessarily want common language – still do not want labels
- Lots of options currently
- Service user names
- Language could be different in 10 years?
- Clients
- Mana motuhake
- Tangat whai ora

- Children as 'caregivers' with unwell parents – need support
- Children, carer respite options
- Support for children of clients
- Look at family as whole unit
- Families often don't deal with mental health issues because of stigma/whakama. Māori like to deal with unwell ness within their own families. Need connectedness within their Whānau

- Issues urban/rural Māori – connectedness – options for Māori are mainstream. Not all Māori want Māori delivered services. Want Māori services in mainstream.
- Vision 10 years
- Holistic approach – connection across sectors
- Family very important – training and support for family
- Children of parents with mental illness – supports, respite
- Connectedness for consumer/to a family or group etc left to individual

Workforce in 10 years

- o Too technical for A&D currently
- o Meeting basic needs – do not need technicalities (medial quals) to treat
- o Training of people with A&D experience
- o Closer interaction/collaboration families, clients to move to recovery
- A& D Clients
 - o Open put in “box”
 - o Need to look at contributing factors
 - o Less fragmentation between A&D and mental health
 - o Collaboration
- Consumers want basics
 - o Stable job
 - o Roof over head
 - o Food in stomach
 - o Having support to guide either through Whānau or other
 - o Vision lives of consumers 10 year plan – confidence/journey
- Child and Adolescent
 - o Same as for adults
 - o Focus still on consumers/families
 - o Greater collaboration amongst agencies (often clients involve din other agencies)
 - o What less fragmentation
 - o Clarity re spectrum of care
 - o Continuity/seamlessness

- Rapid exits
- Formalise external stakeholder relationships outside of consumer setting to enhance support
- If supports in community don't always need medical intervention
- Reduce medication
- Want other interventions e.g. respite, consumer driven but supported

Workforce in 10 Years

- Facilitators for MDT teams lay out options (consumer driven)
- Scenario - consumer goes to service – they identify support etc need – workforce interface facilitates access
- Clinical cross over is still very important
- Diversity of treatments
- Family process is parallel to that of client

- C&A
- More resources support for families so people do not become users of adult system
- Less case load for C&A workers as include families in therapy – need to factor the intersect oral ramifications on workload
- Holistic service delivery means watch out for case load
- High turnover CAMHS staff
- Cannot run service life and adult service
- What is holistic? Looks different for everyone
- Responsiveness with service – acknowledge everyone does it differently – service users see 'holistic' in their own paradigm

- Look at the basics
- Supports that guide
- Less fragmentation between services
- Diverse models
- Diversity
- Basic skills should be recognised within family unit – includes children
- Full family inclusion within mental health services
- Terminology – family not necessarily blood ties, family is who ever the service user chooses
- Support

- Carer respite
- Education
- Information
- Recovery processes

- Family/Whānau intrinsically part of recovery – listened to, valued
- Different levels of assessment
- Service delivery mainly in primary sector
- Mental health professionals be employed in PHOs
- Integration NGOs and PHO
- Recovery delivered in the community
- Outcome based funding rather than numbers
- Each discipline have input into their workforce development with a common framework
- Consumer pathway – grass roots to government level representation, succession pathway
- Effective independent consumer network working collaboratively with other mental health services
- Workforce with excellence in clinical skills and recovery focused
- Incentives to stay in clinical vs. managerial roles
- Clinical governance
- Ground level recruitment to address aging workforce
- Move away from economic decision re innovations, best practice, and latest medications to consumer need driven decisions.
- Individual outcomes

APPENDIX B

Provider	Provider Type *	Group **	Contract Name / Number	Volume	Vol Unit ***	Locality of Service	M/P/A&D *****	BP Volume
ADULT SERVICES								
A1 - Acute Inpatient - beds/care pkgs								
MHIS01 - Acute Inpatient Beds + MHIS09 - Intensive Care Inpatient Beds								
BOP								
BOP DHB	DHB	IP	Māori Mental Health Consumer Service 226737-00	32.00	B	B	0	32.00
Lakes								
Lakes DHB	DHB	IP	Residential Services - Hutt 270887-00	12.00	B	L	0	12.00
Lakes DHB	DHB	IP	Residential support 247727-01	4.00	B	L	0	4.00
Tairāwhiti								
Tairāwhiti DHB	DHB	IP	Alcohol & Drug Services for Adults	7.30	B	TT	0	7.30
Taranaki								
Taranaki DHB	DHB	IP	Recontracted-Mental Health Services 196857-02	22.00	B	TK	0	22.00
Taranaki DHB	DHB	IP	Mental Health Primary Shared Care Pilot 250990-00	4.00	B	TK	0	4.00
Waikato								
Waikato DHB	DHB	IP	Social and Recreational Services 251247-00	40.00	B	W	0	40.00
Waikato DHB	DHB	IP	Community Support Work 155673-05	13.00	B	W	0	13.00
MoH								
Ashburn Hall Charitable Trust 225975	NGO	IP	255688-01	659.67	BD	MR	0	1.81
A1 - TOTAL MIDLAND REGION								136.11
A2 - Community mental health teams - adult - FTE's								
MHCS06A - Community Mental Health Service (Other Clinical FTEs)								
BOP								

BOP DHB	DHB	CMH	Community Services for Māori 191077-01	72.00	FTE	B	0	72.00
Nga Mataapuna Oranga 582469	NGO	CMH	285891-00	0.58	FTE	B	0	0.58
Whakatohea Māori Trust Board 246886	NGO	CMH	285918-00	0.58	FTE	B	0	0.58
Lakes								
Lakes DHB	DHB	CMH	Work Rehabilitation/Employment & Education Support/Consumer Network 157795-05	37.07	FTE	L	0	37.07
Rural Dental Services 497663	NGO	CMH	289599-00	0.20	FTE	L	0	0.20
Rural Dental Services 497663	NGO	CMH	289599-00	1.00	PR	L	0	0.21
Tairāwhiti								
Tairāwhiti DHB	DHB	CMH	Community Alcohol and Drug Service 256847-01	23.60	FTE	TT	0	23.60
Ngati Porou Hauora Incorporated 248198	NGO	CMH	274538-02	5.00	FTE	TT	0	5.00
Taranaki								
Taranaki DHB	DHB	CMH	Alcohol & Drug Services for Adults	41.13	FTE	TK	0	41.13
Tui Ora Limited 250003	NGO	CMH	283312-01	2.00	FTE	TK	0	0.50
Waikato								
Waikato DHB	DHB	CMH	Te Whānau Manaaki o Manawatu 250837-01	102.20	FTE	W	0	102.20
Waikato DHB	DHB	CMH	Adolescent Educational, Pre-vocational & Pre-employment Programme 214457-01	3.00	FTE	W	0	3.00
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	1.00	PR	W	0	5.88
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	3.00	FTE	W	0	3.00
Linkage Trust 488253	NGO	CMH	278605-00	1.00	FTE	W	0	1.00
Linkage Trust 488253	NGO	CMH	283567-01	1.00	FTE	W	0	1.00
Linkage Trust 488253	NGO	CMH	283567-01	0.50	PR	W	0	0.08
Linkage Trust 488253	NGO	CMH	283568-00	1.00	FTE	W	0	1.00
Linkage Trust 488253	NGO	CMH	283568-00	4.00	FTE	W	0	4.00
Rural Dental Services 497663	NGO	CMH	277849-01	1.00	PR	W	0	0.37
MoH								
Wise Limited 593936	NGO	CMH	285161-00	2.40	FTE	TK	0	2.40
Wise Limited 593936	NGO	CMH	285161-00	5.50	FTE	W	0	5.50
SUB-TOTAL MIDLAND REGION								310.32
MHCS06A7 - Clinical Rehabilitation Service - Community (Other Clinical FTEs)								
Waikato								

Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	278093-00	1.00	FTE	W	0	1.00
SUB-TOTAL MIDLAND REGION								1.00
MHCS06B - CMHT - 30% ICT staff / Community Mental Health Service (Senior Medical FTEs)								
BOP								
BOP DHB	DHB	CMH	Crossroads Clubhouse 262366-00	7.53	FTE	B	0	7.53
Lakes								
Lakes DHB	DHB	CMH	Work Rehabilitation/Employment & Education Support/Consumer Network 157795-05	5.30	FTE	L	0	5.30
Tairawhiti								
Tairawhiti DHB	DHB	CMH	Community Alcohol and Drug Service 256847-01	1.70	FTE	TT	0	1.70
Tairawhiti DHB	DHB	CMH	Community Alcohol and Drug Service 256847-01	0.50	FTE	TT	0	0.50
Taranaki								
Taranaki DHB	DHB	CMH	Alcohol & Drug Services for Adults	4.20	FTE	TK	0	4.20
Waikato								
Waikato DHB	DHB	CMH	Mental Health Services 232177-00	12.00	FTE	W	0	12.00
Waikato DHB	DHB	CMH	Consumer Support Services - Northland 240600-01	1.00	FTE	W	0	1.00
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	1.00	FTE	W	0	1.00
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	1.00	FTE	W	0	1.00
SUB-TOTAL MIDLAND REGION								34.23
MHCS19 - Kaupapa Māori Mental Health Services - Adult Community Teams (Clinical FTEs)								
BOP								
BOP DHB	DHB	CMH	Mason - Training and Supervision 228997-00	5.11	FTE	B	M	5.11
Lakes								
Lakes DHB	DHB	CMH	Kaupapa Māori Community Support Services 257075-00	9.50	FTE	L	M	9.50
Tairawhiti								
Ngati Porou Hauora Incorporated 248198	NGO	CMH	274538-02	5.00	FTE	TT	M	5.00
Taranaki								
Tui Ora Limited 250003	NGO	CMH	283312-01	1.00	FTE	TK	M	1.00

Tui Ora Limited 250003	NGO	CMH	283312-01	0.75	FTE	TK	M	0.75
Tui Ora Limited 250003	NGO	CMH	283312-01	1.00	PR	TK	M	1.00
Tui Ora Limited 250003	NGO	CMH	283312-01	0.25	FTE	TK	M	0.25
SUB-TOTAL MIDLAND REGION								22.61
MHCS19C - Kaupapa Māori Mental Health Services - Adult Community Teams (Non-Clinical FTEs)								
BOP								
Te Tomika Trust 245515	NGO	CMH	145865-06	1.00	PR	B	M	0.14
Tairawhiti								
Te Hauora O Turanganui A Kiwa Limited 245511	NGO	CMH	216717-05	2.00	FTE	TT	M	2.00
Te Hauora O Turanganui A Kiwa Limited 245511	NGO	CMH	216717-05	2.92	FTE	TT	M	2.92
SUB-TOTAL MIDLAND REGION								5.06
A2 - TOTAL MIDLAND REGION								373.22
A3 - Community residential beds level I & II - beds or care packages								
MHCR01 - Community residential beds level I & II - beds or care packages								
Lakes								
Mangakino Trust	NGO	Res	274951	3.01	B	L	0	3.01
SUB-TOTAL MIDLAND REGION								3.01
MHCR02 - Community Residential - Level 2								
BOP								
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	275590-01	3,285.75	BD	B	0	9.00
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	275590-01	1,460.34	BD	B	0	4.00
Tairawhiti								
Ngati Porou Hauora Incorporated 248198	NGO	Res	274538-02	1,825.00	BD	TT	0	5.00
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	274826-00	1,460.00	BD	TT	0	4.00
BOP								
Te Tomika Trust	NGO	Res	147264	0.52	B	B	0	0.52
RAU-O-Te-Huia Trust	NGO	Res	228857	1.00	B	B	0	1.00

Lakes								
Karldon House Trust	NGO	Res	271620	1.00	B	L	0	1.00
Braemore Ltd	NGO	Res	271680	2.67	B	L	0	2.67
Mangakino Trust	NGO	Res	274951	1.00	B	L	0	1.00
Taranaki								
Te Toka O Maru O Taranaki Trust	NGO	Res	149172	0.03	B	TK	0	0.03
Tui Ora Limited	NGO	Res	283311	0.47	B	TK	0	0.47
Waikato								
Te Runanga O Kirikiriroa	NGO	Res	149023	0.02	B	W	0	0.02
Waihi Community Living Trust	NGO	Res	282865	5.58	B	W	0	5.58
Ballymena Properties Ltd	NGO	Res	284422	1.11	B	W	0	1.11
SUB-TOTAL MIDLAND REGION								35.41
TOTAL MIDLAND REGION								38.42
A4 - Community residential beds level III+ - beds/care packages								
MHCR03 - Community Residential - Level 3								
BOP								
BOP Community Homes Trust 587772	NGO	Res	283261-01	5,124.00	BD	B	0	14.04
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	275590-01	1,095.25	BD	B	0	3.00
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	275590-01	1,460.33	BD	B	0	4.00
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	275590-01	2,920.66	BD	B	0	8.00
BOPC - BOP Community Homes Trust	NGO	Res	-	0.90	B	B	0	0.90
Oceanside Rest Home	NGO	Res	-	0.03	B	B	0	0.03
Sunrise Trust	NGO	Res	140928	0.07	B	B	0	0.07
Avenues Home Trust	NGO	Res	145150	0.07	B	B	0	0.07
Te Tomika Trust	NGO	Res	147264	10.05	B	B	0	10.05
Vincent House	NGO	Res	149222	8.56	B	B	0	8.56
RAU-O-Te-Huia Trust	NGO	Res	228857	16.77	B	B	0	16.77
Deo GratiasTrust	NGO	Res	271549	2.11	B	B	0	2.11
Ellora Enterprises Limited	NGO	Res	276970	1.00	B	B	0	1.00

Athenree Rest Home & Hospital Ltd	NGO	Res	280748	1.13	B	B	0	1.13
Lakes								
Karlton House Trust	NGO	Res	271620	17.99	B	L	0	17.99
Bainbridge House Trust	NGO	Res	271678	8.87	B	L	0	8.87
Braemore Ltd	NGO	Res	271680	15.25	B	L	0	15.25
Pretoria Lodge Ltd	NGO	Res	271961	14.27	B	L	0	14.27
Mangakino Trust	NGO	Res	274951	13.66	B	L	0	13.66
Tairāwhiti								
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	274826-00	3,650.00	BD	TT	0	10.00
Taranaki								
Campbell House Trust	NGO	Res	149025	4.95	B	TK	0	4.95
Te Toka O Maru O Taranaki Trust	NGO	Res	149172	15.70	B	TK	0	15.70
Tui Ora Limited	NGO	Res	212857	4.11	B	TK	0	4.11
Mount View Residential Trust	NGO	Res	242806	4.21	B	TK	0	4.21
Jt Vent Ngati Ruanui Tahua Iwi/Te Toka O Maru Taranaki Inc	NGO	Res	262381	2.23	B	TK	0	2.23
Tui Ora Limited	NGO	Res	283311	6.55	B	TK	0	6.55
Te Toka O Maru O Taranaki Trust	NGO	Res	289321	0.38	B	TK	0	0.38
Waikato								
Hamilton Health Management Limited 167464	NGO	Res	283370-00	366.00	BD	W	0	1.00
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	286101-01	2,555.00	BD	W	0	7.00
Manaaki Trust	NGO	Res	140947	0.03	B	W	0	0.03
Te Runanga O Kirikiriroa	NGO	Res	149023	0.08	B	W	0	0.08
Nga Whare Awhina Trust	NGO	Res	282846	19.12	B	W	0	19.12
Ngati Maniapoto Marae Pact Trust	NGO	Res	283212	8.02	B	W	0	8.02
Manaaki Trust	NGO	Res	283215	14.26	B	W	0	14.26
Te Runanga O Kirikiriroa	NGO	Res	283329	7.37	B	W	0	7.37
Ballymena Properties Ltd	NGO	Res	284422	13.98	B	W	0	13.98
Canterbury								
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	276166-00	1,825.00	BD	W	0	5.00
SUB-TOTAL MIDLAND REGION								263.77

MHCR04 - Community Residential - Level 4								
BOP								
Kingswood House Limited 597568	NGO	Res	287343-00	1.00	PR	B	0	0.27
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	275590-01	3,285.75	BD	B	0	9.00
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	279447-01	365.98	BD	B	0	1.00
Deo Gratiastrust	NGO	Res	271549	3.90	B	B	0	3.90
Oceanside Rest Home	NGO	Res	278109	3.07	B	B	0	3.07
Kingswood House Limited	NGO	Res	287343	0.66	B	B	0	0.66
Kingswood House Limited	NGO	Res	289453	0.66	B	B	0	0.66
Lakes								
Te Aroha o Hinemaru Trust 561064	NGO	Res	284262-00	3,650.00	BD	L	0	10.00
Taranaki								
Te Toka O Maru O Taranaki Trust	NGO	Res	149172	4.28	B	TK	0	4.28
Te Whare Puawai O Te Tangata	NGO	Res	212857	0.01	B	TK	0	0.01
Tui Ora Limited	NGO	Res	212857	1.05	B	TK	0	1.05
Te Toka O Maru O Taranaki Trust	NGO	Res	255596	1.00	B	TK	0	1.00
Sunhaven Rest Home	NGO	Res	263339	1.00	B	TK	0	1.00
Tui Ora Limited	NGO	Res	283311	1.98	B	TK	0	1.98
Te Toka O Maru O Taranaki Trust	NGO	Res	289321	0.11	B	TK	0	0.11
Tairāwhiti								
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	274826-00	1,825.00	BD	TT	0	5.00
Waikato								
Hamilton Health Management Limited 167464	NGO	Res	283394-00	366.00	BD	W	0	1.00
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	286101-01	2,129.17	BD	W	0	5.83
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	286101-01	1,277.50	BD	W	0	3.50
Te Runanga O Kirikiriroa	NGO	Res	149023	0.07	B	W	0	0.07
Te Runanga O Kirikiriroa	NGO	Res	283329	8.15	B	W	0	8.15
Ballymena Properties Ltd	NGO	Res	284422	15.73	B	W	0	15.73
Canterbury								
Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	276166-00	912.50	BD	W	0	2.50

Richmond Fellowship NZ Inc - National Office 226422	NGO	Res	276166-00	1,520.83	BD	W	0	4.17
SUB-TOTAL MIDLAND REGION								83.97
A4 - TOTAL MIDLAND REGION								347.74
A6 - Home based support services - FTE's								
MHCR09 - Other Residential Support								
Auckland								
Framework Trust 248291	NGO	CoSup	Main Mental Health Services 250756-00 / 284102-01	1.00	FTE	MR	0	1.00
BOP								
BOP DHB	DHB	CoSup	Early Intervention Services 165237-02	2.20	FTE	B	0	2.20
SUB-TOTAL MIDLAND REGION								3.20
MHCR09.1 - Other Residential Support - Home Based Support Services								
BOP								
BOP DHB	DHB	CoSup	Contract for Service Caregivers 173882-02	1.00	FTE	B	0	1.00
Healthcare of New Zealand Ltd 244688	NGO	CoSup	283855-01	1.00	FTE	B	0	1.00
Healthcare of New Zealand Ltd 244688	NGO	CoSup	283855-01	2.00	FTE	B	0	2.00
Poutiri Charitable Trust 249942	NGO	CoSup	274649-00	1.00	FTE	B	0	1.00
Richmond Fellowship NZ Inc - National Office 226422	NGO	CoSup	275590-01	1.60	FTE	B	0	1.60
Richmond Fellowship NZ Inc - National Office 226422	NGO	CoSup	275590-01	2.40	FTE	B	0	2.40
Richmond Fellowship NZ Inc - National Office 226422	NGO	CoSup	275590-01	2.40	FTE	B	0	2.40
Te Manu Toroa Trust 248707	NGO	CoSup	274686-00	1.00	FTE	B	0	1.00
Canterbury								
Richmond Fellowship NZ Inc - National Office 226422	NGO	CoSup	276166-00	1.38	FTE	W	0	1.38
Lakes								
Healthcare of New Zealand Ltd 244688	NGO	CoSup	283847-00	1.50	FTE	L	0	1.50
Healthcare of New Zealand Ltd 244688	NGO	CoSup	286315-00	3.96	FTE	L	0	3.96
Tairāwhiti								

Ngati Porou Hauora Incorporated 248198	NGO	CoSup	274538-02	1.00	FTE	TT	0	1.00
Richmond Fellowship NZ Inc - National Office 226422	NGO	CoSup	274826-00	1.16	FTE	TT	0	1.16
Te Hauora O Turanganui A Kiwa Limited 245511	NGO	CoSup	216717-05	1.00	FTE	TT	0	1.00
Taranaki								
Healthcare of New Zealand Ltd 244688	NGO	CoSup	284073-00	3.10	FTE	TK	0	3.10
Healthcare of New Zealand Ltd 244688	NGO	CoSup	284073-00	0.05	FTE	TK	0	0.05
Healthcare of New Zealand Ltd 244688	NGO	CoSup	284073-00	0.05	FTE	TK	0	0.05
Pathways Trust 245234	NGO	CoSup	285344-01	1.33	FTE	TK	0	1.33
Waikato								
Hauora Waikato Māori Mental Health Services 246494	NGO	CoSup	250756-01	1.00	FTE	W	0	1.00
Healthcare of New Zealand Ltd 244688	NGO	CoSup	276045-00	0.31	FTE	W	0	0.31
Healthcare of New Zealand Ltd 244688	NGO	CoSup	283576-02	2.50	FTE	W	0	2.50
Healthcare of New Zealand Ltd 244688	NGO	CoSup	283576-02	1.88	FTE	W	0	0.08
Healthcare of New Zealand Ltd 244688	NGO	CoSup	283576-02	0.94	FTE	W	0	0.94
Richmond Fellowship NZ Inc - National Office 226422	NGO	CoSup	286101-01	1.93	FTE	W	0	1.93
Te Korowai Hauora o Hauraki Incorporated 247791	NGO	CoSup	283603-01	2.16	FTE	W	0	2.16
The Salvation Army New Zealand Trust 453989	NGO	CoSup	257293-00	1.00	PR	W	0	0.11
The Salvation Army New Zealand Trust 453989	NGO	CoSup	285658-01	0.15	FTE	W	0	0.15
The Salvation Army New Zealand Trust 453989	NGO	CoSup	285658-01	0.13	FTE	W	0	0.01
SUB-TOTAL MIDLAND REGION								
MHCR09.2 - Other Residential Support - Community Support Work								
MoH								
Wise Limited 593936	NGO	CoSup	285161-00	12.80	FTE	B	0	12.80
Wise Limited 593936	NGO	CoSup	285161-00	75.90	FTE	W	0	75.90
Waikato								
Healthcare of New Zealand Ltd 244688	NGO	CoSup	283576-02	1.00	FTE	W	0	1.00
Healthcare of New Zealand Ltd 244688	NGO	CoSup	283576-02	0.50	PR	W	0	0.02
Maniapoto Māori Trust Board 438219	NGO	CoSup	283600-00	3.00	FTE	W	0	3.00
Te Awhi Whānau Charitable Trust 419931	NGO	CoSup	140926-05	1.50	PR	W	0	0.08
Te Awhi Whānau Charitable Trust 419931	NGO	CoSup	140926-05	3.50	PR	W	0	0.14

Te Awahi Whānau Charitable Trust 419931	NGO	CoSup	140926-05	7.00	FTE	W	0	7.00
Te Awahi Whānau Charitable Trust 419931	NGO	CoSup	140926-05	3.00	FTE	W	0	3.00
Te Runanga O Kirikiriroa Charitable Trust 242836	NGO	CoSup	283329-01	0.30	FTE	W	0	0.30
Te Runanga O Kirikiriroa Charitable Trust 242836	NGO	CoSup	283329-01	0.15	PR	W	0	0.01
The Ngati Maniapoto Marae Pact Trust Incorporated 244874	NGO	CoSup	276104-02	1.00	FTE	W	0	1.00
The Ngati Maniapoto Marae Pact Trust Incorporated 244874	NGO	CoSup	276104-02	0.50	PR	W	0	0.02
SUB-TOTAL MIDLAND REGION								104.27
MHCR09.3 - Other Residential Support - Support For Independence								
BOP								
BOP DHB	DHB	CoSup	Kaupapa Māori Day Program Mental Health 235158-01	1.00	FTE	B	0	1.00
Waikato								
Pathways Trust 245234	NGO	CoSup	283573-01	1.32	FTE	W	0	1.32
Pathways Trust 245234	NGO	CoSup	283573-01	0.66	PR	W	0	0.03
SUB-TOTAL MIDLAND REGION								2.34
MHCS06A1 - Needs Assessment & Service Co-ordination (Other Clinical FTEs)								
BOP								
Nga Mataapuna Oranga 582469	NGO	CoSup	285891-00	0.58	PR	B	0	0.58
Poutiri Charitable Trust 249942	NGO	CoSup	223297-01	1.00	PR	B	0	14.29
Te Manu Toroa Trust 248707	NGO	CoSup	223877-02	1.00	PR	B	0	4.76
Tuwharetoa Ki Kawerau Hauora Trust 250071	NGO	CoSup	285917-00	0.58	FTE	B	0	0.58
Whakatohea Māori Trust Board 246886	NGO	CoSup	285918-00	0.58	PR	B	0	1.77
Taranaki								
Tui Ora Limited 250003	NGO	CoSup	283312-01	1.00	FTE	TK	0	1.00
Tui Ora Limited 250003	NGO	CoSup	283312-01	1.00	FTE	TK	0	1.00
Waikato								
Hauora Waikato Māori Mental Health Services 246494	NGO	CoSup	250756-01	4.50	FTE	W	0	4.50
Maniapoto Māori Trust Board 438219	NGO	CoSup	283598-00	3.00	FTE	W	0	3.00
SUB-TOTAL MIDLAND REGION								31.49

MHRE01 - Adult Planned Respite								
Tairawhiti								
Ngati Porou Hauora Incorporated 248198	NGO	CoSup	274538-02	68.00	BD	TT	0	0.11
Richmond Fellowship NZ Inc - National Office 226422	NGO	CoSup	274826-00	68.00	BD	TT	0	0.11
Te Hauora O Turanganui A Kiwa Limited 245511	NGO	CoSup	216717-05	68.00	BD	TT	0	0.11
Waikato								
Family and Caregiver Support Incorporated 250002	NGO	CoSup	286879-00	1.00	PR	W	0	0.17
Healthcare of New Zealand Ltd 244688	NGO	CoSup	286786-00	0.50	PR	W	0	1.70
SUB-TOTAL MIDLAND REGION								2.20
MHRE01 - Planned Respite - Older Peoples								
Lakes								
Lakes DHB	DHB	CoSup	Mental Health Residential Services 212317-02	1.00	PR	L	0	0.47
Taranaki								
Taranaki DHB	DHB	CoSup	Alcohol & Drug Services for Adults 219617-02	1.00	PR	TK	0	0.26
Waikato								
Waikato DHB	DHB	CoSup	Mental Health Services 244021-00	1.00	PR	W	0	1.70
Waikato DHB	DHB	CoSup	Whānau Support and KM Day Programmes - Tihi Ora 251600-00	1.00	PR	W	0	3.40
SUB-TOTAL MIDLAND REGION								5.83
MHRE02 - Adult Crisis Respite								
BOP								
BOP DHB	DHB	CoSup	A & D Service Contract 252048-00	1.60	PR	B	0	1.81
Lakes								
Lakes DHB	DHB	CoSup	Mental Health Residential Services 212317-02	1.00	PR	L	0	0.95
Tairawhiti								
Tairawhiti DHB	DHB	CoSup	Alcohol & Drug Services for Adults	112.00	PR	TT	0	0.46
Taranaki								
Taranaki DHB	DHB	CoSup	Alcohol & Drug Services for Adults 219617-02	1.00	PR	TK	0	1.47
Waikato								
Waikato DHB	DHB	CoSup	Whānau Support and KM Day Programmes - Tihi Ora 251600-00	1.00	PR	W	0	4.24
Hauora Waikato Māori Mental Health Services	NGO	CoSup	250756-01	1.00	PR	W	0	1.00

246494									
Te Runanga O Kirikiriroa Charitable Trust 242836	NGO	CoSup	283594-01	1.02	PR	W	0	3.28	
SUB-TOTAL MIDLAND REGION									13.21
A6 - TOTAL MIDLAND REGION									198.64
A8 - Medium term and extended inpatient services - beds or care packages									
MHIS03 - Clinical Rehabilitation/Sub-Acute/Extended Care Inpatient Beds									
Capital and Coast									
Capital and Coast DHB	DHB	IP	National Mental Health contract (Contract 1) 218077-05	2.68	B	TT	0	2.68	
Waikato									
Waikato DHB	DHB	IP	Consumer Run Facility 250378-00	13.00	B	W	0	13.00	
A8- TOTAL MIDLAND REGION									15.68
A9 - Employment and educational support - FTE's									
MHCS14 - Work Rehabilitation/Employment and Educational Support Services (Clinical FTEs)									
BOP									
Turning Point Trust 248251	NGO	CoSup	141541-03	1.00	FTE	B	0	1.00	
Turning Point Trust 248251	NGO	CoSup	141541-03	1.00	FTE	B	0	1.00	
Lakes									
Te Aratu Trust 243539	NGO	CoSup	271759-02	1.00	FTE	L	0	1.00	
Tairāwhiti									
Vanessa Lowndes Centre 245586	NGO	CoSup	285340-00	1.00	FTE	TT	0	1.00	
Vanessa Lowndes Centre 245586	NGO	CoSup	285340-00	1.00	FTE	TT	0	1.00	
Waikato									
Raukawa Trust Board 245022	NGO	CoSup	151041-04	1.00	PR	W	0	1.00	
SUB-TOTAL MIDLAND REGION									6.00
MHCS14C - Work Rehabilitation/Employment and Educational Support Services (Non-Clinical FTEs)									
Taranaki									

Workwise Trust Board 594479	NGO	CoSup	285996-00	0.50	PR	TK	0	0.50
Waikato								
New Progress Enterprises Charitable Trust 249826	NGO	CoSup	283513-00	1.50	FTE	W	0	1.50
New Progress Enterprises Charitable Trust 249826	NGO	CoSup	283513-00	2.00	FTE	W	0	2.00
New Progress Enterprises Charitable Trust 249826	NGO	CoSup	283513-00	2.50	FTE	W	0	2.50
Te Korowai Hauora o Hauraki Incorporated 247791	NGO	CoSup	283789-00	1.38	FTE	W	0	1.38
Workwise Trust Board 597234	NGO	CoSup	287192-00	1.25	FTE	W	0	1.25
SUB-TOTAL MIDLAND REGION								9.13
A9- TOTAL MIDLAND REGION								15.13
A10 - Support and education for recovery - FTE's								
MHCS16 - Activity-Based Rehabilitation Service/Day Activity and Living Skills (Clinical FTEs)								
BOP								
Tirohia Te Kopere Trust 249931	NGO	CoSup	278275-01	1.08	FTE	B	0	1.08
Turning Point Trust 248251	NGO	CoSup	142582-03	1.00	PR	B	0	2.71
Turning Point Trust 248251	NGO	CoSup	142582-03	1.00	FTE	B	0	1.00
Lakes								
Contact Trust Rotorua 245206	NGO	CoSup	271685-03	1.00	FTE	L	0	1.00
Te Aratu Trust 243539	NGO	CoSup	271758-03	0.83	PR	L	0	0.83
Taranaki								
Tui Ora Limited 250003	NGO	CoSup	283312-01	0.68	FTE	TK	0	0.68
Tui Ora Limited 250003	NGO	CoSup	283312-01	1.43	FTE	TK	0	1.43
Waikato								
Te Runanga O Kirikiriroa Charitable Trust 242836	NGO	CoSup	283594-01	3.12	FTE	W	0	3.12
SUB-TOTAL MIDLAND REGION								11.85
MHCS16C - Activity-Based Rehabilitation Service/Day Activity and Living Skills (Non-Clinical FTEs)								
BOP								
Eastern BOP Consumer Advisory Group Trust 597001	NGO	CoSup	289918-00	0.10	FTE	B	0	0.10
Lakes								
Te Aratu Trust 243539	NGO	CoSup	271758-03	0.50	FTE	L	0	0.50
Tuwharetoa Health Services Limited 245574	NGO	CoSup	271687-04	1.00	FTE	L	0	1.00

Tairāwhiti								
Te Hauora O Turanganui A Kiwa Limited 245511	NGO	CoSup	216717-05	1.73	FTE	TT	0	1.73
Waikato								
Waikato DHB	DHB	CoSup	Operational Contract 168937-01	6.70	FTE	W	0	6.70
New Progress Enterprises Charitable Trust 249826	NGO	CoSup	283513-00	2.00	FTE	W	0	2.00
New Progress Enterprises Charitable Trust 249826	NGO	CoSup	283513-00	3.00	FTE	W	0	3.00
The Ngati Maniapoto Marae Pact Trust Incorporated 244874	NGO	CoSup	283561-01	1.00	FTE	W	0	1.00
SUB-TOTAL MIDLAND REGION								16.03
MHCS42 - Kaupapa Māori Day Programmes								
BOP								
Whaioranga Trust 245641	NGO	CoSup	235158-02	1.00	PR	B	M	0.28
SUB-TOTAL MIDLAND REGION								0.28
A10 - TOTAL MIDLAND REGION								28.16
A11 - Outreach (rural) - FTE's								
MHCS06A6 - Community Mental Health Service - Intensive Treatment Service – Mobile								
BOP								
BOP DHB	DHB	CMH	Community Services for Māori 191077-01	4.58	FTE	B	0	4.58
Taranaki								
Tui Ora Limited 250003	NGO	CMH	283312-01	0.45	FTE	TK	0	0.45
Waikato								
Waikato DHB	DHB	CMH	Mental Health Services 232177-00	3.50	FTE	W	0	3.50
A11 - TOTAL MIDLAND REGION								8.53
A12 - Consumer advisory and consumer run initiatives - FTEs								
MHCS21 - Advocacy/Peer Support - Consumers								
BOP								
Poutiri Charitable Trust 249942	NGO	Cons	228857-03	1.00	FTE	B	0	1.00
Tuhoe Hauora Trust 249180	NGO	Cons	149301-05	1.00	PR	B	0	0.24

Tuhoe Hauora Trust 249180	NGO	Cons	149301-05	0.75	FTE	B	0	0.75
Lakes								
Lakes DHB	DHB	Cons	Day Activity Services 197597-02	1.50	FTE	L	0	1.50
Tuwharetoa Health Services Limited 245574	NGO	Cons	148467-04	1.00	FTE	L	0	1.00
Tuwharetoa Health Services Limited 245574	NGO	Cons	148467-04	1.00	FTE	L	0	1.00
Tairāwhiti								
Tairāwhiti DHB	DHB	Cons	Community Alcohol and Drug Service 256847-01	0.50	FTE	TT	0	0.50
Ngāti Porou Hauora Incorporated 248198	NGO	Cons	274538-02	2.00	FTE	TT	0	2.00
Taranaki								
Taranaki DHB	DHB	Cons	Kaupapa Māori MH & Alcohol & Drug Services 242422-00	2.00	FTE	TK	0	2.00
Waikato								
Waikato DHB	DHB	Cons	Service contract - Ngāti Kahu Social Services 172137-03	2.00	FTE	W	0	2.00
Hauora Waikato Māori Mental Health Services 246494	NGO	Cons	250756-01	1.50	FTE	W	0	1.50
New Progress Enterprises Charitable Trust 249826	NGO	Cons	247505-01	2.00	FTE	W	0	2.00
New Progress Enterprises Charitable Trust 249826	NGO	Cons	247508-00	6.00	FTE	W	0	6.00
SUB-TOTAL MIDLAND REGION								21.49
MHCS21.1 - Advocacy/Peer Support/Consumers (Adult)								
Auckland								
GROW New Zealand Incorporated 226460	NGO	Cons	Main Mental Health Services 250756-00 / 284140-01	1.00	PR	MR	0	1.00
BOP								
BOP DHB	DHB	Cons	HHS Subcontract-Social & Rec Services 152097-09	2.00	FTE	B	0	2.00
Consumer Action Network Trust 596143	NGO	Cons	286282-01	1.00	PR	B	0	0.08
Consumer Action Network Trust 596143	NGO	Cons	287434-00	1.00	PR	B	0	1.00
Consumer Action Network Trust 596143	NGO	Cons	287434-00	1.00	PR	B	0	0.08
Drug Awareness & Relief Movement Incorporated 245762	NGO	Cons	145871-03	1.00	PR	B	0	0.25
Eastern BOP Consumer Advisory Group Trust 597001	NGO	Cons	286999-01	1.00	PR	B	0	0.08
Eastern BOP Consumer Advisory Group Trust 597001	NGO	Cons	289408-00	1.00	PR	B	0	0.10
GROW New Zealand Incorporated 248331	NGO	Cons	142589-03	1.00	PR	B	0	0.01

Lakes								
Contact Trust Rotorua 245206	NGO	Cons	255597-01	1.00	FTE	L	0	1.00
Tairāwhiti								
Men for Change Incorporated 244349	NGO	Cons	149118-04	1.00	PR	TT	0	0.07
Taranaki								
Like Minds Taranaki 244909	NGO	Cons	282268-01	0.25	FTE	TK	0	0.25
Tui Ora Limited 250003	NGO	Cons	283312-01	0.50	FTE	TK	0	0.50
Tui Ora Limited 250003	NGO	Cons	283312-01	0.50	FTE	TK	0	0.50
Waikato								
Centre 401 Trust 244388	NGO	Cons	283571-00	3.00	FTE	W	0	3.00
Centre 401 Trust 244388	NGO	Cons	284287-00	2.75	FTE	W	0	2.75
New Progress Enterprises Charitable Trust 249826	NGO	Cons	283513-00	2.00	FTE	W	0	2.00
Stepping Out Hauraki Incorporated 245380	NGO	Cons	283386-00	2.00	FTE	W	0	2.00
Te Runanga O Kirikiriroa Charitable Trust 242836	NGO	Cons	283594-01	1.02	FTE	W	0	1.02
SUB-TOTAL MIDLAND REGION								17.69
MHCS21.7 - Advocacy/Peer Support/Consumers (Child)								
BOP								
Te Manu Toroa Trust 248707	NGO	Cons	286815-00	0.42	FTE	B	0	0.42
SUB-TOTAL MIDLAND REGION								0.42
MHCS21.8 - Advocacy/Peer Support - Consumers (A&D)								
BOP								
BOP DHB	DHB	Cons	Residential Rehab & Community Support Work 157878-07	0.42	FTE	B	A&D	0.42
Waikato								
Pai Ake Solutions Limited 572107	NGO	Cons	284247-00	2.29	FTE	W	A&D	2.29
SUB-TOTAL MIDLAND REGION								2.71
MHCS25 - Māori Advisory Services								
BOP								
Moni Nursing Services Limited 598435	NGO	Cons	288007-00	1.00	FTE	B	M	1.00
Pirirakau Hauora Charitable Trust 244449	NGO	Cons	287877-00	1.00	FTE	B	M	0.40

Tuhoe Matauranga Trust 248247	NGO	Cons	287878-00	1.00	FTE	B	M	1.00
Waikato								
Waikato DHB	DHB	Cons	Service contract - Ngati Kahu Social Services 172137-03	3.00	FTE	W	M	3.00
Waikato DHB	DHB	Cons	KM Day Programmes and Whānau Support Ngati Kahu 251592-00	3.00	FTE	W	M	3.00
SUB-TOTAL MIDLAND REGION								8.40
A12 - TOTAL MIDLAND REGION								50.70
A13 - Family advisory and family run initiatives - FTEs								
MHCS22 - Advocacy/Peer Support - Families/Whānau								
BOP								
BOP DHB	DHB	Cons	Residential Rehab & Community Support Work 157878-07	1.00	FTE	B	0	1.00
Poutiri Charitable Trust 249942	NGO	Cons	228857-03	1.00	FTE	B	0	1.00
Canterbury								
Schizophrenia Fellowship NZ Inc - National Office 225965	NGO	Cons	279748-02	1.00	FTE	TK	0	1.00
Schizophrenia Fellowship NZ Inc - National Office 225965	NGO	Cons	279748-02	1.26	FTE	L	0	1.26
Schizophrenia Fellowship NZ Inc - National Office 225965	NGO	Cons	279748-02	2.00	FTE	TT	0	2.00
Schizophrenia Fellowship NZ Inc - National Office 225965	NGO	Cons	279748-02	2.80	FTE	W	0	2.80
Waikato								
Family and Caregiver Support Incorporated 250002	NGO	Cons	276106-00	0.06	FTE	W	0	0.06
SUB-TOTAL MIDLAND REGION								9.12
MHCS22.1 - Advocacy/Peer Support - Families/Whānau (Adults)								
BOP								
Alzheimer's Society - Tauranga 571704	NGO	Cons	274835-00	1.00	PR	B	0	0.32
Ngati Awa Social and Health Services Trust 249133	NGO	Cons	191057-02	1.00	PR	B	0	1.00
Poutiri Charitable Trust 249942	NGO	Cons	228857-03	0.75	FTE	B	0	0.75

Schizophrenia Fellowship NZ Inc - National Office 225965	NGO	Cons	284732-01	0.42	FTE	B	0	0.42
Schizophrenia Fellowship NZ Inc - National Office 225965	NGO	Cons	284732-01	1.00	PR	B	0	0.16
Tuhoe Hauora Trust 249180	NGO	Cons	191097-03	1.00	PR	B	0	1.00
Western BOP Mental Health Trust 244097	NGO	Cons	Alcohol & Drug Services for Adults / 278246-01	1.50	FTE	B	0	1.50
Western BOP Mental Health Trust 244097	NGO	Cons	Alcohol & Drug Services for Adults / 284416-00	0.46	FTE	B	0	0.46
Western BOP Mental Health Trust 244097	NGO	Cons	Alcohol & Drug Services for Adults / 284416-00	1.00	PR	B	0	0.24
Whakatohea Māori Trust Board 246886	NGO	Cons	Odyssey House 249855-00 / 191077-02	1.00	PR	B	0	1.00
Tairāwhiti								
Te Hauora O Turanganui A Kiwa Limited 245511	NGO	Cons	216717-05	0.42	FTE	TT	0	0.42
Waikato								
Family and Caregiver Support Incorporated 250002	NGO	Cons	283392-01	1.00	FTE	W	0	1.00
Family and Caregiver Support Incorporated 250002	NGO	Cons	283392-01	0.19	FTE	W	0	0.19
People Relying on People Inc 245203	NGO	Cons	277965-00	0.05	FTE	W	0	0.05
People Relying on People Inc 245203	NGO	Cons	283453-00	1.00	FTE	W	0	1.00
People Relying on People Inc 245203	NGO	Cons	283455-00	1.00	FTE	W	0	1.00
Rostrevor House Inc 248287	NGO	Cons	283391-00	1.00	FTE	W	0	1.00
SUB-TOTAL MIDLAND REGION								11.50
MHCS22.2 - Advocacy/Peer Support - Families/Whānau (Older Adults)								
BOP								
Alzheimer's Society - Tauranga 571704	NGO	Cons	286032-00	0.50	PR	B	0	0.16
SUB-TOTAL MIDLAND REGION								0.16
MHCS22.7 - Advocacy/Peer Support - Families/Whānau (Child & Youth)								
BOP								
Te Manu Toroa Trust 248707	NGO	Cons	274686-00	1.00	FTE	B	0	1.00
Te Rangimarie Trust 245496	NGO	Cons	181397-05	0.50	FTE	B	0	0.50
Te Rangimarie Trust 245496	NGO	Cons	181397-05	0.50	FTE	B	0	0.50
Whakatohea Māori Trust Board 246886	NGO	Cons	274639-00	1.00	FTE	B	PI	1.00
Waikato								
People Relying on People Inc 245203	NGO	Cons	277965-00	0.04	FTE	W	0	0.04
SUB-TOTAL MIDLAND REGION								3.04

MHCS22.8 - Advocacy/Peer Support - Families/Whānau (Alcohol & Drug)								
BOP								
Nga Mataapuna Oranga 582469	NGO	Cons	285891-00	0.25	FTE	B	A&D	0.25
Nga Mataapuna Oranga 582469	NGO	Cons	285891-00	0.44	FTE	B	A&D	0.44
Whakatohea Māori Trust Board 246886	NGO	Cons	285918-00	0.25	FTE	B	PI/A&D	0.25
Whakatohea Māori Trust Board 246886	NGO	Cons	285918-00	0.19	FTE	B	A&D	0.19
Tairāwhiti								
Te Hauora O Turanganui A Kiwa Limited 245511	NGO	Cons	216717-05	1.70	FTE	TT	A&D	1.70
Waikato								
t/as Parentline Parentline Charitable Trust 246042	NGO	Cons	285980-00	1.70	FTE	W	A&D	1.70
SUB-TOTAL MIDLAND REGION								4.53
MHCS46 - Kaupapa Māori Mental Health Services - Crisis Intervention								
Taranaki								
Tui Ora Limited 250003	NGO	Cons	283312-01	2.00	FTE	TK	M	2.00
Tui Ora Limited 250003	NGO	Cons	283312-01	0.50	FTE	TK	M	0.50
SUB-TOTAL MIDLAND REGION								2.50
A13 - TOTAL MIDLAND REGION								30.85
A14 - General hospital liaison - FTEs								
MHCS07 - General Hospital Liaison Service								
BOP								
BOP DHB	DHB	CMH	Auckland City Mission - A&D Services 155429-01	2.35	FTE	B	0	2.35
Lakes								
Lakes DHB	DHB	CMH	Work Rehabilitation/Employment & Education Support/Consumer Network 157795-05	1.90	FTE	L	0	1.90
Waikato								
Waikato DHB	DHB	CMH	Iwi Support to Mental Health & Alcohol & Drug Services 210997-02	2.50	FTE	W	0	2.50
A14 - TOTAL MIDLAND REGION								6.75

A16 - Early intervention programme - FTEs								
MHCS06A5 - Early Intervention for people with first time psychosis (Other Clinical FTEs)								
BOP								
Tuhoe Hauora Trust 249180	NGO	CMH	148705-04	4.00	FTE	B	0	0.96
Taranaki								
Tui Ora Limited 250003	NGO	CMH	283312-01	1.00	FTE	TK	0	1.00
Tui Ora Limited 250003	NGO	CMH	283312-01	1.00	FTE	TK	0	1.00
SUB-TOTAL MIDLAND REGION								2.96
MHCS44 - Kaupapa Māori Mental Health Services - Early Intervention								
BOP								
Poutiri Charitable Trust 249942	NGO	CMH	228857-03	1.50	FTE	B	0	1.50
Poutiri Charitable Trust 249942	NGO	CMH	228857-03	1.00	FTE	B	0	1.00
Tairāwhiti								
Te Hauora O Turanganui A Kiwa Limited 245511	NGO	CMH	216717-05	0.50	FTE	TT	0	0.50
Taranaki								
Tui Ora Limited 250003	NGO	CMH	283312-01	1.00	FTE	TK	0	1.00
Waikato								
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	1.00	FTE	W	0	1.00
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	1.00	PR	W	0	1.00
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	1.00	FTE	W	0	1.00
SUB-TOTAL MIDLAND REGION								7.00
A16 - TOTAL MIDLAND REGION								9.96
A17 - A&D - Community assessment and treatment - FTEs								
MHCS01A - Community Alcohol & Drug Services (Other Clinical FTEs)								
BOP								
BOP DHB	DHB	A&D Co	Community Services for Māori 191077-01	17.03	FTE	B	A&D	17.03

t/as Hanmer Clinic Tauranga Charitable Trust 596979	Hanmer BOP	NGO	A&D Co	286961-00	2.06	FTE	B	A&D	2.06
t/as Hanmer Clinic Tauranga Charitable Trust 596979	Hanmer BOP	NGO	A&D Co	286961-00	1.00	PR	B	A&D	1.00
t/as Hanmer Clinic Tauranga Charitable Trust 596979	Hanmer BOP	NGO	A&D Co	286961-00	1.00	PR	B	A&D	0.21
Lakes									
Lakes DHB		DHB	A&D Co	Youth Health Services 142237-02	2.40	FTE	L	A&D	2.40
Drug and Alcohol Support Taupo Trust 249602		NGO	A&D Co	271959-04	1.00	FTE	L	A&D	1.00
Te Utuhina Manaakitanga Trust 245582		NGO	A&D Co	283870-01	5.00	FTE	L	A&D	5.00
Tuwharetoa Health Services Limited 245574		NGO	A&D Co	271687-04	1.00	PR	L	A&D	1.00
MoH									
Waikato Ex Hanmer		NGO	A&D Co		5.00	FTE	W	A&D	5.00
Tairawhiti									
Tairawhiti DHB		DHB	A&D Co	National Residential Services 251266-00	4.20	FTE	TT	A&D	4.20
Ngati Porou Hauora Incorporated 248198		NGO	A&D Co	274538-02	1.00	FTE	TT	A&D	1.00
Taranaki									
Taranaki DHB		DHB	A&D Co	Alcohol & Drug Services for Adults	8.80	FTE	TK	A&D	8.80
Tui Ora Limited 250003		NGO	A&D Co	283312-01	0.50	FTE	TK	A&D	0.50
Waikato									
Waikato DHB		DHB	A&D Co	Workforce Development 238760-00	18.50	FTE	W	A&D	18.50
Cambridge Community Agencies Network Charitable Trust 243401		NGO	A&D Co	283388-00	0.50	FTE	W	A&D	0.50
Pacific Peoples' Addiction Services Incorporated 247712		NGO	A&D Co	283597-00	2.00	FTE	W	A&D	2.00
Te Korowai Hauora o Hauraki Incorporated 247791		NGO	A&D Co	283601-00	0.50	FTE	W	A&D	0.50
The Salvation Army New Zealand Trust 158929		NGO	A&D Co	283604-00	0.50	FTE	W	A&D	0.50

Waahi Whaanui Trust 247350	NGO	A&D Co	283385-00	2.00	FTE	W	A&D	2.00
Waikato Alcohol & Addiction Counselling Centre 594234	NGO	A&D Co	285766-01	1.00	PR	W	A&D	1.00
SUB-TOTAL MIDLAND REGION								74.20
MHCS01B - Community Alcohol & Drug Services								
BOP								
BOP DHB	DHB	A&D Co	Community Services for Māori 191077-01	0.42	FTE	B	A&D	0.42
Te Rangimarie Trust 245496	NGO	A&D Co	145862-05	1.18	FTE	B	A&D	1.18
Tairawhiti								
Tairawhiti DHB	DHB	A&D Co	National Residential Services 251266-00	0.30	FTE	TT	A&D	0.30
Taranaki								
Taranaki DHB	DHB	A&D Co	Alcohol & Drug Services for Adults	1.00	FTE	TK	A&D	1.00
Waikato								
Waikato DHB	DHB	A&D Co	Kaupapa Māori Mental Health and Alcohol & Drug Services 196977-03	1.50	FTE	W	A&D	1.50
SUB-TOTAL MIDLAND REGION								4.40
MHCS01C - Community Alcohol & Drug Services (Non-Clinical FTEs)								
Auckland								
The Salvation Army New Zealand Trust 426733	NGO	A&D Co	Community Alcohol & Drug Services 219577-02 / 284324-01	0.34	FTE	B	A&D	0.34
The Salvation Army New Zealand Trust 426733	NGO	A&D Co	Community Alcohol & Drug Services 219577-02 / 284324-01	0.34	FTE	B	A&D	0.34
The Salvation Army New Zealand Trust 426733	NGO	A&D Co	Mental Health Services 197537-02 / 284324-01	3.97	FTE	W	A&D	3.97
Hutt								
Care NZ Limited 244227	NGO	A&D Co	217837-06	3.80	FTE	MR	A&D	3.80
Tairawhiti								
Tairawhiti DHB	DHB	A&D	National Residential Services 251266-00	1.00	FTE	TT	A&D	1.00

		Co						
Taranaki								
Taranaki DHB	DHB	A&D Co	Alcohol & Drug Services for Adults	1.00	FTE	TK	A&D	1.00
Waikato								
Northern King Country Drug & Alcohol Counselling & Education 245498	NGO	A&D Co	283510-00	2.00	FTE	W	A&D	2.00
The Higher Ground Drug Rehabilitation Trust 430665	NGO	A&D Co	286287-00	0.58	FTE	W	A&D	0.58
SUB-TOTAL MIDLAND REGION								13.02
MHCS02A - Kaupapa Māori Alcohol & Drug Services (Other Clinical FTEs)								
BOP								
Poutiri Charitable Trust 249942	NGO	A&D Co	228857-03	3.00	FTE	B	M/A&D	3.00
Poutiri Charitable Trust 249942	NGO	A&D Co	228857-03	0.75	FTE	B	M/A&D	0.75
Tuhoe Hauora Trust 249180	NGO	A&D Co	Recontracted-Mental Health Services 196857-02 / 149301-05	1.00	FTE	B	M/A&D	0.11
Tuhoe Hauora Trust 249180	NGO	A&D Co	Recontracted-Mental Health Services 196857-02 / 149301-05	0.38	FTE	B	M/A&D	0.38
Whakatohea Māori Trust Board 246886	NGO	A&D Co	191077-02	0.50	FTE	B	M/A&D	0.50
Lakes								
Te Utuhina Manaakitanga Trust 245582	NGO	A&D Co	283870-01	2.00	FTE	L	M/A&D	2.00
Tuwharetoa Health Services Limited 245574	NGO	A&D Co	148467-04	1.00	FTE	L	M/A&D	1.00
Taranaki								
Tui Ora Limited 250003	NGO	A&D Co	283312-01	2.00	FTE	TK	M/A&D	2.00
Tui Ora Limited 250003	NGO	A&D Co	283312-01	1.00	FTE	TK	M/A&D	1.00
Tui Ora Limited 250003	NGO	A&D Co	283312-01	1.00	FTE	TK	M/A&D	1.00
Waikato								
Raukawa Trust Board 245022	NGO	A&D Co	283587-00	1.50	FTE	W	M/A&D	1.50

Te Runanga O Kirikiriroa Charitable Trust 242836	NGO	A&D Co	283594-01	2.69	FTE	W	M/A&D	2.69
SUB-TOTAL MIDLAND REGION								15.93
MHCS02C - Kaupapa Māori Alcohol & Drug Services (Non-Clinical FTEs)								
BOP								
Maketu Health Charitable Company Limited 245230	NGO	A&D Co	147694-04	1.00	FTE	B	M/A&D	1.00
Ngati Awa Social and Health Services Trust 249133	NGO	A&D Co	191057-02	1.00	PR	B	M/A&D	0.13
Poutiri Charitable Trust 249942	NGO	A&D Co	228857-03	1.00	PR	B	M/A&D	0.11
Poutiri Charitable Trust 249942	NGO	A&D Co	228857-03	0.75	PR	B	M/A&D	0.09
Poutiri Charitable Trust 249942	NGO	A&D Co	228857-03	0.75	FTE	B	M/A&D	0.75
Te Ika Whenua Counselling Services Trust 245821	NGO	A&D Co	171337-04	1.00	FTE	B	M/A&D	1.00
Tuhoe Hauora Trust 249180	NGO	A&D Co	191097-03	1.00	PR	B	M/A&D	0.13
Whakatohea Māori Trust Board 246886	NGO	A&D Co	191077-02	1.00	PR	B	M/PI/A&D	0.13
Tairawhiti								
Ngati Porou Hauora Incorporated 248198	NGO	A&D Co	274538-02	1.00	FTE	TT	M/A&D	1.00
Te Hauora O Turanganui A Kiwa Limited 245511	NGO	A&D Co	216717-05	1.63	FTE	TT	M/A&D	1.63
Waikato								
Raukawa Trust Board 245022	NGO	A&D Co	283587-00	1.50	FTE	W	M/A&D	1.50
SUB-TOTAL MIDLAND REGION								7.47
MHCS26 - Early Intervention Alcohol & Drug Service								
BOP								
Tuwharetoa Ki Kawerau Hauora Trust 250071	NGO	A&D Co	165237-03	1.00	FTE	B	A&D	1.00
Tairawhiti								

Ngati Porou Hauora Incorporated 248198	NGO	A&D Co	274538-02	2.50	FTE	TT	A&D	2.50
Te Hauora O Turanganui A Kiwa Limited 245511	NGO	A&D Co	216717-05	1.00	FTE	TT	A&D	1.00
Taranaki								
Ngati Ruanui Tahua Society Incorporated 245024	NGO	A&D Co	283325-00	1.00	FTE	TK	A&D	1.00
SUB-TOTAL MIDLAND REGION								5.50
MHCS36A - Children and Youth Alcohol and Drug Community Services (Other Clinical FTEs)								
Waikato								
Care NZ Limited 244227	NGO	A&D Co	276897-00	0.38	FTE	W	A&D	0.38
Care NZ Limited 244227	NGO	A&D Co	285164-00	1.12	FTE	W	A&D	1.12
Care NZ Limited 244227	NGO	A&D Co	286796-00	0.87	FTE	W	A&D	0.87
SUB-TOTAL MIDLAND REGION								2.38
A17 - TOTAL MIDLAND REGION								122.90
A18 - A&D - Methadone specialist - treatment places								
MHCS29.2 - Methadone Treatment - Specialist								
BOP								
BOP DHB	DHB	Meth	Mental Health Services For Deaf People 250049-01	90.00	PL	B	A&D	90.00
Lakes								
Te Utuhina Manaakitanga Trust 245582	NGO	Meth	283867-01	65.00	PL	L	A&D	65.00
Tairāwhiti								
Tairāwhiti DHB	DHB	Meth	Alcohol & Drug Services for Adults	45.00	PL	TT	A&D	45.00
Taranaki								
Taranaki DHB	DHB	Meth	Recontracted-Mental Health Services 196857-02	80.00	PL	TK	A&D	80.00
Waikato								
Waikato DHB	DHB	Meth	Community Support Work 155674-05	221.00	PL	W	A&D	221.00
A18 - TOTAL MIDLAND REGION								501.00

A19 - A&D - Methadone GP - treatment places								
MHCS29.1- -Methadone Treatment - General Practitioner								
BOP								
BOP DHB	DHB	Meth	Residential Rehab & Community Support Work 157878-07	25.00	PL	B	A&D	25.00
Western BOP Primary Health Organisation Limited 591972	NGO	Meth	Alcohol & Drug Services for Adults / 284490-01	27.08	PL	B	A&D	8.80
Lakes								
Te Utuhina Manaakitanga Trust 245582	NGO	Meth	283867-01	20.00	PL	L	A&D	20.00
Taranaki								
Taranaki DHB	DHB	Meth	Residential Mental Health Services 197077-02	50.00	PL	TK	A&D	50.00
Waikato								
Waikato DHB	DHB	Meth	Child & Youth Alcohol and Drug Services 243290-00	76.00	PL	W	A&D	76.00
A19 - TOTAL MIDLAND REGION								179.80
A20 - A&D - Residential treatment - beds or care packages								
MHCR06 - Detoxification - Residential								
Auckland								
The Salvation Army New Zealand Trust 426733	NGO	A&D Re	Community Alcohol & Drug Services 219577-02 / 284324-01	3,770.13	BD	MR	A&D	10.33
SUB-TOTAL MIDLAND REGION								10.33
MHCR07 - Residential Treatment - Alcohol and Drug Service								
Auckland								
The Salvation Army New Zealand Trust 426733	NGO	A&D Re	Mental Health Services 209497-02 / 284324-01	4,778.30	BD	MR	A&D	13.09
BOP								
Kahunui Trust	NGO	A&D Re	145849	10.48	B	B	A&D	10.48
Waikato								
Odyssey House Trust 158957	NGO	A&D	253129-01	1.00	PR	W	A&D	5.57

		Re						
Odyssey House Trust 158957	NGO	A&D Re	253129-01	0.75	PR	W	A&D	0.11
Raukawa Trust Board 245022	NGO	A&D Re	243804-01	1.00	PR	W	A&D	2.16
Te Runanga O Kirikiriroa Charitable Trust 242836	NGO	A&D Re	283595-00	5,856.00	BD	W	A&D	16.04
The Higher Ground Drug Rehabilitation Trust 430665	NGO	A&D Re	286287-00	852.00	BD	W	A&D	2.33
SUB-TOTAL MIDLAND REGION								49.79
A20 - TOTAL MIDLAND REGION								60.12
A21 - A&D - Supported living services - beds or care packages								
MHCR18 - Alcohol and Drug - Supported Living Services								
Waikato								
Alcohol And Drug Community Support Trust 500063	NGO	A&D Re	283328-01	1.00	FTE	W	A&D	3.07
Alcohol And Drug Community Support Trust 500063	NGO	A&D Re	283328-01	0.50	FTE	W	A&D	0.06
SUB-TOTAL MIDLAND REGION								3.13
MHCR19 - Child and Youth Community Alcohol and Drug Residential Services								
Hawkes Bay								
Te Whatuiapiti Trust 161986	NGO	A&D Re	252213-00	1.00	PR	TT	A&D	0.96
SUB-TOTAL MIDLAND REGION								0.96
A21 - TOTAL MIDLAND REGION								4.09
A22 - A&D - Home and community detox - FTEs								
MHCS03 - Detoxification - Home/Community								
BOP								
Te Rangimarie Trust 245496	NGO	A&D Co	210517-03	0.59	FTE	B	A&D	0.59

Waikato									
Waikato DHB	DHB	A&D Co	Kaupapa Māori Mental Health and Alcohol & Drug Services 196977-03	1.00	FTE	W	A&D	1.00	
A22 - TOTAL MIDLAND REGION								1.59	
A24 - Mental health and alcohol and drug services - Specialist expertise - FTEs (DDX)									
MHCS04 - Dual Diagnosis - Mental Health and Alcohol & Drug									
Auckland									
The Salvation Army New Zealand Trust 426733	NGO	CMH	Mental Health Residential Services 209897-02 / 284324-01	0.68	FTE	W	A&D	0.68	
The Salvation Army New Zealand Trust 426733	NGO	CMH	Mental Health Residential Services 209897-02 / 284324-01	0.68	FTE	W	A&D	0.68	
BOP									
BOP DHB	DHB	CMH	Community Services for Māori 191077-01	2.40	FTE	B	A&D	2.40	
Ngati Awa Social and Health Services Trust 249133	NGO	CMH	191057-02	1.00	PR	B	A&D	0.26	
Poutiri Charitable Trust 249942	NGO	CMH	228857-03	1.50	FTE	B	A&D	1.50	
Te Rangimarie Trust 245496	NGO	CMH	148472-05	1.00	FTE	B	A&D	1.00	
Tuhoe Hauora Trust 249180	NGO	CMH	191097-03	1.00	PR	B	A&D	0.26	
Tuhoe Hauora Trust 249180	NGO	CMH	191097-03	1.00	PR	B	A&D	0.12	
Capital and Coast									
Capital and Coast DHB	DHB	CMH	Mental Health Services 212157-00	0.10	FTE	TT	A&D	0.10	
Lakes									
Lakes DHB	DHB	CMH	Residential Mental Health Services 157793-06	1.00	FTE	L	A&D	1.00	
Te Utuhina Manaakitanga Trust 245582	NGO	CMH	283868-01	1.50	FTE	L	A&D	1.50	
Tuwharetoa Health Services Limited 245574	NGO	CMH	271687-04	1.00	FTE	L	A&D	1.00	
Tairāwhiti									
Tairāwhiti DHB	DHB	CMH	National Residential Services 251266-00	1.00	FTE	TT	A&D	1.00	
Taranaki									
Tui Ora Limited 250003	NGO	CMH	283312-01	1.00	FTE	TK	A&D	1.00	
Waikato									
Waikato DHB	DHB	CMH	Kaupapa Māori Mental Health and Alcohol & Drug Services 196977-03	3.00	FTE	W	A&D	3.00	
Waikato DHB	DHB	CMH	Kaupapa Māori Mental Health and Alcohol & Drug	2.00	FTE	W	A&D	2.00	

			Services 196977-03					
Northern King Country Drug & Alcohol Counselling & Education 245498	NGO	CMH	283510-00	1.00	FTE	W	A&D	1.00
Te Runanga O Kirikiriroa Charitable Trust 242836	NGO	CMH	283594-01	1.04	FTE	W	A&D	1.04
Waahi Whaanui Trust 247350	NGO	CMH	283385-00	1.00	FTE	W	A&D	1.00
SUB-TOTAL MIDLAND REGION								20.52
MHCS43 - Kaupapa Māori Mental Health Services - Dual Diagnosis with Alcohol and Drug problems								
BOP								
Poutiri Charitable Trust 249942	NGO	CMH	228857-03	1.00	FTE	B	M/A&D	1.00
Poutiri Charitable Trust 249942	NGO	CMH	228857-03	1.00	FTE	B	M/A&D	1.00
Tuhoe Hauora Trust 249180	NGO	CMH	149301-05	1.00	FTE	B	M/A&D	1.00
Whakatohea Māori Trust Board 246886	NGO	CMH	191077-02	1.00	PR	B	M/A&D	0.26
Whakatohea Māori Trust Board 246886	NGO	CMH	191077-02	1.00	FTE	B	M/A&D	1.00
Lakes								
Te Utuhina Manaakitanga Trust 245582	NGO	CMH	283868-01	1.00	FTE	L	M/A&D	1.00
Taranaki								
Tui Ora Limited 250003	NGO	CMH	283312-01	1.00	FTE	TK	M/A&D	1.00
Tui Ora Limited 250003	NGO	CMH	283312-01	1.00	FTE	TK	M/A&D	1.00
Waikato								
Te Runanga O Kirikiriroa Charitable Trust 242836	NGO	CMH	283594-01	2.09	FTE	W	M/A&D	2.09
SUB-TOTAL MIDLAND REGION								9.35
A24 - TOTAL MIDLAND REGION								29.87
A27 - Mental health and intellectual disability - Specialist expertise - FTEs								
MHCS31 - Dual Diagnosis with Intellectual Disability								
BOP								
BOP DHB	DHB	CMH	Mental Health Services For Deaf People 250049-01	0.92	FTE	B	0	0.92
Capital and Coast								
Capital and Coast DHB	DHB	CMH	National Mental Health contract (Contract 1) 218077-05	0.11	FTE	TT	0	0.11
Waikato								

Waikato DHB	DHB	CMH	Community Support Work 155674-05	3.00	FTE	W	0	3.00
A27- TOTAL MIDLAND REGION								
SERVICES FOR CHILDEN AND YOUNG PEOPLE								
B1 - Acute inpatient - child and youth - beds or care packages								
MHIS07 - Child and Youth Inpatient Beds (SSH CFU)								
Auckland								
Auckland DHB	DHB	IP	Dual Diagnosis 149301-03	3.00	B	MR	0	3.00
Tairāwhiti								
Tairāwhiti DHB	DHB	IP	Alcohol & Drug Services for Adults	0.27	B	TT	0	0.27
B1 - TOTAL MIDLAND REGION								
B3 - Community mental health teams - child and youth - FTEs								
MHCS08A - Children & Young People Community Services (Other Clinical FTEs)								
BOP								
BOP DHB	DHB	CMH	Auckland City Mission - A&D Services 155429-01	29.86	FTE	B	0	29.86
Nga Mataapuna Oranga 582469	NGO	CMH	285891-00	0.58	FTE	B	0	0.58
Poutiri Charitable Trust 249942	NGO	CMH	228857-03	0.75	FTE	B	0	0.75
Poutiri Charitable Trust 249942	NGO	CMH	228857-03	0.75	FTE	B	0	0.75
Te Manu Toroa Trust 248707	NGO	CMH	286815-00	0.42	FTE	B	0	0.42
Turning Point Trust 248251	NGO	CMH	231057-04	1.00	PR	B	0	0.03
Turning Point Trust 248251	NGO	CMH	231057-04	0.75	PR	B	0	0.09
Tuwharetoa Ki Kawerau Hauora Trust 250071	NGO	CMH	285917-00	0.58	FTE	B	0	0.58
Whakatohea Māori Trust Board 246886	NGO	CMH	285918-00	0.58	FTE	B	0	0.58
Canterbury								
Richmond Fellowship NZ Inc - National Office 226422	NGO	CMH	276166-00	4.04	FTE	W	0	4.04
Capital and Coast								
Capital and Coast DHB	DHB	CMH	Alcohol and Drug / Workforce Development	0.49	FTE	TT	0	0.49
Lakes								

Lakes DHB	DHB	CMH	Work Rehabilitation/Employment & Education Support/Consumer Network 157795-05	17.00	FTE	L	0	17.00
Tuwharetoa Health Services Limited 245574	NGO	CMH	271687-04	1.00	FTE	L	0	1.00
Tairawhiti								
Tairawhiti DHB	DHB	CMH	Community Alcohol and Drug Service 256847-01	7.20	FTE	TT	0	7.20
Taranaki								
Taranaki DHB	DHB	CMH	Alcohol & Drug Services for Adults	13.10	FTE	TK	0	13.10
Linkage Trust 488253	NGO	CMH	260216-01	1.00	FTE	TK	0	1.00
Tui Ora Limited 250003	NGO	CMH	283312-01	1.00	FTE	TK	0	1.00
Tui Ora Limited 250003	NGO	CMH	283312-01	1.00	FTE	TK	0	1.00
Waikato								
Waikato DHB	DHB	CMH	Iwi Support to Mental Health & Alcohol & Drug Services 210997-02	22.60	FTE	W	0	22.60
Central Pacific Trust 465149	NGO	CMH	274036-03	1.00	PR	W	0	1.00
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	1.00	PR	W	0	1.00
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	6.00	FTE	W	0	6.00
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	6.00	FTE	W	0	6.00
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	6.00	FTE	W	0	6.00
Linkage Trust 488253	NGO	CMH	283568-00	1.00	FTE	W	0	1.00
Northern King Country Drug & Alcohol Counselling & Education 245498	NGO	CMH	283510-00	1.60	FTE	W	0	1.60
Richmond Fellowship NZ Inc - National Office 226422	NGO	CMH	286101-01	5.66	FTE	W	0	5.66
t/as Parentline Parentline Charitable Trust 246042	NGO	CMH	188457-04	0.13	PR	W	0	0.13
t/as Parentline Parentline Charitable Trust 246042	NGO	CMH	188457-04	1.00	FTE	W	0	1.00
t/as Parentline Parentline Charitable Trust 246042	NGO	CMH	285980-00	0.30	FTE	W	0	0.30
Te Ahurei a Rangatahi 249562	NGO	CMH	286880-00	0.50	FTE	W	0	0.50
Waikato Pasifika Health Trust 598266	NGO	CMH	288397-00	1.00	FTE	W	0	1.00
SUB-TOTAL MIDLAND REGION								133.26
MHCS08A1 - Children & Young People Community Services - Needs Assessment (Other Clinical FTEs)								

Waikato									
Waikato DHB	DHB	CMH	Iwi Support to Mental Health & Alcohol & Drug Services 210997-02	3.00	FTE	W	0	3.00	
SUB-TOTAL MIDLAND REGION								3.00	
MHCS08B - Children & Young People Community Services (Senior Medical FTEs)									
BOP									
BOP DHB	DHB	CMH	Auckland City Mission - A&D Services 155429-01	1.50	FTE	B	0	1.50	
Capital and Coast									
Capital and Coast DHB	DHB	CMH	Development of Parent & Child Accommodation Service 230017-04	0.07	FTE	TT	0	0.07	
Lakes									
Lakes DHB	DHB	CMH	Mental Health Day Services 157735-05	1.50	FTE	L	0	1.50	
Taranaki									
Taranaki DHB	DHB	CMH	Alcohol & Drug Services for Adults	1.00	FTE	TK	0	1.00	
Waikato									
Waikato DHB	DHB	CMH	Iwi Support to Mental Health & Alcohol & Drug Services 210997-02	3.00	FTE	W	0	3.00	
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	1.00	FTE	W	0	1.00	
t/as Parentline Parentline Charitable Trust 246042	NGO	CMH	188457-04	0.75	FTE	W	0	0.75	
t/as Parentline Parentline Charitable Trust 246042	NGO	CMH	285980-00	0.02	FTE	W	0	0.02	
SUB-TOTAL MIDLAND REGION								8.84	
MHCS39 - Kaupapa Māori Mental Health Services - Tamariki and Rangatahi									
BOP									
Poutiri Charitable Trust 249942	NGO	CMH	228857-03	3.00	FTE	B	M	3.00	
Poutiri Charitable Trust 249942	NGO	CMH	228857-03	4.00	FTE	B	M	4.00	
Tuhoe Hauora Trust 249180	NGO	CMH	Recontracted-Mental Health Services 196857-02 / 149301-05	1.00	FTE	B	M	0.22	
Tuhoe Hauora Trust 249180	NGO	CMH	Recontracted-Mental Health Services 196857-02 / 149301-05	0.75	FTE	B	M	0.75	
Lakes									
Te Runanga O Ngati Pikiao Trust 243682	NGO	CMH	251246-02	1.00	FTE	L	M	1.00	
Tuwharetoa Health Services Limited 245574	NGO	CMH	148467-04	2.00	FTE	L	M	2.00	

Tairāwhiti								
Te Hauora O Turanganui A Kiwa Limited 245511	NGO	CMH	216717-05	0.50	FTE	TT	M	0.50
Taranaki								
Tui Ora Limited 250003	NGO	CMH	283312-01	1.00	FTE	TK	M	1.00
Tui Ora Limited 250003	NGO	CMH	283312-01	1.00	FTE	TK	M	1.00
Waikato								
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	1.00	FTE	W	M	1.00
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	1.00	PR	W	M	5.26
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	1.00	FTE	W	M	1.00
Maniapoto Māori Trust Board 438219	NGO	CMH	283600-00	3.00	FTE	W	M	3.00
Raukawa Trust Board 245022	NGO	CMH	283587-00	3.00	FTE	W	M	3.00
SUB-TOTAL MIDLAND REGION								26.73
MHCS47A - Child and Youth Intensive Clinical Support Service (Other Clinical FTEs)								
Waikato								
The Youth Horizons Trust 494814	NGO	CMH	284540-00	5.00	FTE	MR	0	5.00
SUB-TOTAL MIDLAND REGION								5.00
MHCS47B - Child and Youth Intensive Clinical Support Service (Senior Medical FTEs)								
Waikato								
The Youth Horizons Trust 494814	NGO	CMH	284540-00	0.50	FTE	MR	0	0.50
SUB-TOTAL MIDLAND REGION								0.50
MHCS48 - Child and Youth Wrap Around Services								
BOP								
BOP DHB	DHB	CMH	Consumer Run Support Services 151888-08	1.00	PR	B	0	0.44
Taranaki								
Taranaki DHB	DHB	CMH	Recontracted-Mental Health Services 196857-02	1.00	PR	TK	0	0.47
Waikato								
Waikato DHB	DHB	CMH	Community Support Work 157881-04	1.00	PR	W	0	1.14

The Youth Horizons Trust 494814	NGO	CMH	284540-00	1.00	PR	MR	0	1.00
SUB-TOTAL MIDLAND REGION								3.04
MHCS49 - Child and Youth Acute Care Packages								
BOP DHB	DHB	CMH	Māori Mental Health Consumer Service 226737-00	1.00	PR	B	0	0.65
Whakatohea Māori Trust Board 246886	NGO	CMH	274639-00	1.00	PR	B	PI	1.00
Taranaki								
Taranaki DHB	DHB	CMH	Recontracted-Mental Health Services 196857-02	1.00	PR	TK	0	0.11
SUB-TOTAL MIDLAND REGION								1.77
B3 - TOTAL MIDLAND REGION								182.14
B4 - Respite services - child and youth - care packages								
MHRE04 - Child and Youth Planned Respite								
Tairāwhiti								
Tairāwhiti DHB	DHB	CoSup	Alcohol & Drug Services for Adults	0.66	PR	TT	0	1.09
Tairāwhiti DHB	DHB	CoSup	Alcohol & Drug Services for Adults	1.00	?	TT	0	1.00
Tairāwhiti DHB	DHB	CoSup	Alcohol & Drug Services for Adults	1.00	?	TT	0	1.00
Tairāwhiti DHB	DHB	CoSup	Alcohol & Drug Services for Adults	1.00	?	TT	0	1.00
Taranaki								
Taranaki DHB	DHB	CoSup	Alcohol & Drug Services for Adults 219617-02	1.00	PR	TK	0	0.12
Taranaki DHB	DHB	CoSup	Alcohol & Drug Services for Adults 219617-02	1.00	PR	TK	0	0.30
Waikato								
Waikato DHB	DHB	CoSup	CHE Subcontract-Social & Rec Services 152101-08	1.00	PR	W	0	2.48
The Youth Horizons Trust 494814	NGO	CoSup	286784-00	0.42	PR	MR	0	0.42
SUB-TOTAL MIDLAND REGION								7.41
MHRE05 - Child and Youth Crisis Respite								
BOP								
Whakatohea Māori Trust Board 246886	NGO	CoSup	285952-00	1.00	PR	B	0	3.29
Whakatohea Māori Trust Board 246886	NGO	CoSup	285952-00	1.00	PR	B	0	1.00
SUB-TOTAL MIDLAND REGION								4.29
B4 - TOTAL MIDLAND REGION								11.70

B5 - Day programmes - child and youth - care packages								
MHCS38 - Children and Youth Day Activity Service								
Lakes								
Te Aratu Trust 243539	NGO	CoSup	271758-03	0.17	FTE	L	0	0.17
B5 - TOTAL MIDLAND REGION								0.17
SERVICES FOR OLDER PEOPLE								
C1 - Older people - assessment, treatment and rehabilitation - beds or care packages								
MHIS02 - Older People Inpatient Beds (Fraser McDonald)								
BOP								
BOP DHB	DHB	IP	Māori Mental Health Consumer Service 226737-00	4.00	B	B	0	4.00
Tairāwhiti								
Tairāwhiti DHB	DHB	IP	Alcohol & Drug Services for Adults	0.32	B	TT	0	0.32
Taranaki								
Taranaki DHB	DHB	IP	Mental Health Primary Shared Care Pilot 250990-00	4.00	B	TK	0	4.00
Waikato								
Waikato DHB	DHB	IP	Alcohol and Drug Services 205497-06	11.00	B	W	0	11.00
Waikato DHB	DHB	IP	Mental Health Services-Ngati Koata Trust 239279-01	0.28	B	B	0	0.28
Waikato DHB	DHB	IP	Mental Health Services-Ngati Koata Trust 239279-01	-0.28	B	W	0	-0.28
Waikato DHB	DHB	IP	Mental Health Services-Ngati Koata Trust 239279-01	0.10	B	L	0	0.10
Waikato DHB	DHB	IP	Mental Health Services-Ngati Koata Trust 239279-01	-0.10	B	W	0	-0.10
Waikato DHB	DHB	IP	Mental Health Services-Ngati Koata Trust 239279-01	0.19	B	TK	0	0.19
Waikato DHB	DHB	IP	Alcohol & Drug Services 250377-00	-0.19	B	W	0	-0.19
C1 - TOTAL MIDLAND REGION								19.32

C2 - Older people daytime support services - care packages								
MHCS45 - Older Persons Hospital Day Programme (Clinical FTE's)								
BOP								
BOP DHB	DHB	Res	GROW Programme for People at Risk of Experiencing Mental Ill Health 151045-02	4.50	FTE	B	M	4.50
Waikato								
Waikato DHB	DHB	Res	Community Support Work 155674-05	4.00	FTE	W	M	4.00
C2 - TOTAL MIDLAND REGION								8.50
C3 - Older people - community teams - FTEs								
MHCS18 - Community Service - Older People								
BOP								
BOP DHB	DHB	CMH	Mason - Training and Supervision 228997-00	9.40	FTE	B	0	9.40
Lakes								
Lakes DHB	DHB	CMH	Mental Health - Manor Park 210437-02	6.40	FTE	L	0	6.40
Lakes DHB	DHB	CMH	Mental Health Residential Services 212317-02	10.00	PR	L	0	0.30
Lakes DHB	DHB	CMH	Mental Health Residential Services 212317-02	10.00	PR	L	0	0.30
Tairāwhiti								
Tairāwhiti DHB	DHB	CMH	Community Alcohol and Drug Service 256847-01	1.00	FTE	TT	0	1.00
Taranaki								
Taranaki DHB	DHB	CMH	Community Residential Service - Level 11 256226-00	6.30	FTE	TK	0	6.30
Waikato								
Waikato DHB	DHB	CMH	Service contract - Ngati Kahu Social Services 172137-03	11.40	FTE	W	0	11.40
Waikato DHB	DHB	CMH	Service contract - Ngati Kahu Social Services 172137-03	1.40	FTE	W	0	1.40
Pathways Trust 245234	NGO	CMH	286893-00	1.00	FTE	W	0	0.36
C3 - TOTAL MIDLAND REGION								36.86

FORENSIC SERVICES								
D1 - Forensic - Acute medium secure inpatient - beds								
MHIS05 - Medium Secure Forensic								
Capital and Coast								
Capital and Coast DHB	DHB	IP	National Mental Health contract (Contract 1) 218077-05	1.33	B	TT	0	1.33
Waikato								
Waikato DHB	DHB	IP	Alcohol and Drug Residential Services 157771-06	20.00	B	W	0	20.00
Waikato DHB	DHB	IP	Alcohol and Drug Residential Services 157771-06	2.44	B	B	0	2.44
Waikato DHB	DHB	IP	Alcohol and Drug Residential Services 157771-06	-2.44	B	W	0	-2.44
Waikato DHB	DHB	IP	Alcohol and Drug Residential Services 157771-06	1.81	B	L	0	1.81
Waikato DHB	DHB	IP	Child & Youth A&D Community Services 223017-01	-1.81	B	W	0	-1.81
Waikato DHB	DHB	IP	Home Based Support Services 211617-07	2.24	B	TK	0	2.24
Waikato DHB	DHB	IP	Alcohol & Drug - Te Awhina Marae trading as Te Makatea Hauora 244043-01	-2.24	B	W	0	-2.24
D1 - TOTAL MIDLAND REGION								21.33
D3 - Forensic - Minimum secure - beds								
MHIS06 - Minimum Secure Forensic								
MoH								
Hauora Waikato Māori Mental Health Services 246494	NGO	IP	283377-00	1,830.00	BD	MR	0	5.01
Waikato								
Waikato DHB	DHB	IP	Alcohol & Drug - Te Awhina Marae trading as Te Makatea Hauora 244043-01	10.00	B	W	0	10.00
Waikato DHB	DHB	IP	Alcohol & Drug - Te Awhina Marae trading as Te Makatea Hauora 244043-01	1.89	B	B	0	1.89
Waikato DHB	DHB	IP	Community Support Services 157680-07	-1.89	B	W	0	-1.89
Waikato DHB	DHB	IP	Community Support Services 157680-07	0.19	B	L	0	0.19
Waikato DHB	DHB	IP	Community Support Services 157680-07	-0.19	B	W	0	-0.19
Waikato DHB	DHB	IP	Consumer Run Services 196597-02	0.60	B	TK	0	0.60
Waikato DHB	DHB	IP	Community Support Work 155673-05	-0.60	B	W	0	-0.60
Hauora Waikato Māori Mental Health Services 246494	NGO	IP	250756-01	1,121.88	BD	MR	0	3.07

Hauora Waikato Māori Mental Health Services 246494	NGO	IP	250756-01	1,122.16	BD	MR	0	3.07
Hauora Waikato Māori Mental Health Services 246494	NGO	IP	250756-01	1,405.96	BD	MR	0	3.85
D3 - TOTAL MIDLAND REGION								25.01
D7 - Forensic - Community liaison Service - FTEs								
MHCS11 - Community Forensic Service								
Capital and Coast								
Capital and Coast DHB	DHB	CMH	Advocacy Peer Support 230997-03	1.93	FTE	TT	0	1.93
Waikato								
Waikato DHB	DHB	CMH	Iwi Support to Mental Health & Alcohol & Drug Services 210997-02	19.40	FTE	W	0	19.40
Waikato DHB	DHB	CMH	Iwi Support to Mental Health & Alcohol & Drug Services 210997-02	0.73	FTE	B	0	0.73
Waikato DHB	DHB	CMH	Mental Health & Alcohol and Drug Services 251972-00	-0.73	FTE	W	0	-0.73
Waikato DHB	DHB	CMH	Community Support Work-Whangarei District 155690-03	0.73	FTE	L	0	0.73
Waikato DHB	DHB	CMH	Community Support Work-Whangarei District 155690-03	-0.73	FTE	W	0	-0.73
Waikato DHB	DHB	CMH	Project Manager - Kaitaia 270886-00	0.73	FTE	TK	0	0.73
Waikato DHB	DHB	CMH	Work Rehab Employment and Education Support 151951-07	-0.73	FTE	W	0	-0.73
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	0.25	PR	W	0	0.25
SUB-TOTAL MIDLAND REGION								21.58
MHCS12 - Prison/Court Liaison								
Waikato DHB	DHB	CMH	Iwi Support Service people with High support needs in mid North Subregion 168322-02	6.70	FTE	W	0	6.70
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	1.00	PR	W	0	1.00
Hauora Waikato Māori Mental Health Services 246494	NGO	CMH	250756-01	1.00	PR	W	0	1.00
SUB-TOTAL MIDLAND REGION								8.70

D7 - TOTAL MIDLAND REGION								30.28
SPECIALIST SERVICES								
E2 - Mothers and babies - Community staff - FTEs								
MHCS28 - Specialist Maternal Mental Health Service								
BOP								
BOP DHB	DHB	CMH	Residential Rehab & Community Support Work 157878-07	2.00	FTE	B	0	2.00
Capital and Coast								
Capital and Coast DHB	DHB	CMH	National Mental Health contract (Contract 1) 218077-05	0.17	FTE	TT	0	0.17
Tairawhiti								
Tairawhiti DHB	DHB	CMH	Alcohol & Drug Services for Adults	0.50	FTE	TT	0	0.50
Taranaki								
Taranaki DHB	DHB	CMH	Quality Improvement 245805-00	0.50	FTE	TK	0	0.50
Tui Ora Limited 250003	NGO	CMH	283312-01	0.50	FTE	TK	0	0.50
Waikato								
Waikato DHB	DHB	CMH	KM Day Programmes and Whānau Support Ngati Kahu 251592-00	3.00	FTE	W	0	3.00
Te Korowai Hauora o Hauraki Incorporated 247791	NGO	CMH	283601-00	0.50	FTE	W	0	0.50
E2 - TOTAL MIDLAND REGION								7.17
E3 - Mothers and babies - Respite services or intensive home support - beds or care packages								
MHRE03 - Maternal Respite								
Waikato								
Waikato Family Centre Trust 248283	NGO	Res	282006-00	1.00	PR	W	0	0.13
E3 - TOTAL MIDLAND REGION								0.13
E6 - Eating disorders - Community teams - FTEs								
MHCS09 - Eating Disorders Service -								

Community (Clinical FTEs)								
Tairawhiti								
Tairawhiti DHB	DHB	CMH	Community Alcohol and Drug Service 256847-01	0.50	FTE	TT	0	0.50
E6 - TOTAL MIDLAND REGION								
E10 - Services for people with disabling personality disorders - Community teams - FTEs								
MHCS10 - Specialist Psychotherapy Service								
Capital and Coast								
Capital and Coast DHB	DHB	CMH	Women with eating disorders Programme 149459-02	0.16	FTE	TT	0	0.16
E10 - TOTAL MIDLAND REGION								
NON BLUEPRINT SERVICES								
F1 - Regional Co-ordination Service								
MHQI01 - Quality Improvements								
Capital and Coast								
McKesson New Zealand Limited 471769	NGO	NonBP	269856-01	1.00	PR	TT	0	1.00
Taranaki								
Tony Waghorn 453629	NGO	NonBP	286036-00	1.00	PR	TK	0	1.00
Tony Waghorn 453629	NGO	NonBP	286036-00	403.23	PR	TK	0	403.23
Waikato								
Cambridge Community Agencies Network Charitable Trust 243401	NGO	NonBP	286783-00	1.00	PR	W	0	1.00
Centre 401 Trust 244388	NGO	NonBP	283571-00	1.50	PR	W	0	1.50
Centre 401 Trust 244388	NGO	NonBP	286956-00	1.00	PR	W	0	1.00
HealthShare Ltd 570458	NGO	NonBP	285659-00	1.00	PR	W	0	1.00
New Progress Enterprises Charitable Trust 249826	NGO	NonBP	286953-00	0.86	PR	W	0	0.86
Pai Ake Solutions Limited 572107	NGO	NonBP	284247-00	1.00	PR	W	0	1.00
Pharmacy 547 Limited t/a Pharmacy 547 243069	NGO	NonBP	286957-00	0.67	PR	W	0	0.67
Taumarunui Community Kokiri Trust 247101	NGO	NonBP	286877-00	0.50	PR	W	0	0.50
Te Korowai Hauora o Hauraki Incorporated 247791	NGO	NonBP	283602-00	1.00	PR	W	0	1.00

Te Runanga O Kirikiriroa Charitable Trust 242836	NGO	NonBP	286752-00	1.00	PR	W	0	1.00
Te Runanga O Kirikiriroa Charitable Trust 242836	NGO	NonBP	286775-00	1.00	PR	W	0	1.00
Te Runanga O Kirikiriroa Charitable Trust 242836	NGO	NonBP	286781-00	1.00	PR	W	0	1.00
The Youth Horizons Trust 494814	NGO	NonBP	286782-00	0.42	PR	MR	0	0.42
Wise Management Services Limited 597240	NGO	NonBP	286814-00	1.00	PR	W	0	1.00
Wise Management Services Limited 597240	NGO	NonBP	286816-00	1.00	PR	W	0	1.00
Wise Trust Board 571804	NGO	NonBP	274981-00	0.23	PR	W	0	0.23
SUB-TOTAL MIDLAND REGION								419.40
MHRD01 - Research and Development								
Auckland								
The Youth Horizons Trust 494814	NGO	NonBP	249772-03	1.00	PR	MR	0	1.00
BOP								
Deo Gratias Trust 246306	NGO	NonBP	288011-00	1.00	PR	B	0	1.00
Richmond Fellowship NZ Inc - National Office 226422	NGO	NonBP	288010-00	1.00	PR	B	0	1.00
Richmond Fellowship NZ Inc - National Office 226422	NGO	NonBP	289728-00	1.00	PR	B	0	1.00
Tirohia Te Kopere Trust 249931	NGO	NonBP	288015-00	1.00	PR	B	0	1.00
Turning Point Trust 248251	NGO	NonBP	288008-00	1.00	PR	B	0	1.00
Western BOP Primary Health Organisation Limited 591972	NGO	NonBP	284490-01	1.00	PR	B	0	1.00
Waikato								
Waikato DHB	DHB	NonBP	Mental Health Services 244021-00	1.00	PR	W	0	1.00
Alcohol And Drug Community Support Trust 500063	NGO	NonBP	286289-00	1.00	PR	W	0	1.00
Family and Caregiver Support Incorporated 250002	NGO	NonBP	286913-00	1.00	PR	W	0	1.00
Richmond Fellowship NZ Inc - National Office 226422	NGO	NonBP	286825-00	0.46	PR	W	0	0.46
The Waikato Clinical Psychology Educational Trust 468049	NGO	NonBP	278002-00	1.00	PR	W	0	1.00
Waikato Institute Of Technology 244012	NGO	NonBP	286823-00	0.67	PR	W	0	0.67
SUB-TOTAL MIDLAND REGION								12.13
MHWD01 - Workforce Development								
BOP								

BOP DHB	DHB	NonBP	A & D Service Contract 252048-00	3.00	PR	B	0	3.00
Anamata Charitable Trust 245035	NGO	NonBP	286020-00	1.00	PR	B	0	1.00
Anamata Charitable Trust 245035	NGO	NonBP	286824-00	1.00	PR	B	0	1.00
BOP Community Homes Trust 587772	NGO	NonBP	287251-00	1.00	PR	B	0	1.00
Blueprint Trust Board 498223	NGO	NonBP	288400-00	1.00	PR	B	0	1.00
Clinpharm Limited 598440	NGO	NonBP	288014-00	1.00	PR	B	0	1.00
HealthShare Ltd 570458	NGO	NonBP	272084-01	1.00	PR	B	0	1.00
Nga Mataapuna Oranga 582469	NGO	NonBP	286892-00	1.00	PR	B	0	1.00
Poutiri Charitable Trust 249942	NGO	NonBP	286829-00	1.00	PR	B	0	1.00
Sage Investments Limited 598281	NGO	NonBP	287927-00	1.00	PR	B	0	1.00
Schizophrenia Fellowship NZ Inc - National Office 225965	NGO	NonBP	288016-00	1.00	PR	B	0	1.00
Te Ao Hou Primary Health Organisation 583083	NGO	NonBP	286958-00	1.00	PR	B	0	1.00
Te Manu Toroa Trust 248707	NGO	NonBP	287880-00	1.00	PR	B	0	1.00
Te Tapenakara mo te Iwi Charitable Trust 248757	NGO	NonBP	287032-00	1.00	PR	B	0	1.00
Te Tomika Trust 245515	NGO	NonBP	286830-00	1.00	PR	B	0	1.00
The Kahunui Trust 244821	NGO	NonBP	286831-00	1.00	PR	B	0	1.00
The Ngaiterangi Iwi Incorporated Society 246935	NGO	NonBP	287379-00	1.00	PR	B	0	1.00
Western BOP Mental Health Trust 244097	NGO	NonBP	Alcohol & Drug Services for Adults / 288013-00	1.00	PR	B	0	1.00
Canterbury								
Schizophrenia Fellowship NZ Inc - National Office 225965	NGO	NonBP	279748-02	1.00	PR	MR	0	1.00
Lakes								
Lakes DHB	DHB	NonBP	Mental Health Residential Services 212317-02	1.00	PR	L	0	1.00
HealthShare Ltd 570458	NGO	NonBP	272086-01	1.00	PR	L	0	1.00
Tairāwhiti								
Tairāwhiti DHB	DHB	NonBP	Alcohol & Drug Services for Adults	3.00	PR	TT	0	3.00
HealthShare Ltd 570458	NGO	NonBP	272088-01	1.00	PR	TT	0	1.00
Te Hauora O Turanganui A Kiwa Limited 245511	NGO	NonBP	216717-05	1.00	PR	TT	0	1.00
Te Hauora O Turanganui A Kiwa Limited 245511	NGO	NonBP	216717-05	1.00	PR	TT	0	1.00
Taranaki								
Taranaki DHB	DHB	NonBP	Residential Mental Health Services 157773-04	1.00	PR	TK	0	1.00
HealthShare Ltd 570458	NGO	NonBP	272091-01	1.00	PR	TK	0	1.00
Taranaki Consumer Consultants Limited 594482	NGO	NonBP	285999-00	1.00	PR	TK	0	1.00
Tui Ora Limited 250003	NGO	NonBP	283312-01	1.00	PR	TK	0	1.00

Tui Ora Limited 250003	NGO	NonBP	283312-01	1.00	PR	TK	0	1.00
Waikato								
Blueprint Trust Board 498223	NGO	NonBP	287998-00	1.00	PR	W	0	1.00
Centre 401 Trust 244388	NGO	NonBP	286954-00	1.00	PR	W	0	1.00
HealthShare Ltd 570458	NGO	NonBP	272093-01	1.00	PR	W	0	1.00
New Progress Enterprises Charitable Trust 249826	NGO	NonBP	247508-00	1.00	PR	W	0	1.00
Pai Ake Solutions Limited 572107	NGO	NonBP	278249-00	1.00	PR	W	0	1.00
Pai Ake Solutions Limited 572107	NGO	NonBP	286774-00	0.50	PR	W	0	0.50
The Waikato Clinical Psychology Educational Trust 468049	NGO	NonBP	283556-01	1.00	PR	W	0	1.00
The Waikato Clinical Psychology Educational Trust 468049	NGO	NonBP	283556-01	0.50	PR	W	0	0.50
SUB-TOTAL MIDLAND REGION								41.00
SUB-TOTAL MIDLAND REGION								472.53

* **GROUP** - A&D Co (Alcohol & Drugs Community); A&D Re (Alcohol & Drugs Residential); CMH (Community Mental Health); Cons (Consumers); CoSup (Community Support); IP (Inpatients); Meth (Methadone); NonBP (Non Blueprint); Res (Residential).

** **PROVIDER TYPE** - DHB (DHB Provider Arm);
NGO

*** **VOLUME UNIT** - BD (Bed Day); B (Bed); FTE (Full Time Equivalent); PL (Place); PR (Program); ?(not yet allocated)

**** **LOCALITY OF SERVICE** - B (BOP); L (Lakes); TK (Taranaki); TT (Tairāwhiti); W (Waikato); MR (Midland Region).

***** **M/PI/A&D** - M (Māori); PI (Pacific); A&D (Alcohol & Drugs); O (general)