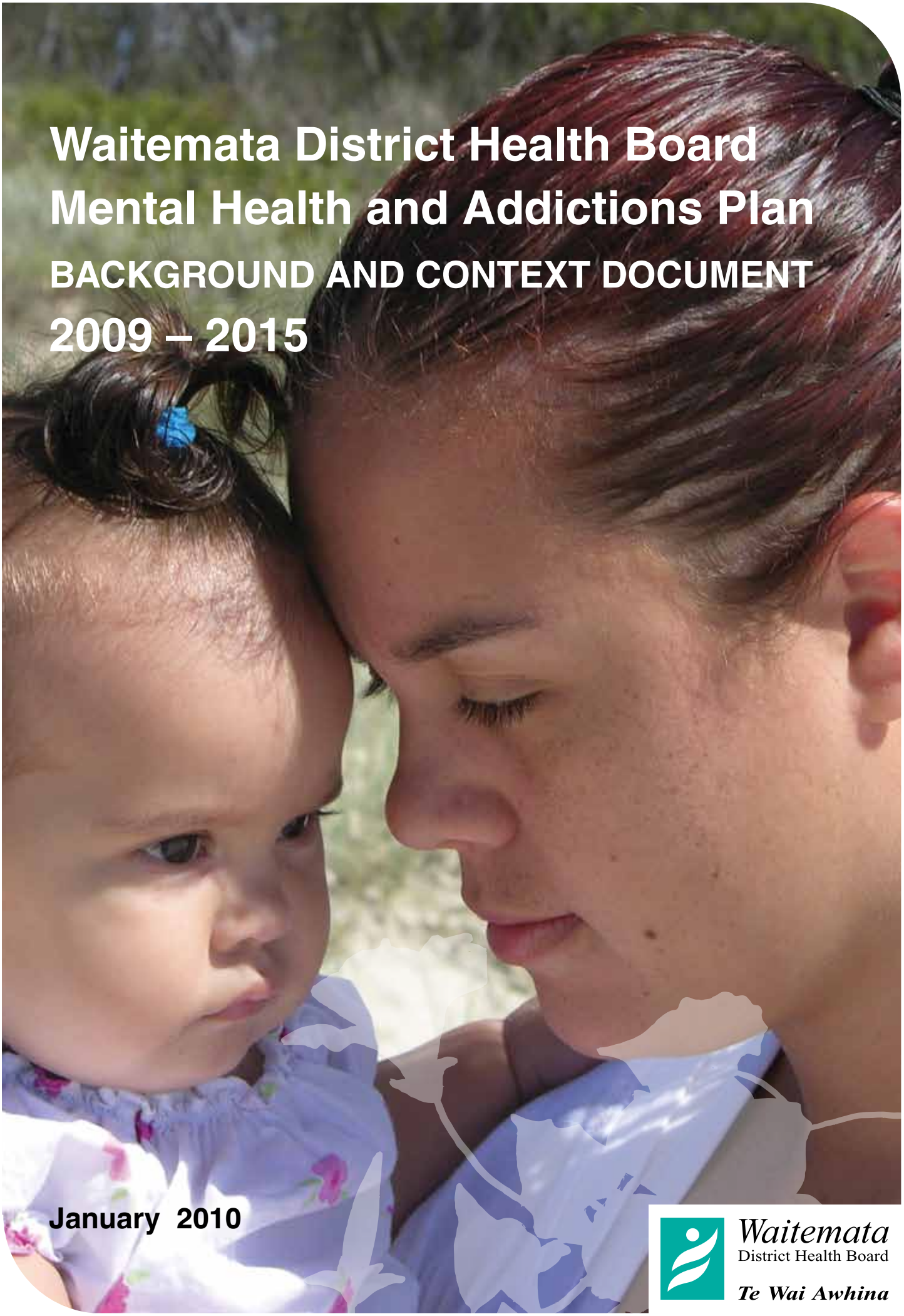


Waitemata District Health Board Mental Health and Addictions Plan

BACKGROUND AND CONTEXT DOCUMENT

2009 – 2015

January 2010

Waitemata
District Health Board
Te Wai Awhina

Executive Summary

The Waitemata District Health Board (WDHB) Mental Health and Addictions Service Development Plan (2009-2015) is a strategic framework to inform planning and delivery of district mental health and addiction services to meet the needs of the growing and changing population of WDHB.

In essence, it has been developed in partnership between both WDHB Provider Arm, Non-Government organisations (NGOs), Primary Health Organisations (PHOs), consumers and families that provide or receive mental health and addictions services in our district, and is a foundation document that signals our intent to work collaboratively for the population we serve.

We recognise the key role that open, transparent and trusting relationships play in the planning and delivery of high quality and effective services and that all providers have their own value and contribution to work towards improving and enhancing the services provided for the sector. The resulting intent is to have a clear direction for all providers to work towards rather than an add hoc approach to future planning.

This background and context document has is a result of collaboration and contributions from a number of people and has been informed by:

- consumers and family/whanau responses
- strategic themes and principles articulated in a range of key policy documents
- significant stakeholder consultation process including workshops and focus groups, and
- six key population based workstreams who developed chapters detailing their key objectives and priority actions for the next five years.

This document supports the WSN Strategic Plan www.waitematadhb.govt.nz and provides a description of the planning processes followed, our vision for the next five years for mental health and addictions services and also attempts to describe what success would look like for the population we serve.

An implementation approach is described at an overarching level, and each workstream has developed detailed plans describing their key objectives, prioritised activities and identified the lead responsibility for achieving these actions.

We will focus not just on reducing symptoms of illness, but also on all the factors that contribute to good mental health, such as housing, employment, education, family relationships and wider social networks.

Contents

1 Introduction

1.1 Purpose of the Plan

The Waitemata District Health Board (WDHB) Mental Health and Addictions Service Development Plan (2009-2015) is intended to provide a strategic framework to inform planning and delivery of district mental health and addiction services to meet the needs of the growing and changing population of WDHB.

In essence, it has been developed in partnership between consumers, family/whanau, WDHB Provider Arm, Non-Government organisations (NGOs), and Primary Health Organisations (PHOs), that receive or provide mental health and addictions services in our district, and is a foundation document that signals our intent to work collaboratively for the population we serve. We recognise the key role that open, transparent and trusting relationships play in the planning and delivery of high quality and effective services and that all providers have their own value and contribution to work towards improving and enhancing the services provided for the sector. The resulting intent is to have a clear direction for all providers to work towards rather than an add hoc approach to future planning.

The plan acknowledges the value of all providers, and aims to give them a clear direction for working together. It also recognises the key role that open, transparent and trusting relationships play in the planning and delivery of high quality and effective services.

This background and context document has been informed by:

- strategic themes and principles articulated in a range of key policy documents
- significant stakeholder consultation process including workshops and focus groups
- consumers and family/whanau responses, and
- six key population based workstreams who developed chapters detailing their key objectives and priority actions for the next five years.

1.2 Planning principles

It is intended the WSN Plan reflects a system of care that creates better outcomes for the people we serve. It must be noted that this is a broad, overarching plan that will still allow for flexibility at individual, cultural and service levels to ensure services are delivered in the best way to meet the population served. The key principles underpinning this the Plan are to ensure we:

- reflect WDHB and the Ministry of Health's commitment to reducing health inequalities
- recognise the importance of addressing the needs of specific populations that are subject to health inequalities
- address mental health and addictions needs of all population groups
- reflect the particular diverse needs of discrete geographic and ethnic communities within DHB boundaries
- are guided by the principles of Recovery, and will promote service developments that further enables recovery for consumers
- reflect a commitment to wellness, health promotion, prevention and early intervention
- encourage and support individuals and their families/whanau to achieve their maximum health and wellbeing
- increase access to integrated care that is safe, effective, seamless and delivered closer to home promote a systems perspective rather than an individual focus, recognising that the system is greater than its component parts

- promote integration and alignment of mental health and addictions services provided by Primary Health Organisations (PHOs), Non Government Organisations (NGOs) and Waitemata DHB
- continue to build on achieving the Ten Leading Challenges of Te Tahuhu and Te Kokiri
- provide a framework for prioritisation for future investment.

The planning process has been reflective of the collaborative relationships and inclusive manner in which we are committed to continuing in the future and has:

- been guided by the principles outlined above
- taken a population based approach to planning
- included consumers and families/whanau in all planning groups
- been inclusive of PHO, NGO and DHB services and workforce
- been informed by Maori, Pacific and Asian focus groups.

1.3 Planning process overview

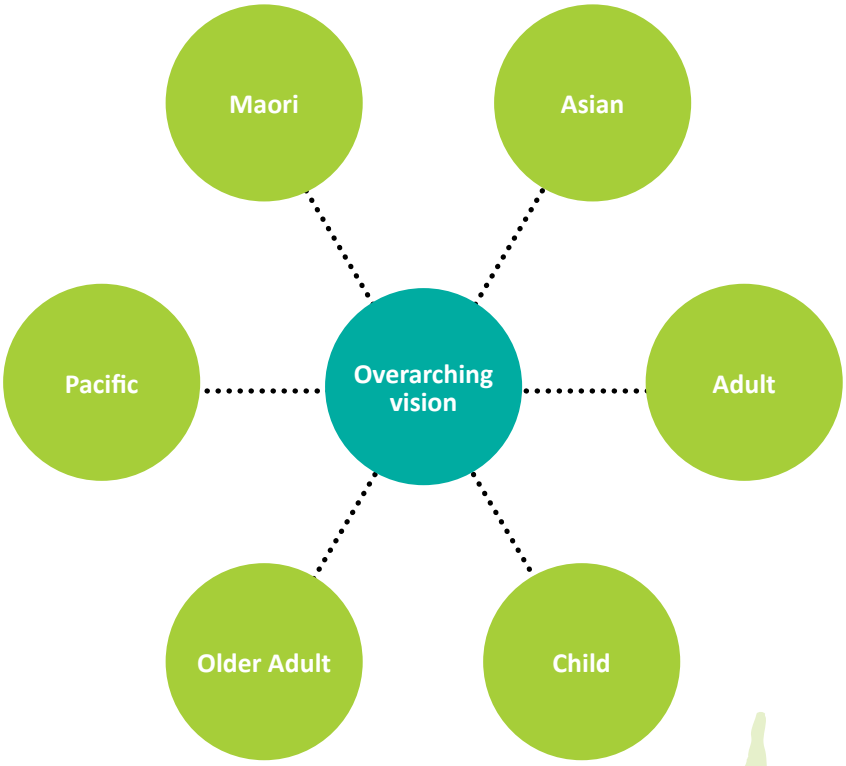
The Planning process has been an ongoing and iterative process, undertaken in four distinct phases, to ensure priorities and activities identified are reflective of a whole of district approach as described below. We are also aware that the six key workstreams provide a response for specific population groups as a starting point, and although we have not specifically reflected the growing migrant and refugee population within WDHB, it is our intention to do so in the future.

Phase	Activity	Components
One	Planning Framework	• Planning Principles and assumptions • Components of the Plan
Two	Whole Sector Vision	• Future Vision for the Sector
Three	Area Specific Planning	• Planning tools/Templates • Six key workstreams – Child and Youth – Adult – Older Adult – Maori – Pacific – Asian
Four	Document development	• Comprehensive Plan (including action plan) incorporating all workstreams specific plans

2 Vision

Based on input from all key stakeholders, our overarching vision influencing the planning and delivery of mental health and addiction services is:

- positive and resilient relationships are fundamental to success
- that by recognising the Treaty partnership, we will work from a bicultural platform that also reflects relationships and responsibilities for a multi cultural community
- to aim for significant change for longer term gains
- to remain customer focused and responsive, regardless of ethnicity, diagnosis, socio-economic status or age
- to build wellness by
  - reducing inequalities
  - ensuring individuals are central to the process
  - building individual health and symptom reduction
- to prioritise an early intervention focus.



2.1 Specific Workstream Visions and intentions

This section provides a high level summay of the visions and intentions articulated in each workstream chapter, and reflects the diversity of views and contributions of Waitemata Stakeholder Network (WSN) members.

Child

Over the next five years our vision in order of priority is that:

- Rangatahi/taitamariki will be involved in the development of services
- Services will be kaupapa rangatahi/taitamariki centred
- Family/whanau views and experience will be valued and proactively sought
- Maori (tamariki and rangatahi/taitamariki) models of hauora will be incorporated into services
- For Maori there will be an acceptable & effective workforce & service providers and more kaupapa based services
- Mental health and service promotion will occur in a variety of settings
- Early recognition of mental health and alcohol and drug issues will occur
- Services will be open longer hours, closer to home, and transport
- Services will have an early intervention and prevention of mental illness focus
- Peer support networks will be available
- Outreach services will be more widely available and child and youth community venues fully utilised
- The workforce will be culturally competent
- Services will be responsive to the needs of local communities
- Entry processes will be clear and straightforward
- Pacific Child and Adolescent Mental Health Services will be developed
- Services will be more accessible to Asian and refugee children and young people; language and cultural barriers will be reduced; more promotion and education on services
- Mental health and addictions services will be collaborative and provided alongside other health or social services
- A wider range of technology will be used in all parts of service delivery
- Services will become more specialised and a wider range of resilience focused options available
- Services will be valued and respected by everyone and there will be no stigma associated with using services
- Maori, Pacific and Asian workforce development will occur.

Adult

"Our vision is of a time when there are no longer health inequalities for Maori and Pacific peoples, people who are socio-economically disadvantaged or any other group within our communities. We will strive for well informed communities that are able to protect and preserve the mental health of their residents, are able to recognise when help is needed, and know how to access high quality and effective treatment and support services to achieve recovery from mental ill health and addictions".

Our vision is of a time when there are no longer health inequalities for Maori and Pacific peoples, people who are socio-economically disadvantaged or any other group within our communities. We will strive for well informed communities that are able to protect and preserve the mental health of their residents, are able to recognise when help is needed, and know how to access high quality and effective treatment and support services to achieve recovery from mental ill health and addictions.

Older Adult

Over the next five years our vision is:

- Service users will be involved in the development and evaluation of services
- Family/whanau views and experience will be valued and proactively sought
- Mental health services for older adults will be available outside of normal working hours
- Peer support networks will be available
- The workforce will be culturally competent
- The workforce will be sub-specialty competent
- Services will be responsive to the needs of local communities
- Services will grow to meet the needs of the rapidly ageing population
- Services will be delivered within an integrated Specialist Service for Older Adult framework
- Services will be co-located within the SSOA framework
- Services will work in partnership with community agencies to support community-based developments and initiatives
- Dedicated inpatient and community services will be in place for people living with Dementia and/or experiencing Delirium
- A broader range of support services will be in place for older adults
- Support the development of older adult expertise in residential aged care, private hospitals, NGOs and adult health services.

Maori

- Oranga Programmes shall become integral to Maori Mental Health and Addictions service provision within Waitemata DHB
- All Health, Social Services, Accommodation and Education providers shall collaborate to provide a holistic approach to Maori wellbeing
- Strengthen the choice of pathways for Maori
- Kaumatua/Taurawhiri (Cultural personnel) and Mental Health and Addictions specialists shall be an integral part of the Primary and Secondary Health Care continuum.
- Maori Oranga Programmes shall operate regularly within Maori communities as a means of reigniting their cultural identity
- Maori models and healing paradigms, alongside strong and robust clinical practices, shall be a key component of Mental Health and Addictions service provision for Maori
- Future directions and structures for provision of mental health and addictions services to Maori (in the context of Whanau Ora) will be formulated and planning will be in place to achieve this vision over the next five years
- Kaumatua/Taurawhiri shall be a dedicated and integral part of multidisciplinary teams across the service system working with Maori and shall contribute to the clinical team's decision making regarding care plans
- All Tangata Whaiora and their Whanau are offered training in Te Reo Me Ona Tikanga thereby commencing Wairua healing. In addition, and when the time is right, empower whanau with the skills and knowledge to maintain their own oranga and build their own "set of knowledge and skills" pertinent to their whanau

- Encourage the involvement of whanau in the Oranga programmes that currently exist: (a) Te Reo me Ona Tikanga (b) Healthy Lifestyle Exercise programme (c) Te Whare Tapa Wha (d) Te Poutama
- Kaumatua to oversee the provision of Tikanga Maori programmes in selected schools within Waitemata DHB region
- Maori stakeholder groups shall hold regular Hui within Maori communities to enable and encourage Maori to engage early
- Partnerships between primary and secondary clinical and cultural staff will demonstrate better access, improved outcomes and greater knowledge sharing and understanding
- That alignment between all Health, Social Services, Accommodation and Educational providers be established by December 2013
- That there will be a more strengthened relationship between clinical and cultural teams thereby retaining and enhancing the mana and uniqueness of services provided by each and every team
- That research would uncover evidence validating Maori Healing practices and caring approaches
- That both clinical and cultural practices would be more fluid, effective and client focused
- That Maori Tangata Whaiora would benefit from the services of highly capable mental health and Addictions Practitioners
- That clinical and cultural practitioners would share equal decision making in the treatment and healing of Maori Tangata Whaiora and their Whanau within Waitemata DHB.

Pacific

The goals that guide implementation and prioritisation from the Plan are:

- Access for Pacific people to Mental Health Service - improve access for Pacific peoples to mental health and addictions services
- Pacific children, young people and their families - expand and develop mental health and addictions services for Pacific youth.
- Workforce Development - develop a competent and qualified Pacific mental health and addictions workforce to improve the quality of mental health and addictions services around competencies
- Primary Mental Health - develop Pacific primary mental health and addictions services
- Information systems and Research infrastructures
- Partnerships - develop partnerships with organisations, communities, families and service users, which will maximise opportunities for Pacific people involved in mental health, alcohol and other drug services
- Quality Mental Health Services – develop quality improvement processes across Pacific Mental Health and Addictions services.

Asian

"Our vision is to ensure our mental health and addictions services are seamless, accessible, culturally responsive, acceptable and appropriate, consumer-orientated and effective for all age groups of Asian communities in every aspects of the health spectrum from promotion, prevention, treatment, provision of care to recovery with no stigma and discrimination."

Our vision is to ensure our mental health and addictions services are seamless, accessible, culturally responsive, acceptable and appropriate, consumer-orientated and effective for all age groups of Asian communities in every aspects of the health spectrum from promotion, prevention, treatment, provision of care to recovery with no stigma and discrimination.

3 Models of Success

We consider it is important to be able to describe what success looks like for consumers, their families/whanau and service providers across the continuum. This will be achieved by promoting a culture within services that:

- Reflects relationships that are strong, resilient, transparent and trusting, resulting in high quality, accessible and responsive services
- Blends cultural models of understanding with existing and evolving clinical models
- Builds on strengths and what we know works
  - Processes are developed to share, inform and educate
  - Feedback mechanisms are enhanced
  - Evaluation /KPIs are routinely employed
- Allows us to share success stories
  - Clinical audits
  - "Case" scenarios
  - What inspires the workforce – promoting a culture of wellness and hope
  - CAPA – Choice and partnership approach (CAMHS/MOH)
- Contribute to and strengthens the development of evidence based models such as
  - EPI
  - Acute home based treatment
  - Individual and family interventions (e.g range of psychological therapies, psycho-education, self management programmes and pharmacology)
- Promote opportunities for choices to be made by service users and carers, on the basis of full understanding of the services available and the implications of these decisions.

4 What will this look like?

In operationalising this plan, stakeholders were asked to consider what would be different over a five year horizon. We are committed to strengthening the range and breadth of high quality, customer focused and responsive mental health and addiction services, and have identified the following activities as key to measuring our attainment of the vision.

- Improved knowledge of customers served with by recording individuals status in the domains of
  - Housing
  - Employment
  - Education
  - Relationships and supports
  - Physical health
- Develop strategies to address these where necessary within individual treatment plans, as well as using collated summary information to assist with bridging service and interagency gaps and guiding collaborative service development activity
- Use information to understand the impact of services delivered for individuals, and measure success against these strategies
- Evaluate performance of services to inform our understanding of the factors that contribute to the outcomes achieved
- Commitment to reducing the barriers to sharing information across and within services
- Infrastructure is in place that supports the sharing of this information
- Technology for self assessment and management is agreed and consistently applied
- Levels of compulsion in treatment will reduce
- Have the ability to measure the quality of our relationships, for example
  - Consumer to services
  - Family/Whanau to services
  - Across stakeholder organisations
  - Between professionals and staff from different parts of the system
- Be able to demonstrate the impact that improved relationships and reciprocity has in terms of quantifiable outcomes for individuals, families/whanau, organisations and the workforce.

5 What will be different in five years?

WSN members were asked what they would like to be different in five years. The quotes below reflect individuals responses in themes for Consumers, Carers, Primary care, Mental health staff and service system perspectives.

From a consumer perspective

- I will be able to engage with services when I need to. I will have **choice** regarding the approach to my care. All options will be explained to me, including specifically what will be provided, and how and when it will be delivered.
- I will know that there will be **good communication** between my GP and other services involved in my care, and I will know what information is shared. I will be confident that attention is being given to my mental health as well as my other health needs.
- I will know what measures I need to take to help me to increase my **resilience,** assisting my **recovery**, and what I can expect from my family and other carers and from services involved in my care.
- **Information** on services and best practice treatments and how to access them will be readily available.

From a family/whānau perspective:

- When a family member or loved-one is involved with ongoing treatment from any service, we will be **acknowledged and valued** as the 'eyes and ears' of that service.
- We will be a part of the assessment and treatment planning; information we have will be taken in to account.
- Attention will be paid to our own needs for **information and support.**

From a primary care perspective:

- **Specialist services will be available** in a timely manner to advise on diagnosis and treatment.
- **Close liaison** with specialist services will enable prompt access to support even without direct referrals.

- Coaching and **professional development** will enhance my ability to care for people enrolled in my practice.
- I will receive **regular communication** with respect to people under my care who are also involved in ongoing care from mental health services.

From mental health professional/ staff member perspective:

- I will be given information about **best-practice.**
- I will be provided with the technology to assist me to be **effective and efficient.**
- I will have access to information that will assist me in **improving outcomes** for individuals under my care and contributing to the overall quality and safety of the service.
- I will recognise and **value the contribution** of the increasing number of my colleagues specifically employed in roles that acknowledge and build upon their own lived experience of mental health problems.
- I am able to contribute to the development and review of services, with information available to support me in this.

From service system perspective:

- There will be **greater blending** between primary care, community and secondary service sectors.
- Information and other **evidence** will be readily available and used to inform service development.
- Priority will be given to systems that support **resilience, early intervention and prevention** and reduction of lasting impacts of mental health conditions.
- Governance and networking arrangements will include multiple perspectives to assist **collaboration in service planning, implementation and review.**
- Attention will be given to the impact of severe general health problems on mental health.
- Consideration will be given to prioritisation and innovation, with attention given to new and improved ways of working in the context of the current and future economic environment.

6 Understanding the Strategic Environment

6.1 National Direction

Te Tahuhu: Improving Mental Health outlines Government policy and priorities for mental health and addiction for the 10 years between 2005 and 2015 – and provides an overall direction for investment in mental health and addiction. It builds on the current Mental Health Strategy contained in Looking Forward (1994) and Moving Forward (1997) and the Mental Health Commission's Blueprint for Mental Health Services (1998). The Ten Leading Challenges set out in Te Tahuhu are:-

Leading Challenge	Intent
Promotion and prevention	Promote Mental health and wellbeing and prevent illness and addiction
Building mental health services	Build and broaden the range and choice of services and supports which are funded for people who are seriously affected by mental illness
Responsiveness	Build responsive services for people who are severely affected by mental illness
Workforce and culture for recovery	Build a mental health and addiction workforce – and foster a culture amongst providers – that supports recovery, is person centered, culturally capable and delivers ongoing commitment to assure and improve the quality of services for people
Maori mental health	Continue to broaden the range, quality and choice of mental health and addiction services for Maori
Primary health care	Build and strengthen the capability of the primary health care sector to promote mental health and wellbeing and to respond to the needs of people with mental illness and addiction
Addiction	Improve the availability of and access to quality addiction services, and strengthen the alignment between people with addiction services and services for people with mental illness
Funding mechanisms for recovery	Develop and implement funding mechanisms for mental health and addiction that support recovery, advance best practice and enable collaboration
Transparency and trust	Strengthen trust in services, accountability and information systems
Working together	Strengthen cross agency working together.

6.2 Waitemata District Health Board Strategic Themes

In order to meet the health gain priorities set out in the WDHB Strategic Plan (2005-2010) the DHB has identified four fundamental areas that should influence the way that the Health Board, and the wider health sector, should operate. These themes are the current ones that guide the service development plan and are as follows:

- **Seamless Service**
  Ensuring that access to services, and movement within the health sector is as seamless as it possibly can be for the health consumer and their family / whanau
- **Consumer and family / whanau focus**
  Ensuring that health services and care pathways are customised based on consumers' strengths, needs, desires and culture
- **Wellness and responsibility**
  Promoting and supporting healthy lifestyles and communities where individuals and communities take responsibility for, and are supported in, maintaining wellness
- **Safety**
  Embedding safety in a clinical, cultural and spiritual sense in the skills of health professionals and systems of care to ensure that patient care is based on the best available scientific knowledge and practice.

We are also aware that these themes may be superseded by the new WDHB District Strategic Plan (DSP) currently being developed, and will ensure our Plan will be responsive to the direction articulated in the new DSP when completed.

6.3 WDHB Mental Health and Addictions WSN Strategic Objectives

In alignment with the broader WDHB objectives, the following high level strategic objectives have been agreed via key stakeholders as part of the development of the Mental Health and Addictions plan.

1. To continue to strengthen and build services – Modest goals, and continue to build capacity. For Adult services – wellbeing/employment/whole health focus. For Older Adult services - linkages across health and social services is the focus
2. To strive for increased gains in Child, Youth and Family. This includes linkages with Whanau ora, and working across all cultural groups
3. To agree priority areas for evaluation
4. To influence other health providers to have a "whole of health" approach, including mental health focus (linkages with Long term conditions, chronic disease).

6.4 WDHB Core Themes from Visioning workshop

A number of key themes were identified by stakeholders as a result of a visioning workshop. It was agreed that these key themes are relevant to all parts of the sector, across all ages and ethnic specific services. These themes have formed the basis of the development of area specific chapters developed by the six key workstreams. We are also aware that the six key workstreams provide a response for specific population groups as a starting point, and although we have not specifically reflected the growing migrant and refugee population within WDHB, it is our intention to do so in the future.

Child and Youth

Adult

Older Adult

Maori

Pacific

Asian

Core Theme	Description
Holistic – wider continuum of care	Holistic health is a philosophy of medical care that views physical, mental and spiritual aspects of life as closely interconnected and equally important approaches to treatment.
Early intervention	Early intervention includes identifying and intervening as soon as emotional, physical, behavioural, cognitive or psychological difficulties emerge. Mental health promotion and prevention should also be encompassed as part of early intervention. Health promotion focuses on improving environments (social, physical and economic) and activities, which affect mental health and enhancing the 'coping' capacity of communities as well as individuals. Prevention is concerned with individuals prior to the onset of a disorder.
Culturally responsive services	Responsive services focus on strengths, recognise the ethnic diversity of the Waitemata DHB population and consider families cultural needs alongside their clinical needs. This includes recognition of the importance of spirituality, family and different understandings of well being.
Family/Whanau involvement	Whanau and friends who care for and are affected by people with experience of mental illness and addiction, will be supported to maintain their own wellbeing, involvement and participation in everyday life. They will also experience providers that operate in ways that allows them to support their family members recovery and maintain their own wellbeing (Te Tahuhu)
Primary Care	Build and strengthen the capability of the primary health care sector to promote mental health and wellbeing and respond to the needs of people with mental health illness and addiction (Te Tahuhu).
Collaboration/Integration	Improving the mental health and wellbeing of the WQDHB population requires the sustained collaboration between and integration of a wide range of health, community (including City and District Councils), social service agencies.
Information and resources	Information is vital and fundamental to service take-up, improvement and development. The Government has stated clearly that it wanted "an environment that supports the dissemination of knowledge and information", and "a research and evaluation-based approach to recovery practice" as they are important "for maintaining quality practice, and promoting innovation in policy, planning and practice". (Te Kokiri, 2006).
Workforce	The future, emerging workforce will need to ensure that it can deliver the right "mix" of services for people – with perhaps the most significant factor shaping the need for new skills and areas of specialised knowledge being the change in the make-up of our demographics, with an increase in the number of Maori and Pacific and Asian people making up our population. Without good people, the sector cannot be effective, and we need to continue to develop a workforce that has the skills and a commitment that enables and encourages service users to take leadership and governance roles (Te Tahuhu).
Consumer led services	Services are planned, delivered and supported by people with lived experience of mental health and addiction.

7 Whanau Ora

While the essence of the Maori plan contains the necessary threads which whanau ora encompasses, there is a large piece of work led by Minister Tariana Turia in progress including strategies and policy review, to launch the whanau ora model in the near future. Because this is happening we consider it is prudent to complete this body of work when the model emerges.

8 Workforce Development

A Draft Workforce Mental Health and Addiction Workforce development strategic plan was commissioned by WDHB (2009 – 2014), designed to help create a mental health and addiction workforce that is competent, capable, resilient and able to meet the changing needs in the Waitemata district. It has also been aligned with key national, regional and local workforce development documents, and the key objectives intersect and compliment the broader WDHB Strategic plan.

8.1 Vision for workforce

"A competent, capable and resilient mental health and addiction workforce that improves the lives of consumers and meets the needs of all our communities within the Waitemata District"

Specifically the strategic themes and accompanying objectives are:

- Co-ordination - to work together in a co-ordinated sector-wide approach
- Excellence - to nurture a culture of learning and research in partnership with consumers & whanau/family
- Expansion - to attract and retain the best people to serve the needs of the population
- Extension - to develop superior clinical and cultural skills with an emphasis on prevention and early intervention

9 Population Scan – including projections

Demographic profile for Waitemata District

The Waitemata district is the largest and fastest growing region in New Zealand. Approximately 492,185 people are living in the Waitemata area. The population has increased around 12% since 2001 and is expected to grow another 34% (to 646,100) by the year 2026.

There are three distinct population areas: Waitekere, North Shore, and Rodney, each with its own specific features. Lifestyles differ from rural, urban and coastal living. The Rodney district is the fastest growing area and has the highest percentage of older people, whereas Waitekere City has the youngest population with about 38% of people under the age of 25.

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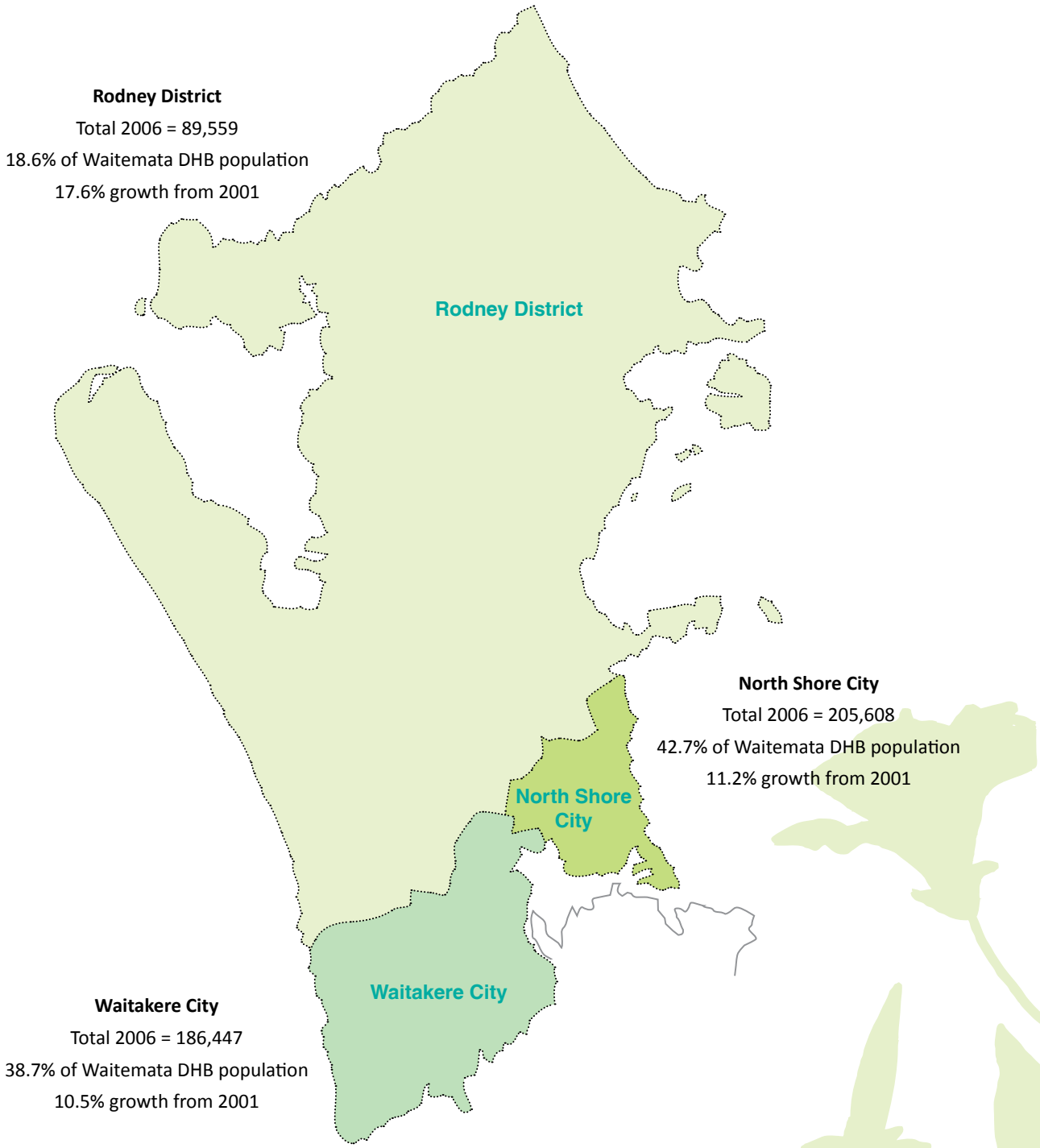
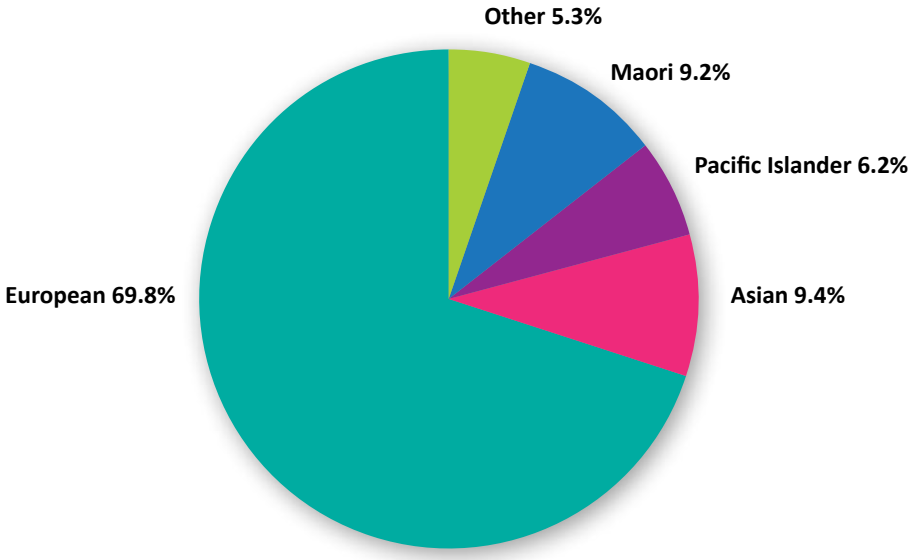
Figure: Population by Ethnic Group in Waitemata DHB, 2001 & 2006

The population of Waitemata is made up of a mixture of cultures and ethnicities with diverse socio economic backgrounds spread unevenly across the region.

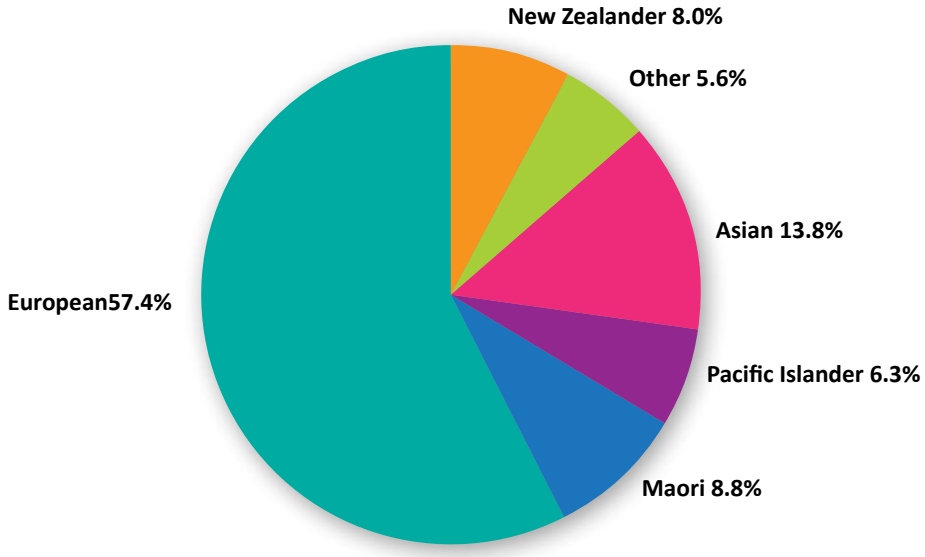
Waitakere has the largest number of Maori and Pacific people in the region, while Asian (Korean, Chinese and Indian) and South African people live mostly in the North Shore area. There are also a growing number of refugees and new migrants entering the Waitemata Region (WDHB, 2007).



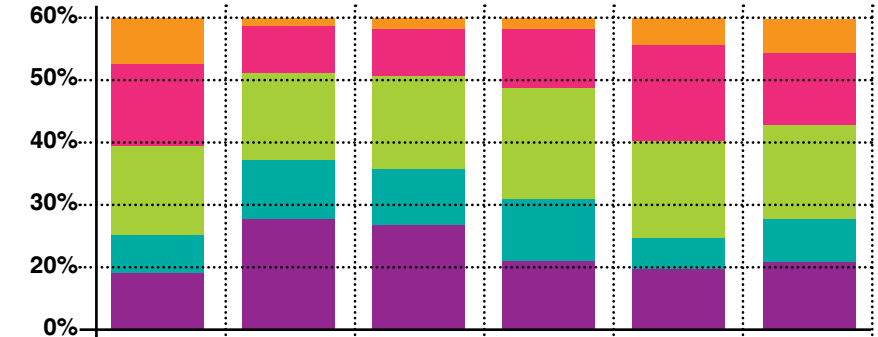
Currently, older people (65+) make up about 11% of the population while roughly 35% of the population are under the age of 25. (See the figure below which also includes a breakdown by ethnicity and shows that Maori and Pacific people have younger populations than other ethnic groups).



2001 Census Total = 429,747



2006 Census Total = 481,611



	European	Maori	PI	Asian	NZ	Total
65+	152	2.9	3.9	4.2	9	11
45-64	26.3	14.4	15.3	19	30.4	23.5
24-44	28	28.8	29.8	34.8	31.7	29.7
15-24	12.1	18.4	17.5	20.2	9.4	14.1
0-14	18.5	35.5	33.5	21.9	19.5	21.7

Age Structure of the Population by TLA, Waitemata DHB, 2006

Socio-economic trends

Socio-economic status is generally regarded as a determinant of mental health status. Maori and Pacific are over-represented amongst those living in areas of highest deprivation relative to non-Maori and non-pacific people. There are serious inequalities for Maori and Pacific people accessing services. For example, Waitekere City has the highest density of deprivation with the highest proportion of Maori and Pacific people living there. In 2008, the unemployment rate in the Waitemata region was about 3.1% with Maori having the highest proportion of unemployed compared with other ethnic groups. Pacific households have the highest percentage of households without a car (8.2%) followed by Maori (7.9%) which raises issues about these groups' ability to access mental health services if required.

In summary Waitemata is the fastest growing region in the country. It has the largest number of older people (Rodney) compared to other regions, the largest population of Asians (North Shore) in the country and the largest group of Maori and young Pacific people (Waitekere). Waitekere City has the highest density of deprivation with the highest proportion of Maori and Pacific people living there.

Demographic profile for the Northern Region

The Northern Region is made up of four DHBs: Counties Manukau, Auckland, Waitemata and Northland and has a population of about 1,467,756 people and is expected to grow to a population of around 1,789,000 by the year 2016. The Northern Region makes up about 36% of the total New Zealand population. Waitemata DHB makes up about 33%, Counties Manukau DHB 30%, Auckland DHB 28% and Northland DHB about 10%.

Between the 2001 Census and the 20006 Census, the Northern region experienced a population growth of about 10.5% (National growth was only 7.2%). The Region's population is about 12.5% Maori, 11% Pacific, 15.6% Asian and 54.3% European (including "New Zealander"), the remaining 6.6% being "Other" or "Not applicable". 10.3% of the Northern Region population was over the age of 65.

The above would represent a population growth between 2006 and 2016 of 13.9% (Compared to an expected national growth of 8.9%). It has the fastest growing national population and the nation's largest migrant population.

10 Key Stakeholders

Whilst this is a local DHB plan, it is important to acknowledge our interface with other Metro DHBs who are partners in providing services to our population, including regional work programmes such as

- Eating Disorders
- Child and Family Unit
- High and Complex needs
- The broader spectrum of AOD services
- Forensic (5 year Strategic Framework & Youth Forensics Framework)

The WDHB population will also access other regionally/nationally provided services (including Dual Disability services, Buchanan clinic, Inpatient Eating Disorders, Tamaki Oranga, Ashburn Hall).

Other interface issues reflecting the systemic nature of service provision includes linkages with

- Primary Care Strategic Plan
- WDHB Clinical Services Plan (Vision 2020)
- Youth Action Plan
- Long term conditions plan
- Effective Interventions
- Justice and Corrections
- Ministry of Social Development
- Child, Youth and Family services
- Social service and community based agencies.

11 Waitemata District Mental Health and Addiction Services

Waitemata District Health Board (WDHB) is the largest mental health provider in New Zealand with services for children, adult and older adult as well as specific services aimed at specialised populations including two regional services: Forensic Mental Health Service (FMHS) and Community Alcohol and Drugs Service (CADS).

It has strong collaboration and partnerships with 24 Non Government Organisations (NGO) and six Primary Health Organisations (PHO) in the region.

The Waitemata Stakeholder Network (DHB, NGO, PHO and consumer representatives) was established in 2005 to promote collaborative work for the benefit of the people of Waitemata and it leads the development of an integrated range of recovery focussed, community-based mental health services.

There are strong partnerships in the sector with local Iwi and other Maori providers, Pacific Communities (Pacific Responsiveness Stakeholders group), Child and Youth Services (Stock take project) and PHO West with Waitekere mental health services.

The development and growth of consumers' participation in the Waitemata workforce is also significant. The establishment of peer support services in the community, the strong consumer networks in the West and North and the number of consumer advisors in the WDHB provider arm, all reflect the shift in Mental Health towards

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recovery focussed services and active consumer participation over the last few years. There is also a strong commitment to develop the primary/secondary interface and develop intervention pathways, including primary health as an important part of mental health service delivery.

The NGO providers have developed a large range of services with packages of care, residential services, day programmes, and peer support along with the continuing development of new services that are needed in our region (e.g. dual diagnosis rehabilitation service). Their focus has developed from being a support service to providing more rehabilitation and treatment services (see figures below). Many initiatives that have been developed in Waitemata have also been implemented elsewhere in the region and country.

The Waitemata Mental Health and Addiction sector is innovative; continually looking to respond to the changing needs of the communities it serves.

Additional mental health and addiction services are provided by contract to other Funders, including the Ministry of Social Development, PHOs, and private clients.

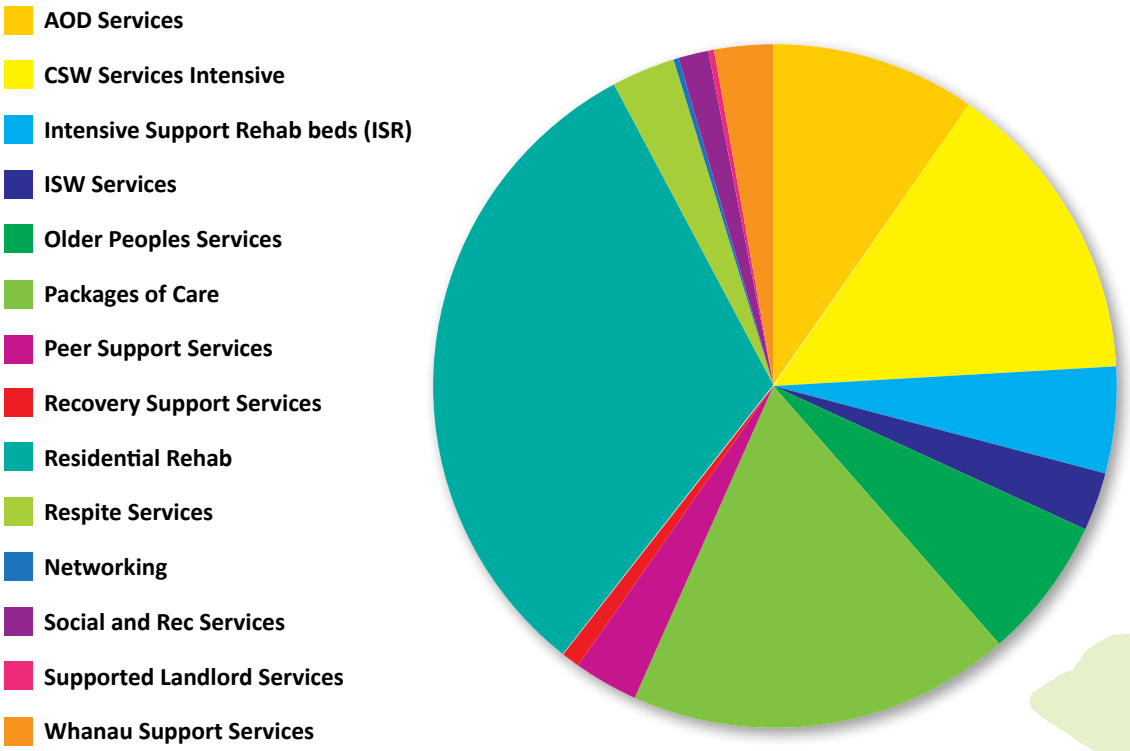

Figure 2: Overview of WDHB Mental Health and Addictions NGOs

12 Our communities' health needs

Our intention is to develop an improved understanding of our communities' needs, prevalence and health status based on epidemiology. A full and comprehensive Health Needs Assessment was conducted by WDHB in January 2009 (www.waitematadhb.govt.nz). It is not the intent to replicate the findings in this Background and Context document, rather note high level determinants that will have an influence of planning and delivery of mental health and addictions services for the population we serve.

12.1 Determinants of Health

Health is largely determined by our environment and behaviours rather than by health services. This section examines these factors.

Social factors

Social capital measures attempt to capture the coherence of our communities. Most people feel that there is a sense of community where they live and that people can usually be trusted although people in Waitakere are less likely to be positive than people in Rodney.

Social support is also known to have a positive impact on health. 40% of people feel isolated at least some of the time. The large majority of people have access to telephones and cars so these are unlikely to be barriers to social support. However many people are relatively new to the place in which they live. Over 20% of children, and over 40% of Maori children, live in single parent families. Many older people, and older women in particular, live alone.

Most people are happy with their lifestyle including their quality of life and work/life balance.

Violence and crime

Crime and violence have important impacts on people's lives. About one third of people do not feel safe walking alone at night and one quarter of people do not think unsupervised children are safe in their area. People in Waitakere are more likely to report these safety issues. Whilst reporting of most crime has been stable over the last six years violence offences have increased since 2005. In particular Police attendances at family violence have increased in line with national trends.

New Zealand and Auckland studies show that over a quarter of women will experience some degree of violence from a partner during their lives although the proportion that has experienced it in the last year is much smaller. A smaller but still significant proportion of men also experience partner violence. Maori are more likely to experience partner violence.

Sexual assault is also a common experience for women (nearly 20%), often from a partner. The majority of these women will have experienced their initial sexual assault by age 17.

Physical violence, emotional abuse and neglect are common experiences for children and young people both at home and school or elsewhere. Children and Young Peoples services in Waitemata carried out investigations which resulted in 2,852 findings of abuse in 2007.

Older people are also victims of abuse, most commonly psychological or neglect, and usually from a family member.

Cultural factors

Culture can be an important positive or negative influence on health. Many people in

Culture can be an important positive or negative influence on health. Many people in Waitemata are immigrants and are therefore somewhat dislocated from their culture. This is particularly the case for Asians (84%) and Pacific people (41%) but is also common amongst Others.

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For Maori although they are tangata whenua access to their culture is often still an important issue. 15% of Maori in Waitemata do not know their Iwi and over 80% cannot speak Te Reo.

Economic factors

Economic factors such as income, occupation and education are the most powerful determinants of health. Maori and Pacific young people in Waitemata are more likely to leave school with little or no formal attainment than Europeans and Asians, and are much less likely to achieve University Entrance standard.

Women are more likely to be unemployed than men. However, these differences are smaller than the differences that exist between ethnic groups with Maori being twice as likely to be unemployed as Other. Women are also much more likely to be on low incomes than men (29% vs 19%). Asians are much more likely to be on low incomes than other groups.

Household crowding is much more common amongst Maori and Asian households than Europeans. However, crowding is most common amongst Pacific households where 45% of households experience crowding.

Environmental factors

Environmental factors have an important impact on both communicable and non-communicable disease. Waitemata's transport use is dominated by cars. Over three-quarters of people travelled to work by private or company vehicle. Only a tiny percentage used active transport. Access to recreational activity areas is good for the large majority of people but green space provision is poorer in more deprived areas.

Access to fruit and vegetable retailers and takeaways is higher near urban centres and highest is more deprived areas (particularly for takeaways).

The large majority of Waitemata residents have access to reticulated water from safe drinking water supplies. Reticulated supplies are fluoridated except for Helensville and Huia.

A substantial minority of Waitemata residents perceive problems with air, noise and recreational water pollution.

Lifestyle factors

14% of Waitemata adults are daily smokers. This is considerably lower than for New Zealand as a whole (19%). However, rates are high amongst some groups, notably Maori (30%), Pacific people (19%) and younger adults. The proportion of Year 10 students who smoke has steadily declined over the last 5 years. Just under 20% of year 10 students still live in homes where smoking is allowed inside.

Poor nutrition is a major cause of poor health in New Zealand. Nutrition is complex and we only have limited information at the Waitemata level. Only 54% of adults eat the recommended daily intake of vegetables and only 61% eat the recommended daily intake of fruit. On these measures women have a healthier diet than men. Pacific and Asian people are also less likely to have the recommended intake of vegetables.

Children in Waitemata tend to have healthier eating habits than their national peers.

Only just over 50% of babies in Waitemata are fully breastfed at three months of age. Europeans and Others are more likely to be breastfed than Maori, Pacific, and Asian babies.

Fewer than half of Waitemata adults are regularly physically active and 15% had done less than 30 minutes of exercise in the last week. Asian people were the least likely to be physically active.

Poor diet and lack of physical activity lead to overweight and obesity. 51% of women and 61% of men in Waitemata are overweight or obese. One in five of our population is obese (compared to one in four of the national population). However, obesity is much more common in our Maori (31%) and Pacific (48%) populations and much less common in our Asian population (8%).

Over 80% of adults and young people in Waitemata drink alcohol. 18% of adults drink alcohol in a way that is classified as hazardous.

Marijuana is the most commonly used illegal drug in Waitemata and New Zealand with about 15% of people having used it in the last year. Maori were particularly likely to have used it (39%) whilst its use was very rare amongst Asians. Nationally other drugs most commonly used were nitrous oxide, Kava, Ecstasy, and Amphetamines but each of these was tried by less than 4% of people in the last year. Party pills were commonly used in 2006 prior to it being made illegal.

Nationally two out of three adults had gambled in the last year but less than one half of a percent of people were problem gamblers. Problem gambling was more common amongst Maori and Pacific people.

High blood pressure and high cholesterol are common risk factors for cardiovascular disease with one in seven Waitemata adults being on medication for high blood pressure and one in 14 being on medication for high cholesterol.

12.2 State of Health

Overall health

Except for Pacific men people in Waitemata have a higher life expectancy than their national counterparts and this is particularly so for Maori. However there are quite large differences in life expectancy between different population groups. Women have a longer life expectancy than men and Maori and Pacific people have a shorter life expectancy than Others. Life expectancy for Asians cannot be accurately calculated because of migration. Similar patterns are seen for overall mortality.

Avoidable mortality (AM) measures deaths that might have been avoided by successful public health (including changing lifestyles) or health service intervention. 37% of all deaths were considered potentially avoidable in 2003-05. Waitemata's avoidable mortality rate was 80% of New Zealand's as a whole. The very marked differences between groups indicate the opportunity for reduction of health inequalities. Men have a 50% higher avoidable mortality rate than women. Maori and Pacific avoidable mortality rates that are more than double Others.

The leading causes of avoidable mortality in Waitemata are ischaemic heart disease (IHD), lung cancer, colorectal cancer, suicide, and stroke. For women breast cancer is also important. For Maori, Pacific, and Asians diabetes is important and for Maori so is chronic obstructive pulmonary disease (COPD).

Avoidable hospitalisation (AH) is another useful measure for examining our ability to improve health and reduce inequalities. It is also important because reductions of these hospitalisations would reduce the burden on our health system. Waitemata has a similar avoidable hospitalisation rate as New Zealand as a whole. The Maori avoidable hospitalisation rate is almost 75% higher than that for Others and the Pacific rate is almost double. Asian is lower than Others.

The commonest avoidable hospitalisations are angina, respiratory infections, cellulitis, road traffic injuries, and ear, nose, and throat infections. For women kidney and urinary tract infections are common. Asthma and COPD are also important for Maori and Pacific people.

More than 60% of adults in Waitemata report that their overall health is excellent or very good although this is somewhat lower for Maori and Pacific people.

The World Health Organisation has calculated the overall burden of diseases for all countries including New Zealand. They use a measure that includes burden from early death and from lives led with disability. The most significant diseases using this measure are cancers, depression, IHD, stroke, COPD, and injuries which together account for 50% of all disease burden. Other important illnesses are diabetes, alcohol use disorders, dementia, hearing loss, asthma, osteoarthritis, and congenital anomalies.

Cardiovascular disease

High blood pressure and high cholesterol are common risk factors for cardiovascular disease with one in seven Waitemata adults being on medication for high blood pressure and one in 14 being on medication for high cholesterol. A lower proportion of Maori and Pacific people are on these medications despite higher rates of cardiovascular disease (CVD).

Many people live with cardiovascular disease with the prevalence reaching 25-40% by the age of 80. CVD mortality was 49% more common in men than women, 69% more common in Maori as Others, and more than twice as common in Pacific people as Others. Asians have a lower rate. CVD hospitalisations show a similar pattern although the ethnic differences are less dramatic.

Diabetes

Over 20,000 people in Waitemata have diabetes. Diabetes prevalence increases dramatically with age reaching 40% of the population in some ethnic groups by the time people are in their 60s. Prevalence in Maori is twice that of Others, and is even higher for Pacific people and South Asians. Whilst these differences are large the differences in the incidence of diabetes complications such as renal failure admissions and lower limb amputation admissions are even larger.

Cancer

Cancer mortality in Waitemata is significantly lower than nationally. Maori and Pacific people have cancer mortality that is almost 50% higher than Others, whilst Asian people have the lowest rates. The most significant causes of cancer mortality are lung cancer, colorectal cancer, breast cancer and colorectal cancer. Waitemata has significantly lower rates of lung and colorectal cancer and than New Zealand as a whole. Maori and Pacific people have much higher rates of lung cancer and cervical cancer mortality than Others. Nationally they also have higher rates of breast cancer mortality. Asian mortality rates for most cancers are low.

Cancer hospitalisation and registration rates tend to mirror these trends although ethnic differences are usually less marked.

Respiratory disease

Nearly 10% of Waitemata adults are taking medication for asthma. Whilst the prevalence of asthma for Maori and Pacific people was similar to Others their hospitalisation rates was about three times that of Others. Asian people had both a low asthma prevalence and low hospitalisation. Women have a higher hospitalisation rate than men.

7% of Waitemata adults have chronic obstructive pulmonary disease (COPD). COPD is a particular burden for Maori with prevalence rates four times as high and hospitalisation rates nearly three times as high as Others.

Infectious disease

Infectious disease is now an uncommon cause of mortality. Many infectious diseases are notifiable. The most commonly notified diseases are those that cause gastroenteritis, particularly campylobacteriosis.

Musculoskeletal disease

Arthritis is very common in adults, particularly amongst Others where 13% of adults report having arthritis. Osteoporosis is also common amongst women.

Injury

ACC claims for injury are common, particularly amongst youth and young adults. Maori and Others have higher rates than Pacific and Asians have the lowest rates of claim. Nearly half of claims are for soft tissue injury, but fractures and dislocations and lacerations and puncture wounds are also common. Most injuries occur at home or during sport or recreation. Injury is also a cause of hospitalisation with Waitemata having higher rates than nationally. Maori and Pacific people have high rates of injury hospitalisation. Maori have high rates of injury mortality.

Oral health

Waitemata children have better oral health than New Zealand children as a whole. However there appears to have been some decline in oral health status between 2004 and 2006. Maori and Pacific children have markedly poorer oral health than Others. Only limited national data is available on adult oral health. About half of adults have had one or more teeth removed due to disease.

Mental Health

12% of adults report they have a chronic mental health condition. Pacific and Asian people are less likely to report this although Pacific people are more likely to report psychological distress which is associated with mental health issues.

The NZ Mental Health Survey found that 21% of adults had a mental health disorder in the last 12 months. This was higher amongst youth and women and uncommon amongst older people. The commonest disorders were anxiety disorders (especially specific phobias), mood disorders (especially major depression) and substance abuse disorders. 0.4% of adults had attempted suicide. Waitemata's suicide rate was slightly lower than the national one.

Disability

Only regional and national data is available. 9% of children in the Auckland region had a disability. Amongst adults the rate of disability increases from 7% amongst young adults to 37% in older people (65 years and older). Nationally Maori have higher rates of disability and Asians low rates. Sensory and physical disabilities are most common types in adults and sensory and chronic health problems in children. Multiple disabilities are common. In children disabilities present at birth are the commonest cause, and remain important through all age groups. In middle ages disease and illness and accidents are important and aging processes become important in older people. Many children with disabilities (16%) have unmet needs.

Maternity and birth

There were 27 admissions for pregnancy complications for every 100 live births in Waitmata but this was a lower complication rate than for New Zealand as a whole. Pacific mothers were more likely to be admitted.

28% of all births in Waitemata were by caesarean section and a further 10% were assisted (e.g. forceps delivery). Maori and Pacific mothers were more likely to have normal deliveries.

6% of babies born have low birth weight. There has been a decline in small for gestational age babies and a smaller increase in preterm babies over the last 20 years.

Infant mortality rates in Waitemata are lower than New Zealand as a whole at about 4 per 1,000 live births. Maori infant mortality rates were higher than all other ethnic groups.

Children

Death in childhood, after the first month of life, is a fortunately rare event with an average of 30 deaths a year in Waitemata, almost half being infants. The most common cause of death in infants were sudden infant death syndrome (SIDS), congenital anomalies, suffocation and injuries. In older children the commonest causes were injury, cancers, and congenital anomalies.

There were 105 admissions to hospital each year for every 1,000 children in Waitemata. 63% of childhood hospital admissions were acute, 9% arranged, and 28% from waiting lists (for surgery etc). The commonest acute admissions were for injury, gastroenteritis, asthma, viral infections, respiratory infections, and skin infections. Admissions for infectious disease, skin infections and respiratory infections have all increased markedly over the last 10 years. The commonest waiting list admissions were for grommets, dental procedures, and tonsils and adenoids.

There were an average of 16 cancers a year registered amongst young people in Waitemata. Leukemia and brain cancer were the most common. The commonest chronic conditions reported amongst children are asthma (15% of children), eczema (14%), allergy (6%), and birth conditions (4%).

Young people

An average of 33 young people (15-24 year olds) died each year in Waitemata. Most of these died from injury or suicide. Suicide deaths seem to have started to decline after a long period of increase.

There were 87 admissions to hospital for every 1,000 young people in Waitemata as well as pregnancy related admissions (including delivery). The commonest acute admissions were injury, abdominal or pelvic pain, and skin infections.

There were an average of 19 cancers a year registered amongst young people in Waitemata (in addition to 51 cases of cancer of the cervix in situ per year). Melanoma and lymphoma were the most common cancers.

About 6% of Maori teenage girls, 3-4% of Pacific teenage girls, and 1.5% of Other teenage girls have a baby each year.

Older people

In 2006 there were nearly 53,000 people aged 65 years or older in Waitmata and nearly 6,000 age 85 years and older. Only a tiny proportion of these were Maori, Pacific, or Asian.

The large majority of older people do not require any assistance. Only 14% of people who are 85 years or older live in a rest home or private hospital, 23% have some funded support at home, and 63% receive no funded assistance. Many older people continue to work or do voluntary work.

The commonest causes of mortality and hospitalisation for older people are similar to the population as a whole. In Waitemata the leading causes of death amongst older people are IHD, stroke, COPD, lung cancer, and diabetes. Cancers together also account for 28% of deaths. The leading causes of hospitalisation are IHD and angina, respiratory infections, falls, COPD, skin cancers, and eye disorders.

Migrants and refugees

32% of Waitemata residents were born overseas (compared to 23% nationally) and of these 32% have lived in New Zealand less than 5 years. This includes 81,486 people of European ethnicity, 13,863 Pacific people, and 56,865 Asian people. 83% of Asian people in Waitemata were born overseas, 39% of Pacific people, and 26% of people of European ethnicity.

English language ability is important in order to participate in New Zealand Society. In Waitemata in 2006 10,482 Asian people, 1,956 Pacific people, 810 European people, and 633 people of other ethnicities said they could not hold a conversation in English about every day things.

New Zealand is one of nine countries which accept a quota of refugees (700 per year). In addition NZ accepts around 300 family reunification refugees and in 2007/08 200 people sought asylum in New Zealand. Recently a number of refugees have settled in Massey, Henderson, Glendene, and Kelston. Recently refugees have come from Afghanistan, Iraq, Iran, Myanmar, Somalia, Eritrea, Ethiopia, Sudan, Burundi, and Congo.

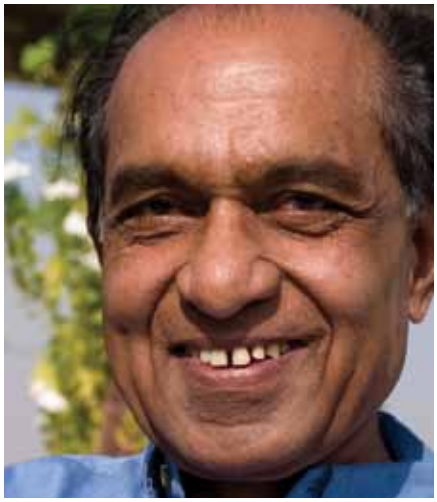
Refugees often have high health needs related to conditions they come from and stress of resettlement. Common issues are infectious disease, mental health issues, woman's health issues, and chronic diseases.

13 Trends – new models, service delivery options

We anticipate that the environment in which we are working will be shaped by local, regional, national and international developments. Some of these will be determined by efforts to ensure the best use of resources, some by efforts to improve access, and some by broader social and cultural influences and expectations. Examples of these include:

- Systems approaches, including the effectiveness of team and inter-agency working
- Development of stronger evaluative and evidence based focus that both develops and draws on new models
- Shared information and reporting systems (e.g ARMHIT/KPI/PRIMHD)
- Technological advances, including Information technology support for providing evidence-based care
- Using increasing access to web-based and other electronic resources and technology to facilitate self directed learning and professional development for service providers, and to increase access to information and therapies for service users

We will need to ensure ongoing attention to trends and to changing practices, reviewing our own approaches in light of these developments.



Appendix One:
Summary of Key Themes from Visioning Day

CURRENT SITUATION - ENABLES WELLNESS

Family Inclusion and Support

- Inner strength – relationship with children and parents
- Assistance to / recognition of family
- Informed, supportive, engaged family/whanau
- Family inclusive practice
- Whanau/family important in recovery
- Having a contact point that can listen to and give support to families/friends/ whanau of person who might be becoming unwell and does not want to be seen
- Ministers, kaumatua, kuia
- Peer support to building rapport
- Work with whanau…give education, information
- Strengthen families

Cultural competence

- Understanding of different cultural expectations within family units
- Competency of existing culturally responsive services
- Maori team that provides a partnership between kaumatua/taurawhiri and nurses/doctors
- Providing culturally specific services and identifying specific needs
- Able to be heard and understood from a cultural perspective
- Language ethnicity matching is important…client – clinician (provider)
- Immediate access/presence of cultural/linguistic Asian support in times of crisis

Spiritual Aspects

- Spiritual support
- Spiritual aspects to wellness
- Community and church programmes
- Karakia

Integration, Collaboration and Communication

- One stop shop – interconnected, coordinated
- Use of networks, continuity of service
- Collaboration (Community/PHO/NGO/WDHB)…through collaboration there will be acceptance of different models of care
- Integration of services, particularly CYFs and Mental Health
- Collaboration
- Integration of services
- Interface between primary/secondary
- Regular communication between DHB provider arm and community support services
- Integrated approach – Asian mental health team working closely with clinical team
- Integration of services – coordination of support
- Public consultation, stakeholder consultation and planning days

Specific Patient Interventions

- Encouragement and support to pursue interests, e.g., music, writing. sport
- Alternative remedies
- Understanding isolation
- Choice in treatment
- The right medical intervention
- Online communication for young people
- Respite in community
- Peer support for drug rehab
- Working with the journey – up and downs
- Valuing the whole person – respect, recognition, participation, sharing, understanding spiritual aspect

Mental Health "Literacy" and Promotion

- Community education (GP aware of mental health issues)
- Education about condition, medication, treatment, etc.
- Recognising that the experience of mental distress does not just impact on one person and having appropriate responses for parents, children, partners and social network

- Information on services and support easily accessible
- Informed and supportive peers
- Services available, share with community, encompass all services
- Supportive schools and other agencies
- Support of employer / family
- Health promotion in schools

Attitudes

- Staff attitudes
- Employers positive attitude
- Being respected
- Consistent, quiet, respectful staff
- No discrimination
- Reduced discrimination

Early Intervention

- Early intervention
- There are good services for older adult – recognition of need for early intervention and diagnosis
- Getting the resources if need be at the schools and then being proactive and accessing the resources/services for mum/dad and family for the child – not just giving them a piece of paper or pamphlet

CURRENT STRENGTHS WE CAN BUILD ON

Cultural

- Cross-cultural awareness training
- Involvement of cultural supports
- Cross-cultural information booklets
- Asian mental health cultural support integrated team
- Understanding of and empathy for pressures brought from the homeland, i.e., high achievement expectation, poor mind is a weakness, bringing shame of family/culture, etc.
- Pockets of strengths in Asian services
- Provide spiritual/wairua healing
- Maori services for and by Maori and other cultures
- Whanau needs based services/whole family approaches
- Clients contacting Asian Health Line/MH service (though a little too late – always in crisis)
- Good access to interpreters
- Maori world belief system as a strength

Coordination

- Continuity and coordination between agencies
- Development of a more holistic approach – including spirituality, nutrition, family/community supports
- Continuing support and development of community, family, marae, etc.
- Getting older adults to services that can provide appropriate level of care

Responsive, Caring

- Services are responsive to client needs
- Support/rehab environment that is friendly and assists person to develop or reshape their skills and interests as they change
- Restore sleep pattern
- Crisis / hospital responded well, very respectful – consistency
- Work with the person after finding out what their strengths are to build on
- AOD - Identifying strengths – importance of working with people/staff who can understand
- AOD – Good access to services when needed
- AOD – good support for families
- PMH liaison role interface between primary – secondary
- Building linkages between practices (PMH) and community
- Caring service for MH inpatient

Community, Peer and Family Support

- Community involvement – church, family, school
- Peer support and CSW support and therapeutic support
- Good family education on different mental health issues
- Spirituality, family support, church
- Peer support for families and consumers
- Family, whanau, fono. Pacific – lots of in-home support
- The “Strengthening Families” services – good services that could be better utilised
- Child – strengthening families (when things get bad enough and gazillions of people involved)

Reducing Discrimination and Education

- Reducing discrimination
- Literacy on mental health vs. mental illness would be absolutely the greatest strength of all

CURRENT SITUATION – HINDERS WELLNESS

- Falling through the cracks on funding
- No addiction services for 65+ years
- Older adults are often isolated by age, geography, health issues
- Illness models can isolate and stigmatise
- Very little support for family, girlfriend – Perhaps peer support group would help – Family, maybe friends, must be involved with the journey
- Lack of information, lack of knowledge of services
- Poor recognition of mental unwellness by primary care
- Lack of awareness in the public generally and families in particular of signs of mental illness and avenues of assistance
- Too many different therapists (try to have the same therapist for the person)
- Lack of coordination of services across the whole community – MHS and PHOs, NGO, Police, schools
- Lack of community resources e.g., rest homes, parenting skills
- Unsustainable illiteracy on what the "mental illness" is about
- Older adult
  - Lack of resources for service development and growth
  - No funding for dementia
  - No specialist input at primary or community level
  - Early identification
  - Need better coordination with OA physical health services
- Siloed funding and support systems – support which exists that is inaccessible
- Contracts narrow flexibility in service delivery – creates barriers to continuity of care
- National level compliance requirements have mushroomed, e.g., documentation risk requirements

Cultural Barriers

- Need to involve whanau as early as possible – not giving information to whanau about medications
- For Maori – peer support, workers, minister, kaumatua to be involved
- Asian – access to services mainly via crisis and lack of information readily available
- Asian – lack of family support and life skills
- Asian – Dictation of service – loss of autonomy
- Fear of mental health stigma in Asian communities means access is not sought early – late intervention is often at point of crisis – suicide thoughts
- Asian – often present with only physical complaint – need expert assessor to pick up MH symptoms
- Systemic lack of understanding of Asian cultural and ethnic needs and differences to Western

- Lack of education that is language/culture responsive
- Limited cultural understanding
- Ignorance of a spiritual dimension
- Full acknowledgement of a Maori world view is essential
- Need wrap around services specific for Maori
- Acknowledgement of cultures within Maori
- More training required
- Paperwork requirements can be insulting
- Language barriers

Fragmental Services

- AOD – lack of follow-up support
- Separation between AOD/MH (i.e., phoning crisis team when under influence)
- Lack of sharing of information between services (particularly in relation to working with families)
- Not enough compulsory treatment facilities for people with severe AOD issues
- Telling you over and over – answering the same questions over and over, accentuating the feeling of failure
- Multiple agencies and multi layered approach, Inflexible frameworks and divided services
- Short interventions that are with one or other whanau member
- Information is not shared – across agencies working with the client, people don't know where to go, people don't know about mental illness
- Sometimes client has a lot of services bombarded upon them so we need to see if that is the one they need – are meeting their needs according to their situation
- Lack of communication and collaboration between services – Clinical/NGO, NGO/NGO, clinical/clinical

Variable Family Involvement and Support

- Families are forced to take legal action to gain services , i.e., Police / sectioning
- Lack of recognition of skills, strengths, expertise of whanau/fono
- Family not believed there is mental illness
- Poor accessibility of MH services for concerned families or friends of person developing mental illness
- Lack of family support (naturalized) – services concentrating on individual
- More support groups needed for families, Lack of family involvement / inclusion
- Lack of information about services and the process for client and family
- Older Adult - Lack of promotion and prevention education for this group or their family/carers

Workforce and Staff Attitudes

- Workforce retention, Little education
- Numbers of clinicians attached to client
- When services don't do what they say they're going to do
- Competence of specialist workforce and resource (size) of specialist workforce
- Having the odd kaumatua in a team rather than a team with a Maori kaupapa
- Not having the right people there
- Staff attitudes, Lack of respect for client emotions
- Insensitivity, lack of cultural knowledge, lack of culturalisation
- Not being listened to, lack of acknowledgement of feelings and culture, being done to
- Experience of indifference from services
- GPs being biased, not dealing with issues that are fundamental and looking further than the drug abuse, what caused the abuse, and directing the appropriate healthcare
- Poor practice…practice that is not evidence-based
- Child and Youth – no real understanding or education in needs assessment of the role of therapists, what treatment achieves and expected duration and outcomes

Delayed intervention

- Late intervention/Late presentations – crisis interventions
- People are undiagnosed and untreated often for a long period of time
- Waiting until you meet the criteria for entry to service

Service Gaps

- Lack of coordinated support and continuity of care after age 18 years
- Rehab and lock down facilities
- Lack of respite for MHSOA and young children and adults
- Lack of facilities for non-compliant dual diagnosis clients
- Lack of facilities, e.g., respite, disability sector, aging – community care, supported accommodation

Stigma

- Overcoming sense of stigma of mental health for Asian community
- De-stigmatise

VISION 2014

Workforce

- Clinician input at all levels
- Workforce represents diversity in community
- Support workers, OTs, social workers, Nutritionists – MH specific included in primary health care
- Have workforce with skills to meet needs of population
- Strong peer workforce developed
- Knowledge of "Let's Get Real" and the 7 essential skills
- Workforce is clinically and culturally competent, aware, sensitive, knowledgeable and have skills to meet needs of different cultures
- Professional and competent workforce

Family/Whanau Involvement

- Family inclusive attitudes
- Family work
- Resource and support families
- Family inclusive services
- Pathway for individual recovery is to involve the family/whanau and resources to support that

Cultural Responsive Services

- Asian people – change name of mental health clinic to wellness clinic
- Need for cultural supports – Aiga/family, Matua, Education/Information
- Asian –
  - better awareness of support services available
  - working with
  - resources to improve services
  - better infrastructure to ensure family work
- Broad range of services can offer culturally and linguistically appropriate support
- Navigation model for Asian service users
- Cultural services to be developed
- Maori health not Maori mental health and addiction – Maori governance
- Mental health and addiction services are relevant and responsive to people from different cultures and ethnicity and treatment and recovery framework incorporates different health beliefs, concepts, frameworks
- All DHB staff have cultural training in Pasifika MH issues
- MH services understand and work with Eastern and Western approaches (spiritual, supernatural)
- Increase cultural awareness – culturally competent workforce

- NGOs – choices of more culturally appropriate services (ethnic community resources)
- Able to acknowledge that different cultures have their own needs
- Services have learned from diverse cultures
- Workforce consists of lots more culturally appropriate staff
- Contracts will request whanau ora approach
- Maori people need Maori context
- Early family support from day one of episode and ongoing whole family care

Consumer Led Services

- Peer support available for all
- Acceptance of consumers by staff
- Focus on self help and peer support
- Peer support needed for newly diagnosed clients from people in recovery
- Consumer input at all levels

Primary Mental Health

- Better information for PHOs
- Working from primary care basis
- Include primary health
- More involvement of GPs within MH
- Culturally appropriate primary mental health options
- GP/PHO point of contact with a knowledgeable navigator (teach family, grandparents, client) who stays the contact coordinator for the whole family… whole family solutions…all in context
- Having specialist staff available/easy access for primary care…for consumers to have a copy of plans…strong community linkages

Holistic and Wider Continuum of Care

- Flexible, culturally aware and knowledgeable workforce
- Nutrition/Diet – mental health specific as well as healthy lifestyle
- Compassionate – holistic, spiritual assessment, nutrition (MH specific) carers, peer support MH services
- Holistic
- Destination recovery
- Home based treatment and respite
- Wellness Centres
- Address number of liquor licenses
- Better responses for young people when in trouble
- More support/input at schools

- Client consent essential
- Collaborate with all different stakeholders
- Increase ease and access to service
  - Culturally appropriate
  - Support for individual needs
  - Treatments are better understood
  - Recognition of family dynamics and background
  - Fulfilling clients own goals and achievements
  - Destigmatisation
  - Understanding levels of cultural attitudes…age, generation
- Older Adults
  - Home based treatment model for older adults
- Engage local communities
- If we want to meet more of the needs of more people, we need to take a community perspective and engage DHB, Council, community organisations, churches, schools, police, in shared planning

Early Intervention

- Increase early intervention at school – building community resilience
- Quick access to CBT, dietician, employment assistance
- Easy access to services for everyone
- Early support and intervention
- Good access – timely, long term, continuous
- Able to respond to complexity – physical, spiritual, psychological, cultural
- Services have high expectation of community
- Advance directives
- Accessibility to services and support
- No long waiting periods to access services
- Focus on prevention and early intervention
- Early intervention that is inclusive of family/whanau with an information and education focus that works well
- Every door is the right door
- Building closer relationships with learning institutions
- Services have outreach component
- Improved service coordination (child and family services)
- User friendly service, particularly at entry
- Earlier supports at right time

Collaboration and Integration

- No silos of funding and no silos of care
- Shared language between agencies

- Linkage and coordination
- Integrated funding
- More effective liaison
- Range of services with collaboration and coordination
- Clinical governance and fiscal governance as the dominant form of governance
- Greater development and integration of services for older people and greatly improved accessibility
- Integration
- Well coordinated approach with continuity of service delivery
- Integrated funding streams = integrated services
- Collaboration regarding MH issues, i.e., MH representation/access with CYFs , WiNZ, schools etc. to assist early detection
- Resources to be held with PHO – maintain coordination role for family needs… one focal point
- A flexible (no capture, no precious) service offered at various outlets…primary and secondary, etc…that allows the client to easily find the "right" person…holds hope, knowledge, way forward
- One stop shops…community hubs
- Community navigator – attached to client throughout delivery of MH services
- Face to face / over the phone – one entry point…triage…branching off to appropriate service

Information and Resources

- Quick access to getting information…one stop shops
- Increased promotion of mental health wellbeing to Asian community
- Improve awareness of MH issues
- Education and support with in community to embrace all cultures to wellbeing
- Clarity of information
- Information readily available to Asian communities and access to services understood
- Information about support services
- Educate kids at secondary school on mental illness and what to look for
- Structured approach to promotion of resources, information, services
- Challenge government to support wellness and recovery rather than risk management
- User friendly especially at point of entry where the resources and services…when redirecting the client/consumer the service is still accountable for the client/consumer to see if they've been moved to the right one
- Know needs of populations and services to meet those needs
- Identify and promote links in the community and services for real collaborative work.