High and Complex Needs

Report for the Mental Health Commission

August 2009

Abbreviations used in this document

DHB	District Health Board
MHS	Mental Health Services
NASC	Needs Assessment and Service Coordination
NDSA	Northern DHB Support Agency
NGO	Non government organisation

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Executive Summary

Purpose and Project Overview

This report has been completed for the Mental Health Commission. It explores definitions used to characterise 'high and complex needs', estimates of the size of the high and complex population within each District Health Board (DHB), and current responses to needs. The overall goal is to inform the development of policy related to the care of people with high and complex mental health and addiction needs.

The methodology included gathering information from DHBs using a standard questionnaire and fourteen of twenty one DHBs participated in this research. A brief literature search was also undertaken.

Definitions and prevalence

Both nationally and internationally definitions of high and complex needs agree that along with a serious mental illness, people have one or more co-occurring problems that may include alcohol and drug misuse, physical health problems and behavioural needs. Common sub-populations include people with an intellectual disability or acquired brain injury, and older people with existing or emerging mental health and age related needs.

In addition to clinical presentations, members of the group may be at risk of harm to self or others; be homeless or transient; be involved with criminal activities; have problems with their families or whanau and be socially isolated with an impaired quality of life.

Compared to some international literature, groups that appear to be less commonly included in definitions of high and complex needs in New Zealand are people with borderline personality disorders and eating disorders.

Although the term 'high and complex needs' is commonly used by DHBs, an exception was identified through this research. Hutt Valley DHB use the term 'long term conditions' to avoid ascribing a label with negative connotations to people services have struggled to provide with an appropriate response. Other DHBs commented on the difficulties of engaging providers with people with poor reputations, and the Mental Health Commission may want to consider the terminology it adopts as part of any further work.

There is a strong level of agreement amongst the DHBs that relative to the size of the population receiving mental health services, the number of people with high and complex needs is small.

Service responses and models of care

All DHBs are operating a model of care that includes primary care, a range of community support and accommodation services, and a range of general and specialist mental health services and inpatient services. Services specifically aimed at responding to high and complex needs fit within two main groups:

- Targeted services including assertive case management and community and accommodation services offering higher and more intensive levels of support and rehabilitation.

- Individualised packages of care that draw on a range of services supplemented with additional levels and types of support as required.

The difference between the approaches is that one seeks to develop services to accommodate a range of needs, while the other aims to develop flexible services and supports in response to individual needs. In practice all the DHBs are providing both groups of services but with some difference in emphasis and focus.

While some of the DHBs recognise the importance of collaborating with a range of other services and agencies including (but not limited to) Housing NZ, Work and Income, abuse counsellors, ACC, NZ Police and the Department of Corrections, few appear to have formal relationships or other enabling processes in place. This is consistent with the findings of the literature review where the lack of collaboration between mental health services and with other agencies is a very common theme.

In New Zealand responsibility for funding and providing services to people with a mental illness and intellectual disability or acquired brain injury, and older people with existing or emerging mental health and age related needs may be disputed between the disability, health of older people and mental health sectors and people are at risk of 'falling through the gaps'. The need for building cross-agency approaches was noted by some DHBs, who gave examples of where this occurs including the High and Complex Need Unit operating from Child Youth and Family.

All the DHBs report gaps and although these are mostly in mental health services, other gaps relate to housing, social and employment services. Some larger DHBs note that the fluctuating demand for services can pose challenges to the development of responses to needs. Other DHBs note the challenges of meeting the intensive needs of a small and sometimes scattered population, particularly in smaller and rural areas.

Future work programme

Amongst the participating DHBs, a number have or are in the process of undertaking detailed analysis, planning and developments aimed at improving responses to people with high and complex needs. Examples identified through this research are from the Northern District Support Agency (NDSA), the Midland region and Hutt Valley DHB. As part of a future work programme, the Mental Health Commission may want to undertake or support a further stock take of initiatives (noting that eight DHBs did not participate in this research) and explore the various planning processes and outcomes achieved. A research question could be shaped around the one action outlined in Te Kokiri that specifically targets people with high and complex needs:

> 'Action 2.18: Expand the range, quality and capacity of services available for people with high and complex needs, including recovery-focussed rehabilitation services according to need, in the least restrictive setting.' (Minster of Health, 2006, p. 24)

There are sub-populations that require specific attention and these include people with mental health needs and an intellectual disability; older people with mental health and age-related needs, and people with multiple health needs. These groups all require assistance across a number of agencies.

A further area for potential focus is policy that enables and supports collaboration across the health of older people and disability service funding groups, and across a range of other Government departments and social service agencies.

Contents

1. Introduction

1.1 Background

The brief developed by the Mental Health Commission for this research notes that although many people with mental health and addiction problems have their needs met through community-based services, some require special consideration. They may present to services only when there is a very acute need and once discharged may continue to have a large number of unmet needs, which eventually propel them back into acute services. Their quality of life may be very poor, and for various reasons, they may not engage well with services and pose challenges to services as they plan for and provide responses to needs.

Because some people with high and complex needs may be hard to reach and difficult to engage with, service responses may be largely mobilised in acute situations and tend to be driven by the acuity and the risk of harm to the person or others. This can mean that a great deal of resource is spent on this population with poor quality results beyond the acute episode. Alternative approaches aim to support a person, often on an ongoing basis, to maintain their wellness and thereby leading to a better quality of life and social inclusion (Mental Health Commission, March 09).

The Mental Health Commission notes that the term 'high and complex' is used to denote a group of people:

- With frequent acuity of need
- Who need intensive continuing support to maintain them out of acute services
- Whose psychiatric disorders form a serious barrier to social inclusion
- With multifaceted presentations which may acutely include risk of harm to self or others, severe failure of self-care, and criminal offending.

People with high and complex needs typically have a serious mental illness with one or more co-occurring problems.

1.2 Objectives

The objectives of the project are to:

- Describe the definitions used to characterise the 'high and complex needs' population within the mental health and addiction sector
- Collate such measures or estimates that exist of the size of the high and complex needs population in each DHB region
- Identify issues in service responses to those with high and complex mental health and addiction needs
- Inform policy about the care of people with high and complex mental health and addiction needs.

1.3 Inclusions

The scope of this project includes:

- Review high-level New Zealand and international policy documents / literature on high and complex mental health and addiction needs.
- Determine from each DHB their definition of 'high and complex' mental health and addictions needs.
- Obtain information from each DHB about the prevalence of high and complex needs in their region.
- Collect information about, and analyse, the service policies of DHBs for their high and complex needs population.
- Identify any barriers to the implementation of service delivery in this population.

1.4 Alignment with Strategic Goals

Mental Health Commission

This project is aligned with the Mental Health Commission's statutory functions and strategic goals through:

- Monitoring and reporting on the population with high and complex needs and service policy responses.
- Contributing to social inclusion by advocating for this group.
- Collaboration with others in the sector concerning the understanding of the prevalence of high and complex needs in the population and the service policies for this group.

Te Tähuhu

This project is also aligned with the following aims of Te Tähuhu (Minister of Health, 2005):

- All New Zealanders can see a trusted and high performing mental health and addictions sector, and have confidence that if they need them, they can access high-quality mental health and addictions services.
- People with mental illness and/or addictions can experience trustworthy agencies that work across boundaries and enable service users to lead their own recovery. They should experience recovery-focused mental health and addictions services that provide choice, promote independence, and are effective, efficient, responsive and timely.

2. Research Results

2.1 Process

The methodology used for the research included distributing information on the project and a questionnaire to the Mental Health Portfolio Managers within the Planning and Funding team of all DHBs by email. They were asked to identify a contact person within each DHB who would be responsible for completing the questionnaire. The DHBs that did not respond to the initial contact were sent a follow-up email.

The participating DHBs had the option of completing the questionnaire independently or through an interview, and subsequently five phone interviews and one face to face meeting were completed. The variation in methods used to complete the questionnaire has meant the level of detail provided by the DHBs differs, however this has not compromised the achievement of the research objectives.

From a potential of 21 responses fourteen DHBs completed the questionnaire, equating to a response rate of 67 percent. Responses were received from the following DHBs:

1. Waitemata
2. Auckland
3. Counties Manukau
4. Bay of Plenty
5. Lakes
6. Taranaki
7. Hawkes Bay
8. Whanganui
9. MidCentral
10. Wairarapa (child and youth)
11. Hutt Valley
12. South Canterbury
13. Otago
14. Southland

This largely self-selected sample provided a variety of perspectives, including from DHBs serving urban, provincial and rural populations.

2.2 Definitions

Of the fourteen DHBs who completed the questionnaire, twelve are using the term 'high and complex needs' to describe a population with a diverse range of needs.

NDSA are currently leading a project across Waitemata, Auckland and Counties Manukau DHBs with the goal of reviewing 'current access by adult populations to contracted Mental Health and Addictions Services (DHB Provider arm and NGOs) and recommending solutions to maximise access and responsiveness for people identified with high and complex needs' (Project Charter: High and Complex Needs, April 2009).

The definition proposed by this project is:

> 'Those persons with serious mental illness and problems of treatment responsiveness or engagement [including itinerant and homeless] who have complicating factors of substance misuse or risk to others or criminality; or those persons with serious mental illness with at least one other complicating factor such as a major physical illness, pre-senile age related disability; acquired cognitive impairment; or intellectual disability that requires a complexity of funding and coordinated service response across agencies which is difficult to achieve'. (Project Charter: High and Complex Needs, April 2009)

Waitemata DHB note problems with operationalising a definition, particularly the difference between high treatment needs and high support needs, and Auckland DHB notes the lack of diagnostic/ etiological clarity between mental illness and substance issues for some people.

Others note the lack of a single or clear definition.

> 'There is no operational definition of the phrase. There are some clients who are on a register called high risk registrar and I suspect that risk [is] in terms of safety and the policy related to that. Looking at the available ... online literature it appears to be a term commonly used in the New Zealand context, and there appears to different contexts.' (MidCentral DHB)

South Canterbury does not use the term high and complex needs, and instead describe the group by the type of service response provided and as users of 'individual packages of care'.

Hutt Valley DHB use the term 'long term conditions' to describe the group, and this assumes contact with Mental Health Services for extended periods of time because needs are not adequately addressed. The DHB considers that this not only provides a more accurate description of the population, but that it also avoids ascribing a label with negative connotations to people for whom services have struggled to provide an appropriate response.

2.3 Types of Needs

Needs are consistently described as 'enduring', 'serious', 'severe' or 'long-term', and all the participating DHBs noted that people have a number of co-existing disorders and multiple problems.

> 'The term is typically applied to clients with enduring mental illness, treatment compliance issues and/or treatment resistance and often use illicit substances and/or alcohol. The typical high and complex needs person is often homeless, lacks a robust support network from whanau/family/significant others and lives a transient lifestyle, are anti-social and on the fringe if not involved in criminal activity.' (Bay of Plenty DHB)

Common sub-groups identified include people with an intellectual disability or acquired brain injury, and older people with existing mental health needs and increasing needs related to their ageing. Responsibility for these vulnerable groups may be disputed by services and between the disability, older people and mental health sectors with some DHBs noting that people may 'fall through the gaps'.

Three of the smaller DHBs (Whanganui, Wairarapa and South Canterbury) noted the needs of adolescents or younger people who may have a mental illness, major issues with their family/ whanau and behavioural problems.

The following table outlines a mix of diagnosis and presentations and these are noted in order of the frequency of mention by the DHBs.

Table 1: Frequency of presentations

Presentations	Frequency
Alcohol or drug misuse	1
Intellectual disability	2
Physical health	3
Age-related need (older people)	3
Acquired brain injury	4
Borderline personality disorder	5
Behavioural	5
Trauma related	5
Eating disorder	5

Table two illustrates the types of problems associated with the population and these are noted in order of the frequency of mention by the DHBs.

Table 2: Types and frequency of problems

Problem descriptors	Frequency
Safety and risk factors	1
Accommodation issues, transience and homelessness	2
Criminality	3
Poor response to treatment	3
Difficult to engage	4
Issues with family/ whanau	5
Socially isolated	6
Require legal and mental health oversight	7

Although risk to self and others and criminal propensities were commonly noted by the DHBs, only five noted a link with forensic services in their description of the population.

2.4 Prevalence

The DHBs were asked to estimate the number of people with high and complex needs living in their district, and there is a strong level of agreement that the population is relatively very small. However, and as noted by some DHBs, in the absence of a clear definition of high and complex needs the numbers are difficult to estimate. For this research this means that the DHBs based their estimates of the population size on different assumptions, for example some included people who were in inpatient rehabilitation services while others did not (Auckland, Waitemata and Hawkes Bay DHBs noted they did not include numbers from current inpatient services and Regional Forensic service populations). Others counted the number of clients using high cost packages of care.

The following table outlines the responses provided by the DHBs, although this should be read with caution due to the variation in assumptions.

Table 3: Estimated number of adults with high and complex needs by DHB

	District Health Board	Estimated number of adults
1	Waitemata	135 - 140
2	Auckland	170
3	Counties Manukau	60
4	Bay of Plenty	30 - 40
5	Lakes	15
6	Taranaki	14
7	Hawkes Bay	21
8	Whanganui	50
9	MidCentral	Not provided
10	Wairarapa	Not provided
11	Hutt Valley	20
12	South Canterbury	10
13	Otago	20
14	Southland	10

2.5 Service Responses and Models of Care

2.5.1 Overview

All DHBs are operating a model of care that includes primary care, a range of community support and accommodation services (NGOs), and a range of general, cultural, and specialist mental health services, and acute and rehabilitation inpatient services (DHB provider arm). In addition DHBs are accessing services provided on a sub-regional and regional basis including forensic services, secure rehabilitation, intensive rehabilitation, dual diagnosis (intellectual disability), eating disorder and personality disorder services, methadone clinics, and early intervention services.

Service responses that specifically aim to respond to high and complex needs fit within two main groups:

- Targeted services including assertive case management and community and accommodation services offering higher and more intensive levels of support and rehabilitation.
- Individualised packages of care that draw on a range of services supplemented with additional levels and types of support as required.

The difference between the approaches is that one seeks to develop services to accommodate a range of needs, while the other aims to develop flexible services and supports in response to individual needs. In practice all the DHBs are providing both groups of services but with some difference in emphasis and focus. Based on the information gathered through this research there is no evidence that one approach is superior to the other.

The level of attention given to the development of responses to people with high and complex needs varies between the respondent DHBs. As already noted, there is agreement that the population is small and from a planning and development perspective their needs will be considered within the context of other priorities. Based on the responses areas that appear to have or had a specific work plan include Waitemata DHB, Auckland DHB and Counties Manukau DHB (including work through NDSA); Bay of Plenty DHB, Taranaki DHB, Hawkes Bay DHB and Hutt Valley DHB. Later in this report (section 3) various approaches used by some DHBs for planning purposes are outlined.

The following table gives an indicative comparison between general mental health services and those developed for people with high and complex needs as identified through the responses.

Table 4: General and High and Complex Mental Health Services

General Mental Health Services	High and Complex Mental Health Services
• Primary Care	• Primary Care
• Community Supports	• Intensive and/ or rehabilitation community supports • Packages of care • Medication services • Mobile support team
• Residential Services	• Intensive rehabilitation • Residential Services with higher levels of support (e.g. level 4+) and/ or clinical input • Packages of care
• Clinical Services (general and specialist)	• Clinical Services (general and specialist) • Assertive care management
• Acute services including crisis response and inpatient	• Acute services including crisis response and inpatient
• Inpatient rehabilitation	• Inpatient rehabilitation
• Forensic services	• Forensic services

The remainder of this section explores key themes related to models of care and most are processes or practices used to respond to high and complex needs. For a summary of the responses from each DHB please see the appendix.

2.5.2 Collaboration with other sectors and agencies

Some DHBs, and generally those with models of care that emphasis person-centred planning, have recognised the importance of collaborating with a range of other services and agencies including

(but not limited to) Housing NZ, Work and Income, abuse counsellors, ACC, police and the Department of Corrections. The purpose of this collaboration is to ensure that service users have access to the necessary services and that planning across services is coordinated.

Mostly the relationship between the DHBs and other agencies appears to be reasonably informal and based on individual needs however some DHBs, for example Hutt Valley, intend to strengthen some relationships and develop partnerships.

Hawkes Bay DHB is an example of where formal relationships exist and there are regular cross agency meetings. The response from Wairarapa DHB addressed adolescents and noted that cross-sector planning must occur for applications to the High and Complex Needs Unit[1].

South Canterbury DHB note that in a smaller district there is very good networking and knowledge of services and this can contribute to effective planning and service delivery for people with high and complex needs.

Areas that would benefit from the strengthening of cross agency planning and relationships are noted in section 2.6

2.5.3 Funding boundaries

Some DHBs also recognised the need to work across traditional health and disability funding boundaries. At Hawkes Bay DHB the mental health, health of older people and disability Needs Assessment and Service Coordination agencies meet each month to discuss service users who have multiple needs. If a lead agency is not identified from this meeting the matter may be escalated to service managers, however this is not usually required as the services have established good protocols and focus on who can meet the needs of the service user.

2.5.4 Person-centred planning

Amongst the responses from the DHBs there were marked differences in the emphasis placed on the role of person-centred planning and, as noted above, this appears to reflect some difference in emphasis in models of care. Some DHBs made a strong link between person-centred or individualised plans and the development of packages of care.

A range of terminology was used to describe planning including:

- 'Personalised solution plan' (Counties Manukau DHB)
- 'Innovative, solution focussed and integrated planning' (Southland DHB)
- 'Innovative and individualised plans' (Whanganui DHB)

[1] The High and Complex Needs Interagency Strategy is funded by the Ministries of Health and Education and Child Youth and Family Services. It promotes collaboration and joint work across agencies to improve outcomes for children and young people with high and complex needs. Specific roles of the HCN Unit are supporting interagency collaboration; collecting and managing information; allocating funding for Interagency Plans, and reporting to Ministers and stakeholders. (http://www.hcn.govt.nz/)

2.5.5 Packages of care

Ten DHBs report that they are providing individual packages of care to supplement the supports available through contracted services.

'Package of care' is the most common term used, and exceptions include Hawkes Bay DHB where 'package of support' is used as the descriptor. Counties Manukau DHB does not appear to use the term 'packages of care' but does have a 'flexi fund' available to support the implementation of a 'personalised solution plan'.

Otago and Southland DHB report that provision of packages of care is limited by resource and funding constraints.

2.5.6 Assertive treatment and case management

Three DHBs reported that they are providing assertive or intensive treatment and case management with small caseloads including people with high and complex needs. The names used for these services are:

- Assertive Community Outreach Services (ACOS) (Auckland DHB)
- Intensive Community Team (ICT) (Counties Manukau DHB)
- Intensive Case Management (ICM team) (Bay of Plenty DHB)

Taranaki previously operated an assertive case management team with 1.5 FTEs; however this was problematic and not sustainable for a number of reasons including workload pressures, safety concerns and the burn out that arose from having such a small team responsible for the client group. The decision was made to disband the service and realign the roles to sit within the adult community mental health teams - this followed the model provided by other services with a similar size of population within the Midland region. The DHB now strongly believes that for rural services, high and complex staff positions should be provided from a well resourced and supported community mental health team.

2.6 Response and Service Gaps

Most of the DHBs reported that there were times when it was difficult to respond to people with high and complex needs for a range of reasons including the nature of specific needs, service gaps and problems accessing all the required supports and services including those provided with mental health funding and by other funders.

This section explores the service gaps and some of the issues that can be challenging to address.

2.6.1 Service gaps

All the DHBs reported gaps in the services and supports available in their district and these are summarised below.

- Vocational and employment opportunities for service users (Counties Manukau DHB, Whanganui DHB, South Canterbury DHB).

- Intensive, flexible home and community based support services (Southland DHB and Otago DHB).
- Broader range of residential options, particularly supported landlord type schemes (Bay of Plenty DHB and Hawkes Bay DHB).
- Secure, clinically based rehabilitation residential service (Bay of Plenty DHB and Lakes DHB).
- Cross agency response to social housing emergencies (Hawkes Bay DHB).
- Residential option (wet house[2]) for people with addictions (Hawkes Bay DHB).
- Secure rehabilitation services for women (Waitemata DHB and Auckland DHB).
- Rest homes accommodation for people under 65 years with dementia (Waitemata DHB and Auckland DHB).
- Capacity for cultural support (Waitemata DHB and Auckland DHB).
- Capacity for neuropsychology assessments (Hawkes Bay DHB) and other psychological services (Whanganui DHB).
- Community services and funding for people with mental illness and an intellectual disability (Whanganui DHB).
- Respite services (South Canterbury DHB).

2.6.2 Residential Options

Several DHBs note the difficulties of accessing suitable accommodation.

> 'Their behaviour/mental health is such that the residential facilities don't want to take them back, as they are unable to meet their complex needs. These [service users] quickly gain a reputation for being "difficult" and once they have exhausted the limited number of providers within a smaller DHB community it is extremely difficult, if not impossible, to find a local provider to give [a service user] a second, third or fourth chance.' (Southland DHB)

Options that span a continuum from supported landlord programmes to secure services were also proposed, and these need to improve the effective of supports while also enabling service users to have some choice.

2.6.3 Smaller and Rural Areas

Some of the smaller DHB's discussed challenges related to providing services.

South Canterbury DHB note that respite is a service gap, but that this is difficult to address in a smaller area due to low volumes across a range of needs and population groups. Wairarapa and Southland DHBs note the difficulties of meeting the needs of people who are living rurally or in isolated areas.

Bay of Plenty view that cross agency and iwi links could be strengthened, particularly to ensure basic and social needs are met e.g. food, clothing and shelter. While bigger centres have night shelters,

[2] Capital and Coast DHB are in the process of developing a wet house.

'The residential centre aims to minimise the harmful consequences of residents' drinking patterns, while providing a stable, culturally appropriate living environment which encourages a reduction in alcohol consumption. Wellington's proposed wet house has received key funding from Wellington City Council and Capital and Coast District Health Board and is being led by members of the Homeless Prevention Steering Group.'(http://www.scoop.co.nz/stories/AK0705/S00023.htm)

soup kitchens etc, these are not available in this district. Some courts are now considering the mental health needs of people who carry out relatively minor offences such as urinating in public places, and the development of social supports may help to reduce higher levels of offending.

2.6.4 District, sub-regional or regional responses

Two DHBs had different views on whether services should be developed on a district, sub-regional or regional basis. Southland DHB supports the development of regional solutions that would support people with high and complex needs, and note that as a smaller DHB the range of options available will be limited.

Bay of Plenty DHB considered that a secure rehabilitation service and a clinical residential community based service were required in the district to complete the mental health service continuum and to support effective treatment and rehabilitation. The preference is for these services to be provided locally rather than regionally.

3. Approaches to Planning

Amongst the participating DHBs, a number have or are in the process of undertaking detailed analysis and planning aimed at improving responses to people with high and complex needs. The following examples of planning process have become apparent throughout this research.

3.1 Midland Region

A survey on mental health consumers with 'extreme and complex' needs was commissioned by the Waikato DHB Mental Health Service on behalf of the Midland Region's High Needs Steering Group and undertaken by Peter McGeorge (2004). The purpose of the survey was to identify the number of consumers with these needs, and service and system issues that required further development to better address these needs.

Across the four[3] DHBS, the survey identified 95 consumers (from a total population of 684,000) who comprised four key sub-groups defined by a mix of diagnosis, behavioural factors, treatment and support needs:

- Persistently active and/ or 'brittle' psychoses who have anti-social personality traits complicated by substances abuse and who need 24 hour supervised care and/ or immediate access to assessment and treatment
- Head injuries complicated by substance misuse, psychosis and/ or impulsive aggressive behaviour
- Intellectual disabilities complicated by substance misuse, psychosis and/or impulsive and aggressive behaviour
- Borderline personality disorder or to a lesser extent anti-social personality disorder, who are impulsively aggressive and have a chaotic lifestyle in many cases complicated by substance abuse

In addition there were smaller sub-groups who had specific conditions such as eating disorders and post-traumatic stress disorder (McGeorge, 2004, p. 2).

Many (63 percent) had two or three diagnoses and when the information was combined with risk profile data, McGeorge concluded that the group was more homogenous in their service and support requirements than was initially apparent. The gender mix was 64 percent males and 35 percent females and, while ages ranged from 20 – 70, 70 percent of the group was aged from 20 – 40 years. The ethnic mix was 53 percent European and 45 percent Maori.

McGeorge noted that DHB clinical staff felt that the current service response was inadequate however, due to the relatively small size of the various sub-groups, the development of a more generic range of services aimed at meeting extreme and complex needs was proposed.

A proposed service model was developed (Dekel, R, 2007) and this aimed to provide a systemic and recovery oriented response to people with high and complex needs and included a mix of established and new options available regionally, sub-regionally and within each district. Since 2007,

[3] Waikato, Taranaki, Lakes and Bay of Plenty DHBs were surveyed

implementation of the plan has progressed and the following table outlines the original options and current progress.

Table 5: Midland Progress Update

Option (2007)	Current progress
• Inpatient and secure rehabilitation service	• Sub-regional planning between Lakes DHB (4 beds), Waikato DHB (6 beds) and Taranaki DHB (3 beds) is progressing • Decision on the location of the service is still to be made but Waikato seems likely
• Community based high and complex rehabilitation supported accommodation service (level 4+) provided through collaboration between Mental Health Services within DHBs and NGOs	• DHBs are at different stages of development: - Established in Bay of Plenty and Taranaki - Waikato have tendered and are in process of establishing the service - Tairawhiti and Lakes are in planning stages • Variance in progress reflects the different priorities of the districts • NGOs are providing residential home and support staff and DHBs are providing clinical input • Significant work has gone to developing memorandums of understandings and shared policies to support the MHS and NGO partnerships
• Integrated social inclusion service aimed at supporting range of needs including housing, treatment, education, primary care etc	• This service is linked to the residential service above and is in different stages of development across the region • Works with the residential service to support people to move to longer term accommodation option e.g. supported landlord
• Regional panel with representatives from a range of stakeholder groups including forensic services, MHS staff, NGOs consumer and cultural advisors	• Planning approach has emphasised collaboration and change management at all levels – regional to local to individual clients • Focus in some areas now includes evaluation

The focus in the initial stages of the project has been on clients that were not compliant with treatment; had extended or multiple acute inpatient stays, and/ or were not well managed for a range of reasons.

Several sub-groups now require further attention and these are:

- People with mental health needs and an intellectual disability
- Older people with mental health and age-related needs (appears to particularly an issue in Bay of Plenty)
- People with multiple health needs

People in these groups often require a cross-agency response to needs and engagement with Disability Services.

3.2 Hutt Valley DHB

Hutt Valley DHB used 'Knowing the People Planning' (KPP) to understand the needs of those engaged with Mental Health Services for a long period (two years or more since first contact). The aim was to use the methodology to 'gain agreement among staff, service users and families about what a good service should look like' (http://www.kpp.org.nz/basics.cfm).The strategy also aimed to demystify and quantify needs, particularly of people Mental Health Services had experienced difficulties in responding to their needs.

Data was collected and analysed through 2008, and below is a sample of the key findings:

- From a daily caseload of approximately 1200, the majority (800) of adults had been engaged with services for more than two years.
- 564 people had been the recipients of continuous treatment by the Mental Health Service for more than two years (n=154 > 10+ yrs; n=143 > 6-10ys).
- 233 of the 800 were supported by mental health non government organisations, and of these 45 received levels of support clinicians considered to be inadequate.
- People with a mental illness and unmet needs related to their physical health, cognition (intellectual disability and acquired brain injury), trauma and/or alcohol or drug misuse were identified.

The DHB estimated that at any given time, a small number of people (under 20) will have needs that are difficult to meet, and some will have disabilities that are subject to dispute between services. The group changes as needs fluctuate, leading the service to the view that the emergence of 'high and complex needs' can be episodic and addressed through person-centred planning and individual packages of care.

> 'The challenge is not set by a group of needs that cannot be met, so much as people whose current needs are difficult to meet (all of whom are well known to services) without individualised packages and cross-sectoral accountability.'

KPP highlighted a broad range of needs outside the domain of Mental Health Services, for example abuse and housing, and is working towards establishing cross-sector partnerships with other agencies.

As already noted, Hutt Valley DHB question the usefulness of the term 'high and complex needs' Instead they prefer 'long term conditions' and recognise that amongst their client group there is a small number of clients whose needs are such that they require a particular focus.

3.3 Waitemata, Auckland and Counties Manukau DHBs

As already noted, NDSA are currently leading a project across the three DHBs[4] aimed at maximising access and developing solutions that are responsive to people with high and complex needs.

[4] Northland DHB have elected not to participate in the initial project activities but retain the option of participating in development of regional solutions.

These are the project deliverables

- Identify, by DHB, the population of concern and describe key characteristics and relevant demographic details.
- A description of current services available for adults with high and complex mental health needs in metropolitan Auckland.
- Reference to current practice examples regarding the continuum of care for adults with high and complex mental health needs.
- A set of recommendations identifying both local and regional solutions in the development of a continuum of clinical care and support required for the high and complex needs population.
- Identify gaps between current availability and future requirements.
- An analysis of resource implications to support the recommendations.
- To identify a range of indicators and gather baseline data relevant to the agreed upon indicators that will assist and inform evaluation of any implemented recommendations (Project Charter: High and Complex Needs, April 2009).

The project will draw on work previously undertaken across the districts including a Camberwell Assessment of Need undertaken in 2004. This tool aims to measure and assess the health and social needs of people with severe mental health problems[5].

Analysis of Camberwell identified 799 persons who meet the criteria for high and complex needs of these 57 percent were males; 40.8 percent were aged between 18-35 years (although Northland had more people in the 36 – 48 year category), and 52.6 percent were Pakeha. Across all DHBs the majority of people were single.

A key process of the regional project is to better understand the relationship of the Camberwell dataset and analysis with current clinical caseloads and service demands.

As this project is currently underway there are no key findings to report at this stage.

[5] The adult Camberwell Assessment of Need (CAN) is a family of questionnaires for assessing the wide range of problems which can be experienced by a mental health service user with severe mental health problems. It covers 22 different areas of life, and can be used to assess the perceptions of the service user, their carer, and a member of staff working with them (i.e. a mental health professional). There are three versions - a clinical version (CAN-C), a research version (CAN-R) and a short version (CANSAS).
(http://www.iop.kcl.ac.uk/virtual/?path=/hsr/prism/can/adultcan/faqs/#2)

4. Literature Review

As part of this project a brief literature review was undertaken. The literature was sourced by the Mental Health Commission and came from New Zealand, the United Kingdom, United States, Canada and Australia, and consisted of strategies, reports and policy papers aimed at defining problems and responding to needs. The literature was then supplemented with select documents identified by Acqumen Ltd.

It is important to note that the literature sourced through this project is not exhaustive.

4.1 Overview

Across the literature there is agreement that deinstutionalisation has led to real developments in specialist and community-based services that have significantly benefited the lives and recovery of people with mental illnesses. However there is agreement both nationally (Dekel, R, 2007, McGeorge, 2004, Southland Joint Project Team, 2001) and internationally (Greatley & Ford, 2002; Victorian Government Department of Human Services, 2003 etc) that responses to those with multiple and high and complex needs have been problematic and there is ample room for improvement.

The following quote summarises the perspective:

> '...it has become clinically apparent that while mental health services in New Zealand are addressing a broader range of need than before, there are still a number of service users whose needs are not being adequately met.' (Dekel, R, 2007, p.5)

Dekel goes on to talk about the risks of harm to self or others that may arise from unmet needs, but this should be contextualised to a wider range of possible harms. Consumers often have chaotic lifestyles (Victorian Government Department of Human Services, 2003), are frequently socially isolated (Greatley & Ford, 2002) and experience a poor quality of life. Major themes from the literature recognise the need to engage with consumers and provide coordinated person-centred responses, with one report highlighting that 'delivering care in the right way may cost society no more, and conceivably less, than providing inadequate care' (Sainsbury Centre, 1998, p. 5).

4.2 Descriptions and Definitions

A range of often interchangeable terms have been used to define the group and include those with 'severe and long term mental health problems' (Greatley & Ford, 2002), 'high and complex' (Thomson Goodall and Associates Pty Ltd, 2002), 'multiple and complex' (Victorian Government Department of Human Services, 2003), 'exceptional' (ACT Health, 2006), and 'extreme needs' (McGeorge, 2004). The terms 'extreme' and 'exceptional' appears to be used to denote the relatively low prevalence of people with this level and complexity of needs.

Although different terms have been used there is general agreement on the types of needs that define the population. The Department of Human Services in Victoria commissioned a literature

review (Thomson Goodall and Associates Pty Ltd, 2002) to inform a project aimed at developing responses to people with high and complex needs, and this uses Keene's[6] five categories as a basis for defining complex needs:

- Psychological, mental health and other problems
- Learning and development difficulties and other problems
- Social problems, homelessness and other problems
- Crimes and other problems
- Drug and alcohol misuse and other problems

Although some of the concepts and language used by Keene have since evolved, the groupings continue to be relevant and all indicate the co-occurring nature of mental illness and other problems.

The Victorian Department of Health Services has undertaken planning for 'people with multiple and complex needs' and notes that:

> 'The primary diagnosis or problem ascribed to the individual might be a major mental illness, personality disorder, or it could be an acquired brain injury, intellectual disability, autism spectrum disorder or a long history of substance abuse. Often it is a combination of any of the above, and attempts to identify a primary or major problem will be the subject of disagreement between service providers. In almost all cases, the presenting difficulties and behaviours are compounded by secondary drug or alcohol use, lack of suitable housing and lack of family or other social supports.' (2003, p. 4)

Other descriptions of the population often relate to interactions with systems and services and possible indicators of complex needs, for example 'experiencing multiple inpatient stays coupled with unsatisfactory community placements and homelessness' (Sainsbury Centre, 1998, p. 8).

The group is very frequently linked to behavioural problems and these are summarised below as:

- Disruptive behaviour that might include violent, threatening, aggressive, antisocial or unpredictable behaviour, inappropriate sexual behaviour and destruction of property
- Radically poor living skills and an associated chaotic lifestyle
- Repeated crises and excessively demanding behaviour (often leading to exclusion from services)
- An almost total lack of social networks
- Violence to self including suicidal and risk taking behaviour and the use of alcohol and drugs (Thomson Goodall and Associates Pty Ltd, 2002)

4.3 Service Problems and Issues

All the literature reviewed recognised improvements in responses to high and complex needs were required and, to varying degrees, noted current systemic and service related issues and barriers. Two reports explored these barriers in some depth including the project undertaken in the Midland Region in 2007 (Dekel, R, 2007), and the Victorian Department of Health Services (2003). The following table summarises the issues identified in the reports. These correlate to some of the issues discussed by the DHBs.

[6] Keene, J. (2001) 'Clients with Complex Needs. Interprofessional Practice'. Blackwell Science Ltd. UK

Table 6: Service issues impacting on responses to high and complex needs across three projects

High and Complex Needs: Midland	Multiple and Complex Needs: Victoria
• Service gaps • Lack of clear definition of 'high and complex needs' – often equates to hard to place • NGO limitations including clinical staffing and support worker skills, and lack of incentives to engage with client group • MHS limitations including difficulties recruiting non-nursing staff to some teams • Regional service models including the distance from other communities • Ongoing issues with the interface between forensic and high and complex need populations • Funding barriers including inflexible use of resources and lack of a clear treatment model within supported accommodation • Lack of collaboration with other sectors including Work and Income, ACC and Disability Services • Need to reflect the preferences of consumers (Dekel, R, 2007, p. 23)	• Service gaps • Comprehensive assessment – including multiple and fragmented assessments and disputed diagnosis • Interface with the criminal justice system • Service delivery and funding models e.g. over-emphasis on throughput and short term interventions, a culture of excluding rather than including the consumer group • Lack of coordination and integration between services and agencies • Consumer need for stability and social connection • Workforce development issues including skill gaps and insufficient training • Current legislation (Victorian Government Department of Human Services , 2003, p.8-9)

Across all the literature the lack of coordination and integration between mental health services and with other agencies is a very common theme, with one report noting that the achievement of positive outcomes will 'often depend on the capacity of the lead provider to negotiate agreement and commitments for services in other sectors' including disability, housing, mental health and drug treatment services, as well as components of the criminal justice system (Victorian Government Department of Human Services, 2003, p. 3-4).

Several reports identify a lack of coordination between specialist and generic mental health services as a barrier. In the US, SAMSHA[7] notes that many people with a serious mental illness have a co-occurring substance abuse disorder and they 'tend to be more symptomatic, have multiple health and social problems, and require the most costly care, including inpatient hospitalisation' (SAMSHA, 2003, p.5). Accessing help can be frustrating, particularly where mental health and substance treatment programmes are not integrated in any way. This has been recognised as a problem in New Zealand and is addressed in Te Kokiri (Minster of Health , 2006).

4.4 International Service Developments

Thomson Goodall and Associates (2002, p.77) found a set of agreed governing and good practice principles can usefully guide development programmes. Invariably these are underpinned by an acknowledgement of the need for collaborative and joint responses involving multiple health, justice and social services agencies at both national and local levels (Thomson Goodall and Associates Pty

[7] Substance Abuse and Mental Health Services Administration

Ltd, 2002; Sainsbury Centre, 1998; Greatley & Ford, 2002; The Standing Committee on Social Affairs, Science and Technology, 2006 etc).

The following principles were developed in Victoria:

- A joined up service response.
- A way through the barriers – the focus should be on complexity and providing flexible responses to needs, rather than operating eligibility criteria that exclude people from services.
- Commitment across the service system.
- Effective assessment and determination of a way forward – a forum and process (with legal authority and mandate) are required to bring relevant providers and experts together to plan appropriate responses to individuals with multiple and complex needs.
- Strengthening existing services to lead the way – new initiatives must complement existing programmes.
- New ways of working – implementation must include a feedback loop to inform further developments.
- Balancing individual rights and needs.

(Victorian Government Department of Human Services, 2003, p.35)

A cornerstone of the Victorian model is a regional gateway and referral process and a multiple high and complex needs panel[8]. Combined, these provide a single point of entry to the referral process, an initial assessment including examination of current service responses, liaison with relevant services and professionals, and facilitation of a case coordination strategy for individual consumers (p.36).

There is consistency in the service models proposed through the literature and these are often comprised of:

- Specialist inpatient services
- A range of graded residential and supported housing options
- A range of community-based treatment and support models
- A range of interventions
- Assertive outreach
- Intensive case management
- Access to generic MHS e.g. crisis intervention

In 2006 Canada recommendations arising from Senate Committee study on mental health and mental illness (The Standing Committee on Social Affairs, Science and Technology, 2006) emphasise a further shift from institutional to community-based care for people with a serious mental illness. The Committee promotes the notion of a 'Basket of Community Services' including housing, assertive community treatment, crisis intervention units and intensive case management programmes. It also promotes the collaborative and integrated care as the 'most promising strategy to improve both access to, and the quality of, treatment and services at the first-line level' (p. 16).

[8] Although not explored in depth, there may be similarities with the approach adopted in New Zealand through the High and Complex Needs Interagency Strategy funded by the Ministries of Health and Education and Child Youth and Family Services. The Strategy promotes collaboration and joint work across agencies to improve outcomes for children and young people with high and complex needs. (http://www.hcn.govt.nz)

The Sainsbury Centre for Mental Health (Sainsbury Centre) has undertaken research on assertive outreach models.

> 'Assertive outreach is a way of organising intensive, user-centre community mental health care and support for people who will not readily engage with services. Assertive outreach has become a central plank of mental health policy.' (Greatley & Ford, 2002, p. vii)

From 1999 to 2001, three teams targeting different populations and communities in London were piloted. The pilots were evaluated by the Sainsbury Centre and the Centre for the Economics of Mental Health and key recommendations were to:

- Tackle social exclusion by addressing areas that are central to inclusion including housing, employment, educations, leisure, religion, benefits and family relationships
- Prioritise and invest in the development of sustainable partnerships with a range of mental health and community agencies
- Ensure new services are integrated with existing services including inpatient and community services. New services will have an impact and it is important to recognise this and ensure all services are aligned (Greatley & Ford, 2002, p. viii – ix).

The Sainsbury Centre also emphasises the need for inter-agency planning and partnerships 'within and outside the mental health field' to ensure wider benefits for people with mental health problems locally and to promote social inclusion (Greatley & Ford, 2002, p. vii).

The Australian Capital Territory (ACT) has a Mental Health Strategy and Action Plan (2003-2008) and the midterm report (ACT Health, 2006) notes progress towards meeting complex needs. Key actions centred on mapping current services and eligibility criteria; developing strategic linkages across agencies to strengthen collaboration through the development of care pathways; addressing systemic limitations; addressing service gaps; establishing mechanisms to address 'exceptional needs' that don't fit within an existing pathway; and promoting assertive management. Specific training for sub-groups (e.g. mental illness and co-occurring substance disorder, borderline personality disorder) was also planned (ACT Health, 2006, p.15-16).

5. The New Zealand Context

Within New Zealand there are a number of current strategic and policy documents relevant to the high and complex needs population (Minister of Health, 2006) and key documents are briefly summarised below in chronological order.

5.1 Services for People with Mental Illness and the Justice System (2001)

There is a link between people with high and complex needs and forensic services and the distinction has been blurred. In this document, the Ministry of Health notes a lack of clarity about the target population for forensic services and the possible consequences this has for service delivery frameworks, and the unnecessary criminalisation and stigmatisation for the consumers involved (Ministry of Health, 2001, p.xii).

In the same document, the Ministry sets the direction for forensic services and notes the need to develop a:

> 'comprehensive, integrated community approach [that] builds on the community care principle at the heart of modern mental health services, aiming for the least restrictive level of care in the most "normal" environment possible.' (Ministry of Health, 2001, p.xii)

The need for a collaborative relationship between adult MHS (AMHS) and forensic services is noted. While forensic services continue to be a specialist service, there is greater focus on working with AMHS 'in a supportive partnership':

> 'AMHS will have an enhanced (and supported) role in providing support community services to people who are discharged from prisons or forensic services' (Ministry of Health, 2001, p.xiii).

5.2 Te Kokiri: The Mental Health and Addiction Action Plan 2006 – 2015

Te Kokiri sets out the strategic framework for the development of mental health and addiction services through to 2015 and outlines ten challenges or areas for development. A number of the challenges are relevant to people with high and complex needs including building responsive services with immediate emphasis on a number of groups including Maori, Pacific and people with intellectual disabilities. Another challenge is 'building and broadening the range of services and supports funded for people severely affected by mental illness' including those with co-occurring disorders (Minster of Health, 2006, p. 17). This challenge emphasises the need to build and strengthen existing services while continuing to develop effective responses that recognise the impacts at an individual level of employment, housing, educational and income needs, and family and community networks.

At a systems-level this requires collaboration and cooperation across specialist MHS and addiction services and government agencies including health, education, social services and justice. Te Kokiri notes that the infrastructure required to achieve the goal should be flexible and accommodate local needs (p.17).

One action specifically targets people with high and complex needs:

> 'Action 2.18: Expand the range, quality and capacity of services available for people with high and complex needs, including recovery-focussed rehabilitation services according to need, in the least restrictive setting.' (Minster of Health, 2006, p. 24)

5.3 Meeting the needs of people with Chronic Conditions (2007)

The most recent report was developed by the National Health Committee (NHC) and addresses the needs of people with chronic conditions defined as:

> 'any ongoing, long-term or recurring condition that can have a significant impact on people's lives.' (National Health Committee, 2007, p. 7)

There are five common chronic conditions in New Zealand and these are (by diagnosis) mental illness (one in five adults); chronic neck or back problems; asthma; arthritis and heart disease (NHC, 2007, p.8). The conditions are a barrier to independence and participation in the workforce and society, and affect not just the individual with the condition but also their family and carers. People with chronic conditions also consume a high proportion of resources, and disproportionately Maori, people on low incomes and Pacific peoples are affected.

Like other literature reviewed for this project, the NHC emphasises the differences between the disease-centred locus of acute care and person-centred locus of chronic care models (NHC, 2007, p.15). The chronic care approach calls for quality acute cares, proactive primary care, as well as greater coordination across hospital and community-based services (NHC, 2007, p.2). This requires a strong emphasis on local planning and responses.

Appendix: Models of Care by DHB

This appendix provides a summary of the model of care as described by each DHB.

Waitemata DHB

This DHB operates with integrated adult community mental health teams that include acute, home based treatment, recovery, early intervention and cultural services. People with high and complex needs are supported by these teams.

Other services for people with high and complex needs include packages of care, medication services, and residential rehabilitation services. The DHB accesses an inpatient secure rehabilitation service for males operated by Counties Manukau DHB. Auckland DHB provides sub-regional (Auckland DHB and Waitemata DHB) non-secure inpatient rehabilitation for males and females. Lastly the Waitemata DHB provides Regional Forensic Psychiatry Services.

Current service gaps include:

- Intensive Residential Rehabilitation (Level IV plus)
- Extended Inpatient Rehabilitation
- Rest-home accommodation for people under 65 with dementia
- Secure environments for women
- Capacity for cultural support

Other issues noted by the DHB include problems with definition and particularly the difference between high support needs and high treatment needs. There are also issues related to planning and responding to need related to fluctuations in the volume of service required and levels of needs. The DHB also notes the ageing nature of the population and the need to plan for this.

Auckland DHB

Services provided to people with high and complex needs include the assertive community outreach service (ACOS), residential rehabilitation, individualised packages of care and inpatient treatment.

Current service gaps include:

- Rest-home accommodation for people under 65 with dementia
- Secure environments for women
- Affordable accommodation
- Capacity for cultural support

Other issues noted by the DHB include the lack of diagnostic/etiological clarity between mental illness and substance use issues for some people. Like Waitemata, this DHB also notes issues related to planning and responding to need related to fluctuations in the volume of service required and levels of needs. The DHB also notes the ageing nature of the population and the need to plan for this.

Counties Manukau DHB

Services provided to people with high and complex needs include a range of residential rehabilitation and intensive community living services with mobile supports where required, and provided according to a 'personalised solution plan'. Flexible responses and solutions are used and a 'flexi-fund' is available to support this.

Counties Manakau DHB provides an inpatient secure rehabilitation service for males with high and complex needs and this operates on a sub-regional basis. The criterion for the service is:

> 'people with mental illness living in inpatient services or intensive residential rehabilitation, or who have recurrently been unable to sustain living within the community even when in 24 hour staffed accommodation'.

Mental Health Services (provider arm of DHB) has an Intensive Community Team (ICT) which operates an assertive community treatment model, and this provides intensive clinically based services as required.

The DHB also provides a regional dual disability service, and the flexi-fund and mobile support options are available for those people with dual disability issues requiring these services.

The key gap noted in the district is vocational and employment opportunities for service users.

Bay of Plenty DHB

This DHB has a dedicated work programme aimed at meeting the needs of people with high and complex needs. Resources associated with the programme are:

- Two health care assistants who work across the inpatient unit and the community
- Supported accommodation services level 4+ (four beds)
- Intensive Case Management (ICM) Team with four registered nurses operating small case loads
- Nurse Practitioner
- Drug and alcohol services
- Forensic services, although access can be problematic for people with high and complex needs

Service gaps centre on the range of residential services available in the district and proposals to address these include a secure rehabilitation service; a clinical residential community based service, and supported landlord services. The development of a secure rehabilitation facility is challenging (i.e. location, joint venture or partnership) and issues are still being worked through, however a local solution is preferred to a regional facility.

Cross agency and iwi links need to be strengthened, particularly to ensure basic and social needs are met e.g. food, clothing and shelter. Bigger centres have centrally based night shelters, soup kitchens, etc and these are not available in this district. Some Courts are now considering the mental health needs of people who carry out relatively minor offences such as urinating in public places, and improving social supports may reduce higher levels of offending.

Lakes DHB

The model of care operating in this district is described as poorly defined, although the usual range of services is available. Service gaps include a secure rehabilitation facility; step down services and appropriate service coordination. The availability of a skilled workforce is also noted as a gap.

Taranaki DHB

There is a currently clinical position within the Taranaki DHB community mental health services dedicated to people with high and complex needs. There is a team approach to managing people with high and complex needs, and a key worker is allocated from the three adult community mental health teams along with an associate or co key worker who is able to assist with visits when required. Each client is discussed at the weekly multi-disciplinary team meeting, and this includes an update of risks and risk management strategies.

Te Whare Whakaahuru Community Supported Living Service is a four bed high and complex needs Rehabilitation service which is jointly managed by Te Puna Waiora (Inpatient Unit) and Te Whare Puawai Trust (Maori NGO), and the main aim of this service is support clients with high and complex needs as they are discharged from the inpatient unit, to work towards getting them into their own homes and communities. A Mobile Support Team is attached to the Whare, and this enables people to be discharged into the community with good follow up and support to help maintain independence.

Previously an assertive case management team with 1.5 FTEs operated in the district, however this was problematic and unsustainable for a number of reasons including workload pressures and the burn out that arose from having such a small team responsible for the client group, and this led to subsequent recruitment problems. The decision was made to disband the service and realign the roles to sit within the community mental health teams - this followed the model provided by other services with a similar size of population within the Midland region. The DHB now strongly believes that for rural services, similar staff positions need to be provided from a well resourced and supported community mental health team, as the role cannot work in isolation due to increased risks to staff safety and burn out of staff.

Current gaps include having sufficient staffing across all services, and skill levels within NGOs. Recruitment to the dedicated community mental health team roles can also be difficult, and these staff need strong clinical skills as a basis for providing a therapeutic context for delivery of care to people with high and complex needs.

Hawkes Bay DHB

Along with the usual range of range of community and support options, this DHB also purchases 'high and complex beds' with a higher bed night rate ($150 compared to $120 for level four) than other residential services.

'Whatever It Takes' is a home based rehabilitation service that supports people with long term mental health issues who find it difficult to engage with services. This includes people with forensic histories who are transitioning to community living and require intensive support. Other providers have expertise in working with people long-term disabilities, intellectual disability, acquired brain injury and behavioural problems. Packages of support are available to address any gaps in the supports available and to enable individualised responses to needs and acute packages of care are also available for children and young people.

Services are coordinated by NASC and there are monthly meetings between the mental health, aged care and disability NASCs. If a lead agency is not identified from this meeting the matter may be escalated to service managers, however this is not usually required as the services have established good protocols and focus on who can meet the needs of the service user.

There are joint monthly interagency meetings with prison services, Probation, NGOs, social service agencies (e.g. Housing NZ, Work and Income), police, ACC, forensic services, etc. Individual service users are discussed and a lead agency identified. Where a lead agency cannot be identified this can lead to a breakdown in care. Where this is the case it is usually because needs are not described well or agreed between the service user, family or agencies.

Services gaps include:

- Capacity for neuropsychology assessments for people with a mental illness, cognitive impairments and behavioural problems. These needs can be difficult to assess and can cause delays in the development of coordinated support arrangements across funding groups.
- A coordinated response to social emergencies such as loss of housing, homelessness and addiction related issues. The DHB funds social emergency houses for mental health services, but there is no coordinated social agency response.
- Accommodation options for people with addiction issues but do not wish to engage with services.

Like some other districts, Hawkes Bay DHB notes that increasingly people want independent accommodation with support. This can work well for people with complex needs that may require regular support but do not necessarily benefit from or want higher levels of staffing. The DHB contracts for medication support, which is a morning and evening service seven days a week and this can work very well for people living independently.

Whanganui DHB

This DHB notes the need for care to be individualised, planned, innovative and consistently provided across services. Frequently people refuse to live in supported accommodation and instead prefer supported housing with intensive supervision by the DHB, although the outcomes can be variable and may result in the need for acute services.

Packages of care are provided and offer additional funding for support with activities of daily living and socialisation following long periods of hospitalisation; individual support for some activities; thrice daily contact by a registered nurse to monitor the safety of the person and the public, and support for families.

Not all needs are currently being adequately met and service gaps are noted as:

- Community resources and funding to accommodate people with mental illness and intellectual disabilities.
- Psychological services.
- Day and social activities that are meaningful and age appropriate.

MidCentral DHB

The response did not detail the range of services provided but note that access will vary on an individual basis. Difficulties in accessing support due to an exclusion criteria or the reluctance of a provider were noted, along with the need to develop interagency responses.

Wairarapa DHB

The response from this DHB addressed children and adolescents with a severe mental illness and complex and often multiple needs who require extra support and resources. They may be receiving an 'acute package of care' and accessing the intensive clinical support service provided by Hutt Valley DHB. The under 20 year old population of the district is approximately 11,000 and it is estimated that around 30 of those with a mental illness will have high and complex needs.

The model of care emphasises the need for multi-organisational collaboration. This includes but is not limited to working with a range of services agencies including youth offending teams, child health services, CYF, and the High and Complex Needs (HCN) unit, and collaboration occurs through a range of methods including meetings. Meetings focus on planning for and providing wrap around care for individuals and/or systemic issues which may impact on quality of care.

Service gaps include:

- Access to services of people in isolated and rural area - a project is currently underway to address this.
- Length of waiting time (currently 18-24 months) for assessment through the Child Development Service provided by Capital and Coast DHB – a project is underway to reduce waiting lists and provide more of the service locally.

Hutt Valley DHB

This DHB is focused on the development of community and primary care orientated services and is currently working with Otago School of Medicine research team to develop a Primary Mental Health Tool Kit. The aim is to shift the locus of care as appropriate, and to promote a proactive response to the needs of all service users, including those who may be unwilling to engage with services.

The DHB is planning to establish cross-sectoral partnerships with NGOs and government agencies and primary health in order to address unmet support needs. Arrangements for sharing experience and ideas with other Mental Health Services are in place.

Although providing appropriate responses to needs can be difficult, the DHB does not consider a single type of service response would address the gap. Instead the emphasis is on developing and providing individualised packages of care.

South Canterbury DHB

The DHB aims to provide 'individual packages of support services and care based in assessed need.' This avoids an assumption that 'one size fits all' and fosters flexible solutions to needs.

Individual packages of care often require working with a range of government and other agencies e.g. Police, Education Child and Youth etc, and the DHB notes that in a smaller district there is very good networking and knowledge of services available, which can contribute well to responses to high and complex needs.

There are always individual and 'one off' needs that are not always easy to manage, but funding is available to assist services users and provide what is needed. The one service gap is respite care, however this is difficult to address in a smaller area due to low volumes across a range of needs and population groups.

Otago DHB

Generally, high and complex needs are managed through existing resources and may include admission for inpatient rehabilitation; additional community support workers (as based on a needs assessment), and time limited packages of care. The availability of packages of care is subject to resource and funding availability as there is no dedicated or flexible funding pool.

In addition to limited provision of packages of care, other service gaps include flexible and intensive home and community based support services. There is also limited ability to increase levels of support provided to people living in supported accommodation due to funding constraints.

Southland DHB

The services available in this district are similar to Otago but with an emphasis on 'innovative, solution focussed and integrated patient management plans' and case management.

In addition to limited provision of packages of care; a lack of flexible and intensive home and community based support services, this DHB reports a shortage of options for people living rurally.

The DHB notes that it is often difficult to find appropriate accommodation options in the community, and this may result in lengthy and non-therapeutic acute inpatient stays. A bed stay in excess of 250 days is not unusual for people with high and complex needs and generally there is at least one person in this situation at any one time. The DHB supports the development of regional solutions that would support people with high and complex needs, and note that as a smaller DHB the range of options available will be limited.

Bibliography

ACT Health. (2006). *ACT Mental Health Strategy and Action Plan 2003- 2008; Mid Term Progress Review .*

Dekel, R. (2007). *Midland Region High & Complex Needs: Continuum of Care Options (Draft).*

Greatley, A., & Ford, R. (2002). *Out of the Maze: Reaching and supporting Londoners with severe mental health problems.* Kings Fund and the Sainsbury Centre for Mental Health.

McGeorge, P. (2004). *Survey of Mental Health Consumers with Extreme Complex Needs.* Midland Health Region.

Mental Health Commission. (March 09). *RFP High and Complex Needs Collation of Information.*

Minister of Health. (2005). *Te Tähuhu – Improving Mental Health 2005–2015.* Wellington: Ministry of Health.

Ministry of Health. (2001). *Services for People with Mental Illness in the Justice System: Framework for Forensic Mental Health Services.*

Minster of Health. (2006). *Te Kokiri: The Mental Health and Addiction Plan 2006 - 2012.* Wellington: Ministry of Health.

National Health Committee. (2007). *Meeting the needs of people with Chronic Conditions: Hapai te whanau mo ake ake tonu.*

Northern District Support Agency. (April 2009). *Project Charter: High and Complex Needs*.

Southland Joint Project Team. (2001). *Clients with Enduring Mental Illness: Report of the Project Team.*

Substance Abuse and Mental Health Services Adminstration. (2003). *Co-occurring mental health and substance abuse disorders: a guide for mental health planning & advisory councils .* US Department of Health and Human Services .

The Sainsbury Centre for Mental Health. (1998). *Keys to Engagement: Review of Care for People with Severe Mental Illness who are Hard to Engage with Services.* The Sainsbury Centre for Mental Health.

The Sainsbury Centre for Mental Health. (2003). *Policy Paper 3: The enonomic and social costs of mental illness .* The Sainsbury Centre for Mental Health.

The Standing Committee on Social Affairs, Science and Technology . (2006). *Out of the Shadows at Last: Highlights and Recommendations .* www.parl.gc.ca.

Thomson Goodall and Associates Pty Ltd. (2002). *Literature Review: To Inform a Department of Human Services Project on Responding to People with High and Complex Needs.* Victoria Government Department of Human Services.

Victorian Government Department of Human Services. (2003). *Responding to people with multiple and complex needs .*