Midland District Health Boards

# MIDLAND REGION HIGH & COMPLEX NEEDS
## Continuum of Care Options

Tuesday, 28 August 2007

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Midland Region Mental Health and Addiction Strategic Planner

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# ACKNOWLEDGEMENTS

The Midland region District Health Boards acknowledge and thank all those who participated in this project and made possible the outcomes achieved:

- First and foremost the members of the reference group who provided their expert advice and helped in the development of this document. The reference group was comprised of experts from NGOs and provider arm and included representatives of He Tipuana Nga Kakano (Midland Regional Service user Network) and Nga Purei Whakataa Ruamano (Midland Maori Regional Network);[1]
- Staff from provider arm and NGOs from across the region who were interviewed and provided valuable information regarding their own services and the issues that the sector is facing in their local areas;[2]
- The participants of the workshop held in July – members of the Midland Clinical Leadership Forum, members of the Expert Group and the Midland Region Mental Health Group (MRG) and representatives from Hauora Waikato and Te Whare Whakaahuru.

Also, we thank those in the region who participated in previous projects and groups that examined the needs of people with high and complex mental health needs in the Midland Region, especially Dr Peter McGeorge who conducted the 2004-05 survey of high and complex users, and Jeff Symonds who followed up the people who were identified two years later. Peter's and Jeff's work provided the bulk of the information for the project.

[1] Reference Group membership included in Appendix 1.
[2] Complete list of interviews and meeting notes are included in Appendices 2 and 3.

# EXECUTIVE SUMMARY

In December 2007 the Midland District Health Board, established a reference group to identify continuum of care options for services to adults who have high and complex mental health needs in the region.

In addition to the expert group's discussions, the project incorporated also a review of national and international approaches to service provision, interviews with key stakeholders including provider arm and NGO providers and data collected through the follow-up on service uses in the region who were identified two years ago as having high and complex needs.

A workshop was held in July 2007 to discuss the diverse opinions held in the sector and seek a consensus regarding the continuum of care options. The participants of the workshop included members of the expert group, clinical leadership forum, portfolio managers, Hauora Waikato and Te Whare Whakaahuru.

Based on the discussion at the workshop and the information gathered previously, the following recommendations were made:

**Recommendation number 1 – Continuum of Care Model**

- That the Midland Region High and Complex Needs Continuum of Care Model - Pathways to Recovery – described on page 28, be adopted
- That all services for High & Complex needs adopt a recovery focused philosophy of service

**Recommendation number 2 - Community-based H&C Rehabilitation Services**

- That each DHB fund Community-based H&C Rehabilitation Services, jointly planned and operated by a provider arm and an NGO to provide services for 15 service users in BOP, 7 in Lakes, 7 in Taranaki (in addition to the existing 3) and 21 in Waikato. Tairawhiti DHB has recently contracted with an NGO for 4 beds.

**Recommendation number 3 - Hospital based Secure Rehabilitation Services**

- That a business case be developed for the establishment of secure, hospital based rehabilitation services in the Midland Region with the scoping of costs to establish either one regional service in the Hamilton area or two sub-regional services, one for 10 beds for BOP and Lakes DHBs and one for 11 beds for Waikato and Taranaki. Tairawhiti will continue to access two beds in the Central Region until a different decision is made by the DHB.
- That a steering group be established to oversee the development of the business case, including Rees Tapsell, Jeff Symonds, Alan Mountfort (Lakes DHB CFO), a portfolio manager, a project manager and a financial analyst.
- That the MOH be informed by Cathy Cooney and Mary Smith regarding Midland region DHBs intentions.

**Recommendation number 4 – Clinical Governance**

- That a clinical governance approach be applied
- That a regional panel be established to review cases and recommend appropriate service users' pathways.
- That a monitoring framework be adopted whereby appropriate monitoring approaches are applied to programmes based on service users needs:

| Service User's Need | Relevant Programme | Monitoring Approach |
|---|---|---|
| Psychotherapy | Clinical | HoNOS |
| Functionality | Rehabilitation | PSP |
| Risk | Systems | Risk score |

# PART ONE – INTODUCTION

## *Background*

The process of de-institutionalisation has accelerated the development of a policy direction that emphasises more and better community based support options available to people with mental health problems and high support needs. This has been embodied in the Mental Health Strategy Looking Forward 1994, Moving Forward 1997, the Mental Health Commission's Blueprint for Mental Health Services in New Zealand 1998 and Te Tahuhu 2005.

Parallel and closely linked to this process was the development of forensic services that aim to provide effective assessment, treatment and rehabilitation for people charged with criminal offences that have or may have a mental illness; offenders with a mental illness; and individuals whose potential danger to themselves and others is such that adult mental health services (AMHS) cannot manage them safely.

Interface issues between the forensic system and general AMHS were identified relating mainly to the target population and core business of each service. These two separate but parallel systems have 'grey' areas concerning who should provide inpatient services to whom. In addition, there are disincentive difficulties over transferring patients between AMHS and forensic services, outpatient follow-up, and access to community facilities and services for forensic service users.

These difficulties led to the recognition that there is a group of service users, who are currently accessing forensic services but without clear need for forensic care, or who alternatively sit within the general AMHS and are at risk of future offending and therefore are potential forensic patients. This group presents higher risks to itself and others and is often more challenging to providers, due to the lower compliance and effective engagement in appropriate treatment and rehabilitation programmes. Some of which via the Justice System end up in forensic services and due to their histories of "difficult to manage" are hard to transfer back into mainstream services.

*Looking Forward* (1994) focused on increasing specialist mental health services in the community, in the homes and in hospitals. The main priority areas were general adult population and their families, youth, and children and their families. There was neither the identification of the different levels and the complexity of needs that people with severe mental illness might have, nor the different level of services that are required.

*Moving Forward* (1997) identified specific needs groups and their services, including "people with the highest support needs". This group, defined as 0.06% of the adult population, was targeted for assertive care management and a number of objectives and targets were identified.

The *Blueprint (*1998) went further to identify that people with ongoing severe and complex illness need access to a range of services within a framework which ensures continuity of care and follow-up. Similarly complex are the needs of those with mental illness with severe alcohol and drug disorders, eating disorders, head injury with compounding mental disorders, borderline personality disorders, mental illness with intellectual disability and 'mothers and babies'.

The *Blueprint* specified that hospital services (as an adjunct to community team services) providing medium-term and extended inpatient services must be available at the local level for those with high disability support needs whose complex symptoms and high support needs require 24 hour treatment and support.

Services have grown substantially since 1998. However 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 in terms of their being a risk to themselves and in some cases the public at large.

The *Forensic Framework* (2001) suggested that individuals may be referred from inpatient settings to intensively supervised step-down beds, in a hostel or supervised residence, which would provide ongoing care and rehabilitation, and gradual integration back into community.

Up until 1997, the Midland region was serviced by a large rural inpatient Mental Health facility, Tokanui Hospital, providing general Mental Health services including specialist services for the aged, adolescent and forensic populations

The expected closure of Tokanui hospital and lack of capacity in the community to provide forensic services and services for high risk patients and the interface between these and the general adult mental health services were a concern for the Midland Regional Health Authority in the early 1990s. A base line survey was commissioned in 1993 resulting in a recommendation for a service model that included a number of components (i.e. acute inpatient unit with close intensive psychiatric care areas, sub acute intensive rehabilitation hostels, medium and long stay supervised accommodations, community based activities and rehabilitation programmes, substance abuse services and Mäori health services) and the establishment of a regional forensic services (medium and minimum secure facilities, community team, long stay/extended care units).

In 2001, a draft report by Tapsell, Simpson and Benesmann recommended that "a non-forensic regional longer term hospital based treatment / rehabilitation facility be established in Midland. The facility would form a key part of a clinical interface between forensic services and adult services and will provide services for people with high and complex mental health needs, including those who are at high risk of offending and who require longer term treatment in rehabilitation in a closely supported and monitored hospital environment".

In mid-2003 discussions were initiated in the region regarding the potential impact that the implementation of the national Forensic Framework will have on general adult mental health services for people with high and complex needs in Midland. It was decided to top slice $1.8m from the 2003/04 regional Blueprint funding and allocate proportionally to District Health Boards (DHBs) to increase local adult mental health capacity – packages of care and assertive community treatment teams – to support people with high and complex needs.

A concern was raised that not all needs will be met locally. It was agreed that regional solutions should be developed for medium to long term rehab options and for regionally agreed definitions of levels of needs and clients assessment, while retaining DHBs independence in developing local services. Consequently, a regional process was developed in late 2003 to identify the numbers and the specific needs of people whose needs could not be met by the existing local community services (i.e. assertive community teams and supported accommodation providers). It was envisioned that once the service users are identified by clinicians, a comprehensive assessment of their needs be undertaken. To oversee the process, a High & Complex Needs Expert Group was established and in April 2004 Dr Peter McGeorge (PMcG) was contracted by Waikato DHB on behalf of the region to undertake a survey to identify the numbers of people involved, their risk profile, their needs and what services should be available to best address them.

Since the release of the report in mid 2005 a Regional Mental Health Clinical Nurse Consultant (RCNC) position was partially funded through the Blueprint regional top slice. The objective of the position is to create expert capacity to assess and support the needs of identified high and complex mental health service users in the Midland Region. Data collected by the RCNC was used in this project.

In late 2006 a regional expert group was established to identify continuum of care options for services to adults who have high and complex mental health needs in the Midland Region. The identified options are expected to inform DHBs' prioritisation process.

## *Aims and Objectives*

The project's aim was to identify continuum of care options for services to adults who have high and complex mental health needs in the Midland Region. The identified options will inform DHBs prioritisation process.[3]

The specific objectives of the project were:

- To explore current national and international literature and best practice regarding continuum of care for adults with high and complex mental health needs, and to explore national best practice kaupapa models of care.
- To examine the recommendations in, and currency of **'Midland Region Survey of Mental Health Consumers with Extreme and Complex Needs'** conducted by PMcG during October-November 2004.
- To map the current services available for people with high and complex needs in the Midland region, and identify DHBs' plans for funding additional services in 2006/07.
- To quantify future requirements for services for people with high and complex needs in the Midland region based on the 2004 Mental Health Needs Assessment and other documents.
- To identify gaps between current availability and future requirements.
- To incorporate the information compiled by the Regional Mental Health Clinical Nurse Consultant pilot that aims to assess and support the needs of identified high and complex mental health service users in the region.
- To recommend continuum of care options for people with high and complex mental health needs in the region, identifying a range of local and regional solutions.

## *Methodology*

The project utilised sector's expertise through a competence-based reference group.

The project included a number of key activities:

- A time limited reference group was established in late 2006, utilising MRG standard process, from a pool of sector nominations and nominations from two regional advisory groups
- A robust literature search including best practice models of care for adults with high and complex mental health needs was carried out
- The results and recommendations of **'Midland Region Survey of Mental Health Consumers with Extreme and Complex Needs'** conducted by of PMcG during October-November 2004 were reviewed.
- The follow-up data collected by the regional mental health clinical nurse was reviewed including service providers views on what worked, what didn't and what was needed at both the local/ district level and regionally
- A stock take of services currently funded for people with high and complex needs by the Midland DHBs was carried out and current models of practice utilised by these services were identified
- DHBs plans for future funding of services for people with high and complex needs in their District Annual Plans were documented.
- Utilise reference group expertise to identify continuum of care options for the region through workshops and discussions.
- Bring in additional experts (national or international) as identified by reference group to become familiar with existing and new models.

[3] Project Scope is available in Appendix 4.

- Incorporate all knowledge obtained throughout the process to identify the best options for the region
- Present report to the Midland Region Mental Health Group
- Present recommendations to Planning & Funding GMs and CEOs Forums.

## *Definition of High & Complex Service Users*

Two robust literature reviews were conducted in the last five years that shed some light on the complexity of the High and Complex: The Victorian Government Department of Human Services, as a lead to developing a service delivery framework for people with H&C needs[4], commissioned a literature review[5] in 2002. The Scottish Executive's, as a lead to its Closing the Opportunity Gap Approach to Tackling Poverty and Disadvantage[6] commissioned a review more recently (2007).

Both reviews demonstrated that a plethora of terms are linked with the concepts of High, Complex and Multiple needs used by various disciplines including health, social, education, housing and justice systems rendering any one definition impossible. The group of H&C people is consequently broad and closely linked to the context, the sector(s) involved and the professional disciplines of the stakeholders. The Victoria review identified the different ways in which sectors define complex needs including homelessness, primary care, disability, dual disorder, personality disorder, child protection, Aspergers Syndrome, and the criminal justice perspectives, each providing additional angles to the issue.

In many jurisdictions the concept of "complex needs" relates to people who have more than one diagnosis who consequently are more vulnerable, have complex and challenging needs, often experiencing abuse, neglect and exploitation. A Canadian review of mental illness and addictions[7] notes the different definitions of co-morbidity, concurrent disorders and dual diagnosis where ***co-morbidity*** denotes that two or more illnesses affect the same individual, whether two different mental disorders, two physical illnesses or a mental disorder and a physical illness; ***concurrent disorders*** refers to individuals who suffer from a mental illness and a substance use disorder at the same point in time; and ***dual diagnosis*** refers to individuals who have a mental health problem or illness together with developmental disability.

Rankin J & Regan S (2004) [8] suggested that complex needs in essence imply both breadth - multiple needs that are interrelated or interconnected; and *depth of need* - profound, severe, serious or intense needs. Furthermore, they suggested to rather than use the term 'complex needs' to *describe* an individual's characteristics, define it in terms of an *active framework for response*:

> *"A framework for understanding multiple, interlocking needs that span health and social issues. People with complex needs may have to negotiate a number of different issues in their life, for example learning disability, mental health problems, substance abuse. They may also be living in deprived circumstances and lack access to suitable housing or meaningful daily activity. As this framework suggests, there is no generic complex needs case. Each individual with complex needs has a unique interaction between their health and social care needs and requires a personalised response from services."*

[4] Responding to people with multiple and complex Needs. Phase one report. Department of Human Services. July 2003.
[5] Literature Review to Inform a Department of Human Services Project on Responding to People with High and Complex Needs. Thomas Goodall Asso. 2002.
[6] A Literature Review on Multiple and Complex Needs. Scottish Executive Social Research. 2007
[7] Mental Health, Mental Illness and Addiction: Overview of Policies and Programs in Canada. Interim Report of the Standing Senate Committee On Social Affairs, Science And Technology. 2004.
[8] Rankin J & Regan S (2004), *Meeting Complex Needs: The Future of Social Care,* London: Turning Points/ Institute of Public Policy Research (IPPR).

## High & Complex Needs Expert Group (2004)

The Midland High & Complex Needs Expert Group (2004) developed the following criteria for identifying H&C service users:

The service user will have:

- Axis 1 diagnosis (DSM4), severe and enduring illness; and
- Significant risk history:
    - To Self - either high lethality, high intent suicidal behaviour; or serious physical injury secondary to psychotic phenomena
    - To Others - either recent history over the last three months of moderate degree i.e. significant damage to property/assault on others without injury; or any history of severe assault on others with significant injury.

Service user will also have one or more of the following:

- Occupying an acute in-patient bed greater than six months (disregarding brief discharges less than one month, considering recent progress i.e. static or continuing to improve).
- Under the Mental Health Act i.e. section 29 or section 30.
- Non-compliance with treatment/poor insight leading to a breakdown in service follow-up and community care
- Dual diagnosis issues – i.e. Drug and Alcohol
- Severe functional/social/occupational disability
- Social dislocation.

## Peter McGeorge Survey (2004-05)[9]

The survey instrument used to identify H&CN service users was based on the Level of Community Support Scale (LOCSS), developed by Kazarian and adapted for the purposes of the survey. Case Managers and/or Psychiatrists were asked to identify, from their caseloads, those service users who needed the highest level of community support and scored 7 on the 1-7 scale as specified by the following criteria:

- Service user does not take medication as prescribed
- Is unwilling to attend clinical appointments
- Has frequent and severe crises involving threats or violence (Including physical and/or sexual) to self and/or others requiring frequent hospitalisations
- Often uses alcohol and/or drugs in a hazardous manner
- Has been frequently asked to leave residences supplied by supported accommodation providers
- Needs help in most aspects of life
- Is unable to access community services on their own
- Has needs that cannot be adequately met by a standard high level of community support.

[9] Midland Region Survey of Mental Health Consumers with Extreme and Complex Needs. Peter McGeorge. 2005.

# PART TWO – PROJECT FINDINGS

## *Profiles of identified H&C service users*

### Peter McGeorge Survey (2004-05)

PMcG identified 95 people in the Midland region as having high and complex mental heath needs, 56% of whom demonstrated hazardous use of alcohol and other drugs.

**Gender, Age and Ethnicity**

- Regionally, the proportions of males out-numbered females (61:34)
- While ages clustered in the 21-40 age range there were a number of service users in the older age groups
- Maori were over-represented (43%) and New Zealand European were under-represented (51%) in the group

**Axis I Diagnoses**

- Schizophrenia related psychoses (Schizophrenia, Paranoid Schizophrenia and Schizo-affective disorder) – 54% of the group (52)
- Affective Disorders (Bi-polar Affective Disorder and Major Depressive Disorder) - 27% of the group (26)
- Substance Abuse Disorder - 29% of the group (28) - all having dual or triple diagnoses with other Axis I and/or II diagnoses.

**Axis II Diagnoses**

- Borderline Personality Disorder, significant Borderline traits or Personality Disorder Not Otherwise Specified (PD NOS) - 23% of the group (22)
- Anti-Social Personality disorder (ASP) – 15% of the group (14)
- Intellectual Disability - 12% of the group (11)
- Only 33 service users (33%) had single diagnoses while 67% had dual and triple diagnoses.

***Case Studies A to E***

***A is a male in his 40s****. He spent two years in Forensic Inpatient Unit after taking an axe to his case manager. Lives alone having refused supervised accommodation. Had multiple acute hospitalisations. Is intelligent but easily disorganised. He has a $100K Package of Care and is gradually making a transition to supervised accommodation. His fragility and aggression are a constant concern.*

***B is a female*** *with diagnoses of Bipolar Affective Disorder and Borderline Personality Disorder. Is non-compliant with medications and appointments with the MHS. Whereabouts often unknown. Her family is not able to provide support. They are involved with drug abuse and crime. B gets exploited by those with whom she comes into contact. Her money often taken by her family. She makes contact with the MHS when her social problems overwhelm her.*

***C is a male in his 40s*** *with Intellectual Disability, Epilepsy, Frontal lobe damage and Schizophrenia. Difficult to find a suitable placement for him because NGO providers cannot manage his physical disabilities and his frequently aggressive and unpredictable behaviour.*

***D is a 28 year old male*** *with 10 year history of disorganised Schizophrenia and hazardous use of Solvents, Drugs and Alcohol. Lives with his father who is also a misuses drugs and alcohol. He is unable to care for himself in terms of his activities of daily living to such an extent that NGOs will no longer take him into their care.*

***E is a 30 year female*** *with diagnoses of Schizophrenia and Obsessive-Compulsive Disorder. History of extensive sexual abuse and rape. She ritualistically cleans. Recently underwent a prison sentence after being charged with stabbing a person. Needs supervised accommodation but NGOs will not accept her due to risk of violence to other residents and fire risk because she smokes in bed.*

## Follow-Up Study (2006-07)

Each service user still registered in 2006 with mental health services was followed up by Jeff Symonds with clinicians applying three quantitative scales and three qualitative questions.

**Global Assessment of Functioning Scale (GAF)**

- The mean rating on the GAF score was 49.2 (SD 16.7) in 2004 and 54.4 (SD 11.5) (p=0.027) in 2006. The scores reflect consistent impairment of functioning but with significant improvement.
- 95% of service users who were in the low/very low categories of GAF score in 2004 had improved their score to be in the top half (moderate or high) in 2006. 9% of those whose scores were in the higher range in 2004 had deteriorated to GAF < 40.

**Health of the Nations Outcome Scales (HoNOS)**

- The mean HoNOS in 2006 was 12.4 (SD 6.1), representing an unexpectedly low HoNOS and a wide score spread.

**Personal and Social Performance Scale (PSP)**

- The mean PSP was 53.5 (SD 14.6).

**Correlation between the three scales**

- High correlation between HoNOS and GAF. Pearson correlation coefficient with rho = -0.7 (p<0.0001).
- High correlation between HoNOS and PSP. Pearson correlation coefficient with rho = -0.65 (p<0.0001).
- High correlation between the GAF and the PSP in 2006 with rho=0.89 (p<0.0001).
- In the presence of an Axis II diagnosis the mean HoNOS scores were higher by two points and the PSP scores non-significantly lower (with the mean dropping from 57 to 50). This demonstrates overall higher psychopathology and lower functionality in those with personality disorder. Age group or gender made no difference to the mean scores on either scale.

***Case Study F***

***F is a 19-year old Maori man*** *who is currently in a DHB Acute Psychiatric Unit under sec 30 of the Mental Health Act. Clinically based concerns are that the environment and services provided are not sufficiently robust to safely meet his needs. F has had multiple interactions with psychiatric, drug and alcohol, supported accommodations and forensic services and is unable to sustain stable accommodations. He has no real support from his family who have at times been victims of his violence. His mental state fluctuates according to his cannabis use and consistency with prescribed medication regimes. He is receiving intramuscular depot medication however this does not eliminate his propensity for active symptoms and potential violence. His long term stay in the acute unit creates negative situations for incidents and a lack of real rehabilitation programmes.*

*F requires a contained environment for a period of time whereupon assessment, treatment and rehabilitation programmes have a reasonable opportunity to take effect.*

*F has acted out in the past randomly with extremes of violence to members of the public, staff and co-patients. If F does not access a secure environment more people will continue to remain at a high risk of serious injury or worse. Clinical staff have tried many different strategies and treatment approaches over the past few years, including high levels of monitoring, periods of intensive psychiatric care and seclusion, partnerships with local NGO/ vocational /cultural support workers with care planning, attempts to engage and work with whanau, various medication regimes, etc, inevitably each time was meet with disaster. The base reason for this failure apart from F's own psychopathology essentially rests in the lack of an appropriate facility to provide a structured longer term rehabilitation service to meet this mans needs in a more effective and safe manner.*

**Key workers interviews**[10]

Each service user still registered in 2006 with mental health services was followed up with three specific questions put to the key worker, the Responsible Clinician or other associated clinical staff. To minimise possible rater bias, wherever possible two separate interviews took place regarding each service user. The questions were - what is working? What is not working? What would you like to see in place for the HCNC (i.e. what would make a difference to their mental state and functioning?). A thematic analysis was carried out on the qualitative questions and those prioritised into the Top 10 for each DHB and the Top 5 for the region.

It is important to note that two factors influenced the regional results:

- The factors identified as either contributing to service users' progress or those who did not work well were directly correlated to the availability of services locally during 2004-2006.
- 56 of the 94 (60%) service users followed were from Waikato DHB, resulting in some regional totals biased towards this DHB's results.

  Accordingly -

- The Top Five for both "***what worked well***" and "***what did not work well***" are less consistent across the DHBs
- The Top Five for "***what is needed***" are less influenced by local service availability and are more consistent across the region.

**Contributions to service users' progress**

- Overall, in the region and each of the four participating DHBs, **Engagement with the provider arm's mental health services**, **Medications** and **Supported/ Stable Accommodation** were seen as contributing factors to progress of service users.
- Other factors were **Counselling** (Lakes and Waikato); **Close Monitoring** (Lakes); **Inpatient Services** (BOP); **Meaningful Activities** (BOP); **Multi-Agency Approach** (Taranaki); **Support Networks** (Waikato); and **Work /Transition** (Taranaki).

**Aspects that did not work well to progress the service user**

- Overall, in the region and each of the four participating DHBs, **Family Dynamics** was seen as the aspect that did not work well for service users.
- Other aspects that were problematic were **Drug & Alcohol Issues** (BOP, Taranaki and Waikato); **Treatment Programme** (Lakes, Taranaki and Waikato); **Accommodation** (BOP and Waikato); **Physical Health** (Lakes and Taranaki); **Engagement with Work Programmes** (BOP); **Independence** (Lakes); Insight (BOP); **Risk Management** (Taranaki); **Safe Sex/Prostitution** (Lakes) and **Social Support** (Waikato).

**Service elements that are necessary to improve H&C mental state and functioning**

- **Stable Accommodations, Improving Family and Social Relationships, Meaningful and Healthy Lifestyles, Employment Opportunities,** and **Counseling** are the top five areas that clinicians felt are needed by service users across the region.
- Bay of Plenty clinicians also indicated the need for **Consistent Approach by Mental Health Services,** and Taranaki indicated that need for **Close Monitoring** for some of the service users in their area.

[10] Complete summary of results can be found in Appendix 6

# *Services Provided to "High and Complex" Service Users*

## Services currently provided across the Midland Region

A wide range of services is currently available across the Midland region for adults with high and complex needs, including services that are purchased specifically for people with high and complex needs and other generic adult mental health services. A number of the H&C services were not in place when PMcG conducted the review but have been funded and established during the last two to three years.

**Services specific for people with high and complex needs**

| DHB | Provider | Beds | Clinical FTEs | Non-clinical FTEs |
|---|---|---|---|---|
| **BOP** | Provider Arm – PACT within Tauranga Mobile Intensive Nursing Team (MIN) Team | | 3.0 | |
| **BOP** | Provider Arm – PACT within the Whakatane Mobile Intensive Nursing Team (MIN) Team | | 1.0 | |
| **BOP** | Provider Arm – Packages of Care service users in aged care facilities | 10 | | |
| | | | | |
| **Lakes** | Health Care NZ Home Based Support Services | | | 12.0 |
| **Lakes** | Health Care NZ Independent Living Choices | | | 3.0 |
| **Lakes** | Richmond Community/ Independent Living Support Service (up to 10 residents) | | 6.4 | |
| **Lakes** | Te Aratu Trust Education & Recovery Child, Youth & Adult | | | 3.0 |
| | | | | |
| **Tairawhiti** | Supported living and mobile support (service currently being developed) | 4 | | |
| | | | | |
| **Taranaki** | Te Whare Whakaahuru (Provider arm / Te Whare Puawai) | 3 | | |
| **Taranaki** | Provider arm ACT | | 2.0 | |
| **Taranaki** | Provider arm mobile (dual diagnosis + clinical mobile) | | 1.0 | |
| **Taranaki** | Te Rau Pani ACT | | 1.0 | |
| | | | | |
| **Waikato** | Provider Arm H&C ACT team | | 4.5 | |
| **Waikato** | Provider Arm secure in-patient H&C beds | 7 B | | |

**Generic mental health services include:**

- Level 3 and 4 Supported Accommodation (male only, female only, mixed) [11]. Currently, 180 Level 3 and 80 Level 4 beds are funded across the region.
- Packages of Care

[11] The complete list is available in Appendix 5

- General adult mobile multidisciplinary teams/ intensive nursing teams/ case management that provide supports to clients in their own home or in a supported accommodation environment.
- Home-based support
- Respite care
- Community based rehabilitation, activities, recovery services, living skills, employment and educational support services
- Provider arm inpatient and community mental health

## DHBs updates and plans for 2007/08

| DHB | Plans and updates |
|---|---|
| BOP | • H&C is a priority for 2007/08 including strengthening participation in Regional processes, ensuring Local Advisory Group membership on regional groups and active involvement in the development of any regional initiatives via the HCN Reference Group<br>• The Mental Health Plan for the BOP for the next 2 financial years includes<br>o Additional POC funding<br>o Funding the Provider arm for dual diagnosis with Intellectual Disability service<br>o Funding additional 4 Level 4 beds for women<br>o Use of POC funding for individuals when the need arises. |
| Lakes | • No H&C plans for 2007/08<br>• Number of services established already including recovery programmes, home based support and residential support. |
| Tairawhiti | • H&C is a priority for Tairawhiti DHB for 2007/08<br>• Investments planned for around 400K for 4 supported residential rehabilitation beds for adults with H&C Needs. Service is expected to be operational Jan 2008<br>• A full adult mental health service review is taking place in Jul 2007 |
| Taranaki | • H&C is not a priority for Taranaki DHB for 2007/08 as a number of services already in place including<br>o Joint venture for H&C 3 beds in partnership with Kaupapa Maori NGO and Provider Arm<br>o Intensive mobile support to transition people back to independent living including 0.36 FTE adult non-clinical mobile support, 0.6 FTE adult clinical dual diagnosis mobile and 0.4 FTE clinical mobile support<br>o 3.0 FTEs Assertive Community Treatment attached to community teams including 1 specialist Kaupapa Maori and 2 in Provider Arm.<br>• A fourth bed for the Joint venture is being scoped for funding from accrued budgets (not sustainable) |
| Waikato | • 2004/05 – provider arm received additional funding for 3 FTEs to augment the existing the mobile intensive team which included 1.5 FTE DBT and 1.5 FTE rural positions. The teams moved from 100% nursing to multidisciplinary. |

| | |
|---|---|
| | • While the mobile intensive teams are currently part of the generic community mental health teams, they will be restructuring to separate H&C from the general case load.<br>• Provider arm reconfigured ward 31 into a secure inpatient rehabilitation unit |
| Midland Region | Regional Mental Health Clinical Nurse Consultant (RCNC) position in place to provide expert capacity to assess and support the needs of identified high and complex mental health service users in the Midland Region. |

## *Identified Needs and Service Gaps for "High and Complex" Service Users*

### Peter McGeorge report

PMcG analysis of the survey focused mainly on gaps in three areas – the service continuum, the service functioning and the clinical practice.

**Service Continuum**

- Adult inpatient unit stays were lengthy resulting in the "blocking of beds" to those requiring urgent admission
- NGOs placements were being terminated because of the inability of providers to manage risks to other residents resulting in "banishment pressures" and homelessness.
- While POC and Assertive follow-up were being utilised in a number of DHBs with increasing success, the development of such services in many cases was patchy and insufficient in terms of funding and infrastructure to address the needs of the identified group.

The above resulted in:

- Urgent assessment and treatment for people experiencing new crisis is likely to be delayed with a escalation of acute clinical risk
- The utilisation of adult inpatient unit for longer stay patients and the lack of rehabilitation and recovery focus will
- Lead to their institutionalisation
- Existing acute beds will be blocked to those in the community requiring inpatient care
- Political pressure for more acute beds will siphon off funding from services providing longer term solutions
- Patient rights in terms of the right to appropriate care will be compromised
- Clinical risk will increase rather abate

**Service functioning**

- Lack of clarity in terms of service objectives and clinical pathway between teams within provider arm, and between provider arm mental health services and NGOs
- Provider arm mental health services experiencing multiple crisis presentations, readmissions and higher than necessary ALOSs
- NGOs were limited in terms of the complexity and acuity of service users that they could safely manage with service users placement often terminated.

**Clinical practice**

- Lack of knowledge of diagnosis and the DSM IV, service utilisation, available and potential services
- Limitations in communication between key staff within and between team members.

## Follow-up study

- Service users with high and complex mental health needs often present high level of risk to themselves and to others and are therefore a major challenge to providers.
- At the same time, the general needs of service users with high and complex mental health needs are similar to those of most people - stable accommodations, positive family and social relationships, meaningful and healthy lifestyles, employment opportunities.
- Relative independent activities of forensic and general mental health services can hinder the management and outcomes required for service users with high & complex needs who often don't have a current conviction but also are regarded as not having rehabilitation potential.

## Interviews with providers in the region

**Total of 16 meetings were held in March 2007**

- DHB Planning & Funding Portfolio mangers – 4 - BOP, Lakes, Taranaki, Waikato
- DHB Provider Arm – 5 - BOP, Lakes, Taranaki, Waikato (2)
- NGOs – 7 - Richmond Rotorua, Rau O Te Huia Trust Rotorua/ Tauranga, Health Care NZ Lakes, Richmond Hamilton, Pathways Waikato, Te Rau Pani Taranaki, Te Whare Whakaaruru (Provider Arm Taranaki/ Te Whare Puawai O Te Tangata Trust)

**Summary of issues identified through interviews**

**Services currently not available in most DHBs**

- Long stay beds with rehabilitation focus and easy access to inpatient beds
- Short term stay sub acute
- Secure, non-forensic service

**Issues and gaps**

- Definition of high and complex not clear for providers – often equals to "difficult to place"
- Very high percentage of service users who have co-morbidity
- NGOs workforce - need professional supervision for staff
- NGOs' pay rates for clinical FTEs often lower than that of provider arm
- NGOs having difficulty recruiting support workers due to competition with other lower paid job
- NGOs' support workers sometimes don't have the skills to move from a custodial environment to a rehabilitative/ recovery focused environment
- NGOs lack staff skilled to work with dual diagnosis (ID/MH) or addictions
- Provider arm workforce - difficulties to recruit non-nursing staff for multidisciplinary and ACT teams
- "Cherry picking" phenomenon – some residential providers avoid accepting H&C because they have difficulties coping with them

- Regional service – concerns that it often tends to benefit the DHB that houses the service more than the outlying areas, and is potentially too far for most communities
- Forensic – H&C interface
  - Difficult for providers to differentiate between forensic and H&C
  - Concern the regional Forensic service is being "gate kept" by forensic liaison staff
- Funding
  - Contractual requirement for L4 – overnight/ sleepover coverage – very rarely needed. Resources can be used otherwise.
  - Residential contracts don't specify what model of treatment needs to be available
  - Mental Health funding is less flexible than DSS
  - No cooperation between WINZ, Housing, DSS, ACC and Health around funding
- Service users preferences
  - Live close to whanau
  - More freedom than in inpatient or group home
  - Live with people that will tolerate their behaviour
  - Often referred to services (i.e. rehab) that don't match their needs and they don't want to attend
- Admission criteria to inpatient services - residential providers can identify that a crisis is imminent up to a week prior to the crisis occurring, but admission criteria don't match
- Discharge of patients from inpatient services is often too early
- Future sector changes – concerns with the future reduction in Level 3 and Level 4 availability in the community and its replacement with home-support services

# PART THREE - THE SOLUTIONS

## *What's in the literature?*

### The Victorian model

The Victorian Government Department of Human Services (2003) identified the following four components of a service response to people with multiple and complex needs:

- A central coordination or policy point, located within the Department of Human Services will have the responsibility for coordinating any new agreed service responses, liaison with the Department of Justice and oversight of any policy or legislative changes.
- A panel or board, located within, or external to, the Department of Human Services, having the capacity to bring together relevant service providers and other experts to consider individual client needs and plan for a response.
- Legislative reform to enable the establishment of an appropriate service response especially in regards to service eligibility requirements and the capacity to provide compulsory treatment and care, when required.
- Strengthening service system capacity through a five components model:
    - An independent panel with state-wide responsibility for determining individual need and implementing and reviewing a care plan. It would have the capacity to direct and compel multidisciplinary assessment and a legal mandate with review and appeal provisions.
    - A specialist multidisciplinary assessment service responsible for holistic and comprehensive assessments and drafting of care plans. While the service would have the capacity to undertake assessments on an outreach basis, these could also occur in a residential assessment unit, in circumstances where the individual required stabilisation prior to assessment. Any admissions to a residential assessment unit would vary according to individual need but would not exceed three months. Such a facility would only be accessible to those aged 18 years or over. The assessment service would work collaboratively with past and present service providers, the family and carers to complete the assessment.
    - A research, development and training function as an essential secondary role of the assessment service. Objectives of this function include identifying new practice technologies and developing links with tertiary education and training institutions. Provision of a secondary and tertiary consultation capacity can also be included.
    - Establishment of a small number of specialist agencies to provide intensive multidisciplinary case management and outreach services when local options were not available. Where possible, existing services would be engaged to assume case management for people within their local environments. The core function of these specialist service providers would be to address the individual's needs in relation to stable housing, health and wellbeing, safety and social connectedness. The development of effective links and working relationships between specialist agencies and other local and regional services was considered essential. The eventual transfer of support of the individual to existing services would be an objective of all care plans.
    - Existing services would continue to be the primary providers to the target population. The panel and specialist assessment service would enable a coordinated response and specialist intensive case management services would supplement service options currently available.

## The Scottish model

The literature review conducted for the Scottish Multiple and Complex Needs recommended changes in three areas:

- Improving service planning
  - At central government level, the issue of MCN must have a clear strategic priority.
  - The funding constraints on access to housing and support must be addressed, particularly to meet the needs of those who require flexible outreach support of varying intensity and those with profound needs who require higher levels of residential-based support.
  - Comprehensive, holistic needs assessment and planning and joint approaches are at the core of effective responses to people with MCN. This applies to strategic planning as well as to support planning for individuals.
  - Local commissioning systems need to be less fragmented and better informed about the population with MCN to develop an appropriate and flexible range of provision.
  - Monitoring the outcomes of people's service engagement needs to be improved to better inform planning.
- Better co-ordination of services
  - Service networks need to be comprehensive, well-coordinated and better informed about needs and service developments.
  - There need to be committed, creative approaches to resource pooling.
  - Services should assess the extent to which service users have multiple and/ or complex needs and are users of other services. Information should be shared between services on shared clients.
  - IT and information sharing strategies and protocols can benefit people with MCN by improving service responses and monitoring.
  - Joint training can promote positive cultures, better understanding of service users' needs and of other agencies' remits and approaches.
- Approach to service delivery
  - The impact of stigma needs to be addressed persistently and jointly in relation to many of the groups covered in this study, and notably in regard to asylum seekers/ refugees and people with mental health problems.
  - Services should adopt an ethos that views 'the problem' as one that is caused by inadequate service responses rather than by 'difficult clients'.
  - Service users (and carers) should be involved at all levels of service planning, development and delivery.

## The Canadian (Ontario) integrated continuum of care model

The final report of the Provincial Forum of Mental Health Implementation Task Force Chairs in Ontario[12] describes an integrated continuum of care model, depicting the range and types of services and supports that are required in a transformed mental health system.

The framework represents a shift from using terms associated with a medical approach, i.e., primary, secondary and tertiary care, to using a "levels of need" terminology (i.e. first-line, intensive and

[12] Out of the Shadows at last: Transforming mental health, mental illness and Addiction Services in Canada. Final Report of the Standing Senate Committee on Social Affairs, Science and Technology. 2006.

specialized), with a fourth category that cuts across the three levels. Each level of need is associated with a particular array of services and supports. People will usually receive most of their services from within a particular level, but they are not limited only to the services within that level.

**First-line level** refers to prevention, assessment and treatment provided by frontline providers, including family physician, primary care clinics, and the providers of mental health services, social services, and hospital emergency services. First-line level is usually the first contact with mental health services. When someone's illness is not too serious or of short duration, the provision of first-line services will usually be enough to meet the person's needs. First-line services and supports must be well connected not only to each other, but also to more intensive and "cross-level" mental health services and supports that can be called upon as needed. Individuals who are diagnosed with serious and ongoing mental illness will usually be referred by first-line service providers to intensive or specialized services for further assistance.

**Intensive level** refers to mental health assessment, treatment and support services that are provided in community or hospital settings for people with serious mental illness who require ongoing, long-term support, but not necessarily daily contact. Intensive services and supports are designed to provide continuous contact and support for people who, without them, would be at risk for repeated or prolonged institutionalization in health care or correctional facilities. The needs of most people living with a serious mental illness should be met by community-based intensive services and supports. People who suffer from acute, severe impairment in personal functioning and are at significant risk, such as someone with a severe post-partum depression, could also require these kinds of intensive services. Services at this level address the serious and complex mental disorders most common among the general population (including concurrent disorders, eating disorders, first episode schizophrenia, and personality disorders). Service integration can be facilitated through intensive case management. Intensive services and supports must be well connected to first-line and "cross-level" services and supports and must be able to access, and be backed up by, specialized services and supports so that together they can address people's unique and/or particularly complex needs effectively.

**Specialized level** refers to highly specialized mental health programs provided in community or hospital settings that focus on serving people whose serious mental illness is characterized by complex and unstable mental disorders. Only those very few people with serious mental illness who require ongoing, daily contact with service providers will need to access such specialized services and supports. As these services are the most specialized, least available and most expensive resources in the mental health system, they must be reserved for those who truly need them and used only when intensive and cross-level services and supports have failed to work for a given individual. The following are among those whose problems require that they be addressed at this level: elderly people suffering from dementia, psychosis and medical illness; people who are developmentally disabled with psychiatric disorders and who often display aggressive behaviours; people living with schizophrenia who are chronically psychotic, aggressive or suicidal; people with complex, treatment-resistant mood disorders. Specialized services are not synonymous with long term, institutionalized care. Rather, treatment, rehabilitation and support services can be provided by multi-disciplinary teams that work in ways to enable many people living with these illnesses to continue to live in the community. Individuals who use specialized services and supports will not always need this level of care. The need of individuals for the whole range of services and supports must be monitored and reassessed continuously as they progress through the recovery processes and as their needs change.

**Cross-level** services and supports refer to those services and supports that may be needed regardless of whether someone is being served at the first-line, intensive or specialized level of the mental health system. They include housing and housing supports, educational and vocational services and supports, drop-ins and other social/recreational supports, as well as service user and family peer/self-help supports. Cross-level services and supports are typically — and most effectively and efficiently — delivered in the community, and are amongst those services and supports most often identified by people living with mental illness and their families as being fundamental to the recovery processes.

## *Other Regions in New Zealand*

**Northern Region**

- **Buchanan Rehabilitation Centre (BRC)**[13] – Point Chevalier Auckland - Auckland DHB – a specialist 40-beds mental health, recovery focused rehabilitation service which provides assessment, treatment and intensive rehabilitation combined with a high level of clinical support in a safe environment. It is most suitable for people with persistent, active mental health symptoms and disabilities who have the potential to benefit from intensive rehabilitation. Clients are aged 16-25 years (Ataarangi) and 25-65 years (Awheronui) and must live within the Auckland District Health Board (Central Auckland) and Waitemata District Health Board (West and North Auckland) areas. The average length of stay is around 18 months. Referrals are accepted from other Mental Health Services only.
- **Mason Clinic - Regional Forensic Psychiatry Services**[14] – Carrington Road, Pt Chevalier Auckland - Waitemata DHB - provides Regional Forensic Psychiatry Services via the Mason Clinic located which includes a 12-bed Pohutukawa Unit (an Intellectual Disability unit) and a ten-bed Kaupapa Maori secure rehabilitation unit as well as open, minimum and medium secure and rehabilitation units. A cultural centre – Te Miro – also exists for cultural activities.

**Central Region**

- **Delta – Intensive rehabilitation**[15] - Wanganui DHB – a 13-bed unit for people aged 20 to 65 years. The aim of the service is to empower and prepare service users so they can successfully manage and deal with their own symptoms of mental illness. This includes organising their lifestyle to allow for a successful discharge into the appropriate accommodation in the community.
- **Delta - Extended Care -** Wanganui DHB – a 12-bed unit for people aged 20-65 years. It offers secure in-patient rehabilitation to people with a long-term mental illness. The aim is that people will then move to intensive rehabilitation or more independent accommodation in the community as appropriate.
- **Central Region Regional Rehabilitation Inpatient Service**[16] **-** Porirua Hospital - Capital & Coast DHB - The Rehabilitation Service has 59 beds at Ratonga Rua. It provides longer-term hospital care and intensive rehabilitation for clients. The service has a mix of accommodation; from a secure unit to an open unit through to a series of self-contained cottages, where suitable clients can prepare for returning to live in the community. Clients are mainly from the central region.

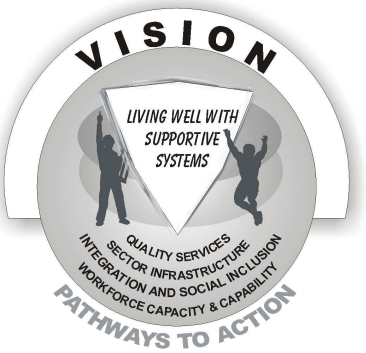
**South Island**

- **Seager Clinic Rehabilitation Service** - The Princess Margaret Hospital – Canterbury DHB - provides extensive care for people assessed as having a significant disorder arising from an established diagnosis of psychiatric illness and who require intensive support.

[13] www.healthpoint.co.nz 07 August 2007
[14] www.waitematadhb.govt.nz 07 August 2007
[15] www.wdhb.org.nz 07 August 2007
[16] www.ccdhb.org.nz 07 August 2007

## *The Midland Options*

Although it is important to learn from the experience in other countries, the national, regional and local settings must also be considered before any recommendations are made. The Midland Region Mental Health and Addiction Strategic Plan 2005-2015[17] provided a vision and guiding principles:




1. Midland region adopted the vision of ***"Living Well with Supportive Systems"*** for its mental health and addiction services. This vision should be kept in mind when recommending and developing services for people with high and complex needs in the region.
2. There are eight overarching principles to guide the system:
    a. **Service users** are central to the Mental Health and Addictions system and will be active partners in system planning, development, and service delivery.
    b. **Recovery -** "Recovery happens when we regain personal power and a valued place in our communities. Sometimes we need services to support us to get there"[18]. Recovery is described as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness".[19]
    **c. Whanau Ora and Responsiveness to Maori -** Cultural identity and belonging are necessary for service user wellbeing and recovery. Whanau ora acknowledges the collective familial supports that assist in the wellness journey. Whanau Ora exemplifies a system responsive to Maori, with respect for Maori concepts, and inclusive of Maori service users and their whanau to achieve optimal health outcomes.
    d. **People in service users' support networks** - family, whanau, friends, and community - are essential to recovery. Their inclusion in system planning, development and service delivery, helps ensure positive outcomes for service users, and recognises their needs may also need to be met by the system. The Midland region definition of support networks is a broad one, but particularly acknowledges the importance of families [in the broadest sense of people or groups who are meaningful to a service user, providers, intersectoral agencies and communities whose tolerance and destigmatisation are crucial for achievement of recovery.
    e. **Services are responsive** to the specific cultural and individual needs and preferences of service users, with particular attention to Maori.
    f. **High quality services** are outcome-focused, underpinned by continuous improvement and are based on evidence and best practice.
    g. **Well-connected health and social services** (housing, social services, employment, education, justice, corrections, and destigmatisation) promote social inclusion and support service users to achieve optimal mental health outcomes.
    h. **Partnerships** are vital within the MH&A system, and between it and related systems, to benefit service users.

[17] Midland Region Mental Health and Addictions Strategic Plan 2005 - 2015
[18] Source: Our Lives in 2014, A recovery vision from people with experience of mental illness for the second mental health plan and the development of the health and social sectors.
[19] Source: Hamilton County (Cincinnati, Ohio, US) Community Mental Health Board website *www.mhrecovery.com*

## Assumptions

1. Midland is the only region in the country that currently does not have hospital based, non-forensic non-acute intensive rehabilitation service. The Buchanan Rehabilitation Centre in Auckland offers specialist 40-beds recovery focused rehabilitation service (assessment, treatment and intensive rehabilitation) with a high level of clinical support. The central region has two units – one in Wanganui and one in Poriroa. The Delta, in Wanganui, includes a 12-bed secure Extended Care unit and a 13-beds Intensive rehabilitation unit , while Regional Rehabilitation Inpatient Service in the Porirua Hospital as 59 beds ranging from a secure unit to an open unit through to a series of self-contained cottages.

1. A large number of generic mental health services and services that were especially developed for people with high and complex needs are already in place in each of the five Midland DHBs. The purpose of this report is not to comment on the quality or evaluate the outcomes of these services, rather to describe an overall continuum of care that these services are part of.

2. Some of the Midland DHBs already identified local responses and invested extensively in specific services for people with high and complex needs locally. Although this area is not a priority for all DHBs for 2007/2008, overall the desire to identify continuum of care solutions for the small group of people with high and complex needs who pose high risk to local providers is supported by all.

3. The purpose of this report is to offer solutions – it is not to impose them on any DHB. Local solutions, if viable financially and sustainable with skilled and experienced workforce, are always the best options.

## Proposed model

The primary goal of the mental health and addiction sector in the Midland region is to facilitate recovery through the process of "Living Well with Supportive Systems". Services are there to support service users' journey of recovery.

Service users with high and complex needs have a longer and more difficult journey to navigate on their way to recovery and therefore often require different pathways which other service users not necessarily go through or can easily navigate.

## Proposed Components

Please refer to the diagram on page 27.

1. ***Forensic Services*** – regional services currently provided by Waikato DHB provider arm and Hauora Waikato, both based in Waikato DHB.

2. ***Adult Mental Health Services*** – local services currently provided by each of the five DHBs provider arms.

3. ***Hospital-based secure rehabilitation service(s)*** – to provide secure long tern transitional service for service users who are not responding to a range of pharmacological or non-pharmacological strategies who carry high risk; or are mental health service users referred from forensic pathways or services who require intensive supports It is most suitable for people with persistent, active mental health symptoms and disabilities who have the potential to benefit from intensive rehabilitation. Service should be recovery focused, and will provide assessment, treatment and intensive rehabilitation combined with a high level of clinical support in a safe environment. It is most suitable for people with persistent, active mental health symptoms and disabilities who have the potential to benefit from intensive rehabilitation

4. ***Community Based High & Complex Rehabilitation Services*** – joint provider arm/ NGO services in each DHB – to provide services to the same client group as above that are able to be supported in a level 4+ non-secure environment.

5. ***Integrated Social Inclusion Services*** – i.e. Housing (level 4, level 3, independent), Assertive Community Treatment, Employment, Education, Training, Recreation, Counselling, Primary health care, home based supports).
6. ***Regional panel*** with representation of forensic and AMHS clinical staff from across the region and including medical, nursing, psychology, service user and cultural advisers. The panel's role will be to review clients' cases and recommend the appropriate pathways.

## *Discussion*

1. **Forensic Services** – regional services currently provided by Waikato DHB provider arm and Hauora Waikato, both based in Waikato DHB. A new model of care is currently being developed for the service, overseen by the Midland Regional Forensic Development Group. The new model will see the integration of best practice in psychiatry and kaupapa Maori. It will inform the redesign of the existing facilities. In addition, a national review of forensic mental health services was recently completed and a five years plan is currently being prepared for the Midland region based on the draft report[20].

   Some difficulties were identified around the interactions between the regional forensic services and the AMHS of the DHBs in the region, resulting from lack of clarity around roles and responsibilities, geographical and philosophical differences, and interface processes. Although this issue is beyond the scope of this project, the establishment of a regional panel (point 6) will help to resolve the difficulties in this area as well.

2. **Adult Mental Health Services** – local services currently provided by each of the five DHBs provider arms. A range of inpatient and community based services are provided by each of the five provider arm in the region based on local priorities identified in District Strategic Plans and District Annual Plans. Waikato DHB has recently reconfigured two wards to safely manage and provide longer stay rehabilitation / recovery focused programmes (non-secure). Other DHBs might be looking in the future at changes within their inpatient units.

3. **Hospital-based secure rehabilitation service(s)** – to provide secure long tern transitional service for service users who are not responding to a range of pharmacological or non-pharmacological strategies who carry high risk; or are mental health service users referred from forensic pathways or services who require intensive supports It is most suitable for people with persistent, active mental health symptoms and disabilities who have the potential to benefit from intensive rehabilitation. Service should be recovery focused, and will provide assessment, treatment and intensive rehabilitation combined with a high level of clinical support in a safe environment. It is most suitable for people with persistent, active mental health symptoms and disabilities who have the potential to benefit from intensive rehabilitation

   The need for a specialised, hospital based regional service was identified previously by a number of experts and re-affirmed by the current H&C Expert Group. Currently, no provider in the region is funded to provide such a service, resulting in service users receiving in-appropriate care either in the regional forensic service or in one of the five acute in-patient units across the region. One of the Midland DHBs – Waikato – has recently reconfigured one of its wards to provide an open "extended care hospital based rehabilitation" service for its own population. Another DHB – Tairawhiti – has access to two secure inpatient beds in Wellington.

   At the workshop held on the 19th July 2007, participants discussed the benefits in establishing either a local, sub-regional or regional hospital based services from each of the five DHBs perspectives. Although a local solution is always preferred due to better continuum of care options and proximity to family/whanau and other providers, it was agreed that economy of scale considerations and ability to attract workforce eliminate the local option.

[20] Review of Forensic Mental Health Services. Future Directions. MOH, June 2007

Either option, regional or sub-regional, will require that beds are allocated to each DHB. Each DHB will have control over the in and out flow of service users which result in better pathways and linkages back to local communities.

- **DHBs' preferences**

  **BOP** – support a sub-regional service with Lakes – populations of the two DHBs very similar and there is already a natural flow of workforce and service users. It will also allow for collaboration between other providers and support the development of local expertise. There is a concern that regional service will not support continuum of care for service users and will only be of benefit to the DHB where it is located.

  **Lakes** – support a sub-regional service with BOP – populations of the two DHBs very similar and there is already a natural flow of workforce and service users.

  **Tarawhiti** – prefer to maintain the status quo – access to two beds in the Central region secure rehabilitation service.

  **Taranaki** – support the development of a sub-regional service in Waikato that will provide services to Taranaki. Governance and control of the use of the beds by each DHB.

  **Waikato** – sub-regional is preferred – enable iwi support, easy to share resources with the provide arm, less costly for family in terms of transportation. It will be easier to attract workforce to Hamilton than to any other locality in the region being the largest urban area,

- **Resource considerations**

  Currently the DHBs are investing in costly packages of care and un-necessary lengthy hospitalisation in acute beds. Establishing a hospital based rehabilitation service will free up the blocked beds for people who need acute hospitalisation and currently cannot access the service, and will also free up resources that can be invested in other services.

  It is assumed that resources for capital will be available.

- **Prevalence**

  The Midland region currently has population of close to 800,000. 95 people or 0.01% of the population were identified by Peter McGeorge through the five provider arms as H&C. With the rate of H&C being so low, it is not expected that any small changes in the population of the region will increase or decrease the need for services.

- **Ethnicity**

  43% of the 95 service uses with H&C needs were identified as Maori while the proportion of Maori in the general population is only 23%. Any service that is developed need to take into consideration the ethnic mix of the service users.

- **Geography of the region**

  The Midland region covers a very large geographical area with a number of remote and difficult to access locations. Travel within and between DHBs is difficult and complicated at times. Any location that is chosen for either sub-regional or regional service must have easy access for service users, their family/ whanau, and for workforce.

4. **Community Based High & Complex Rehabilitation Services** – joint provider arm/ NGO services in each DHB – to provide services to the same client group as above that are able to be supported in a level 4+ non-secure environment. Currently available only in Taranaki DHB and being developed in Tairawhiti DHB. It is expected that the other four DHBs will implement similar

initiatives over time within their own DHB area based on local annual priorities and availability of funding.

The need for a joint provider arm/ NGO services in each DHB was identified previously by a number of experts and re-affirmed by the current H&C Expert Group. This model of service is currently available only in Taranaki DHB and similar is being developed in Tairawhiti DHB.

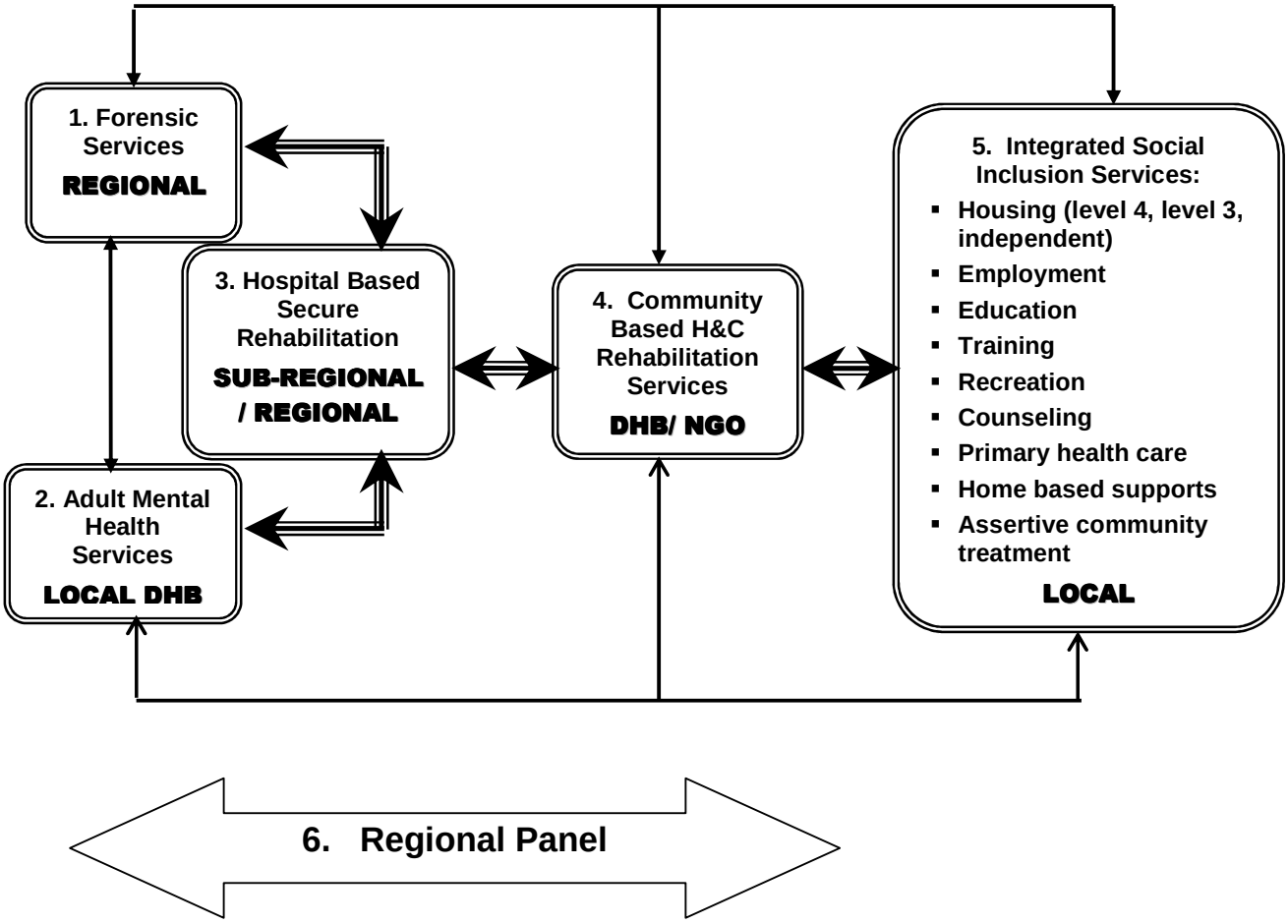
The Taranaki service, Te Whare Whakaahuru, opened in January 2006, and provides services to high and complex needs clients by way of Community Supported Living Service (CSLS), residential and mobile support. It is a joint venture between the provider arm acute unit and Te Whare Puawai O Te Tangata Trust, working to its own Te Pataka governance model.

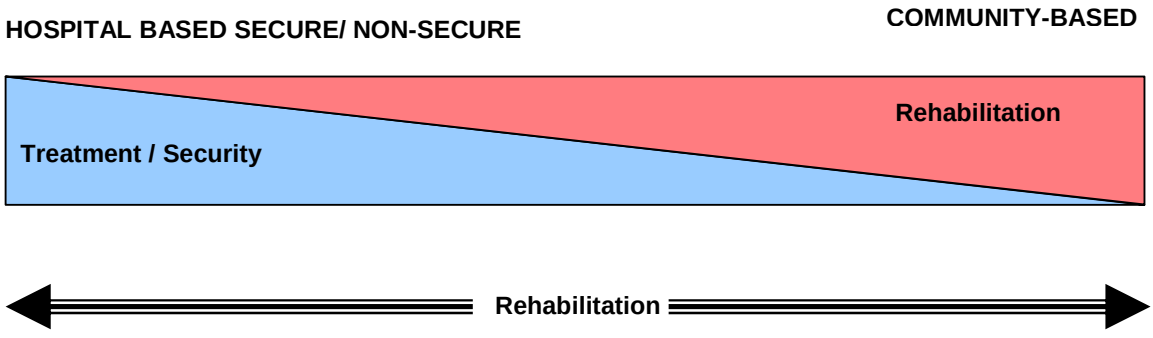
The service is defined as a Community Supported Living Service for high and complex needs clients, all of whom have previously spent inordinate amounts of time in the Acute Unit. Services span the treatment/ rehabilitation continuum, utilising a "single-point-of-contact" team approach with a capacity for transition to more independent Living. As a joint venture - TDHB employ clinical nurse leader and registered nurses and Te Whare Puawai employ residential support workers. All Staff have the option of "rotational placements" within the acute unit, thus developing expertise across the acute treatment/rehabilitation continuum. The service also delivers Mobile Support FTE and has access to provider arm clinicians.

5. **Integrated Social Inclusion Services** – i.e. Housing (level 4, level 3, independent), Assertive Community Treatment, Employment, Education, Training, Recreation, Counselling, Primary health care, home based supports) – provided locally in each DHB by NGOs, provider arm and other sectors. Additional services are expected to be funded and developed over time depending on local annual DHB priorities and availability of funding.

6. **Regional panel** with representation of forensic and AMHS clinical staff from across the region and including medical, nursing, psychology, service user and cultural advisers. The panel's role will be to review clients' cases and recommend the appropriate pathways. Details around a panel will need to discuss once a business case regarding the hospital based services is finalised.

## Midland Region High and Complex Needs Continuum of Care Model
## Pathways to Recovery



## Volume of Services Required

| | BOP | Lakes | Tairawhiti | Taranaki | Waikato | Midland Region |
|---|---|---|---|---|---|---|
| **2006 Population** | 198,700 | 101,600 | 44,500 | 105,100 | 342,300 | **792,200** |
| | | | | | | |
| **Hospital Based Secure Rehabilitation Service** | | | | | | |
| McGeorge (2004) Recommendation | 10 | 5 | 2 | 5 | 17 | **40** |
| Current Service Position (2007) | 0 | 0 | 2[21] | 0 | 7[22] | **9** |
| Current Service View of Needs (2007)[23] | 6 | 4 | 0 | 5 | 6 | **21** |
| | | | | | | |
| **Integrated Community Based Rehabilitation (Level 4+)** | | | | | | |
| McGeorge (2004) Recommendation | 10 to 12 | 5 to 6 | 2 to 3 | 5 to 6 | 17 to 20 | **40-46** |
| Current Service Position (2007) | 0 | 0 | 0 | 3 | 0 | **3** |
| Current Service View of Needs (2007)[23] | 15 | 7 | 4[24] | 7 | 21 | **54** |
| | | | | | | |
| **ACT for 10-15 HCN / 100,000 population @ 1:10 FTE ratio** | | | | | | |
| McGeorge (2004) Recommendation | 20 to 30 | 10 to 15 | 4 to 7 | 11 to 16 | 34 to 51 | **79 to 119** |
| Forensic Framework (2001) Recommended ACT FTE's | 2.0 to 3.0 | 1.0 to 1.5 | 0.4 to 0.7 | 1.1 to 1.6 | 3.4 to 5.1 | **7.9 to 11.9** |
| Current Service Position (2007) | 4 | 2[25] | 0 | 3 | 4.5 | **13.5** |
| | | | | | | |
| **Acute Day Programmes for 5-10 HCN / 100,000** | | | | | | |
| McGeorge (2004) Recommendation | 10 to 20 | 5 to 10 | 2 to 4 | 5 to 10 | 17 to 34 | **40 to 80** |
| Current Service Position (2007) | | | | | | |
| | | | | | | |
| **Work opportunities for 10-15 HCN / 100,000 population** | | | | | | |
| McGeorge (2004) Recommendation | 20 to 30 | 10 to 15 | 4 to 7 | 11 to 16 | 34 to 51 | **79 to 119** |
| Current Service Position (2007) | | | | | | |
| | | | | | | |

[21] Tairawhiti access to secure inpatients beds in Central Region (Wellington)
[22] Current reconfiguration of Ward 31 includes 7 H&C adult intensive rehabilitation (open).
[23] Based on discussions by Clinical Leadership forum and Expert Panel. Figures do not included the existing volumes but rather the additional identified need.
[24] 4 supported residential rehabilitation beds – service currently being developed
[25] 2 FTEs are not operational yet

# RECOMMENDATIONS

## *Recommendation number 1 – Continuum of Care Model*

a. That the Midland Region High and Complex Needs Continuum of Care Model - Pathways to Recovery – described on page 28, be adopted

b. That all services for High & Complex needs adopt a recovery focused philosophy of service

## *Recommendation number 2 - Community-based H&C Rehabilitation Services*

a. That each DHB fund Community-based H&C Rehabilitation Services, jointly planned and operated by a provider arm and an NGO to provide services for 15 service users in BOP, 7 in Lakes, 7 in Taranaki (in addition to the existing 3) and 21 in Waikato. Tairawhiti DHB has recently contracted with an NGO for 4 beds.

## *Recommendation number 3 - Hospital based Secure Rehabilitation Services*

a. That a business case be developed for the establishment of secure, hospital based rehabilitation services in the Midland Region with the scoping of costs to establish either one regional service in the Hamilton area or two sub-regional services, one for 10 beds for BOP and Lakes DHBs and one for 11 beds for Waikato and Taranaki. Tairawhiti will continue to access two beds in the Central Region until a different decision is made by the DHB.

b. That a steering group be established to oversee the development of the business case, including Rees Tapsell, Jeff Symonds, Alan Mountfort (Lakes DHB CFO), a portfolio manager, a project manager and a financial analyst.

c. That the MOH be informed by Cathy Cooney and Mary Smith regarding Midland region DHBs intentions.

## *Recommendation number 4 – Clinical Governance*

a. That a clinical governance approach be applied

b. That a regional panel be established to review cases and recommend appropriate service users' pathways.

c. That a monitoring framework be adopted whereby appropriate monitoring approaches are applied to programmes based on service users needs:

| Service User's Need | Relevant Programme | Monitoring Approach |
|---|---|---|
| Psychotherapy | Clinical | HoNOS |
| Functionality | Rehabilitation | PSP |
| Risk | Systems | Risk score |

# APPENDICES

## *Appendix 1 - Reference Group Membership*

- Diane Irwin, Tairawhiti DHB Provider Arm
- Erina Morrison, Lakes DHB Provider Arm
- Eseta Nonus-Reid, HealthCare of NZ
- Gavin Pike, Mana Mental Health Services Ltd, Lakes
- Genesis Potini, Te Kupenga, Tairawhiti
- Graham Mellsop, Waikato DHB, Clinical School
- Jean Mansner, Richmond NZ Inc Rotorua
- Jeff Symonds, Waikato DHB Provider Arm
- Jo Van Leeuwan, Te Rau Pani Kaupapa Maori Mental Health Trust, Taranaki
- Julie Fidoe, Pathway Trust Waikato
- Larry Clarke, Waikato DHB, Planning & Funding
- Mārua (Tekaumārua) Wharepōuri, Tuhoe Hauora, Eastern BOP
- Paul Ingle, Pathway Trust
- Paula Hakesley, Taranaki DHB Provider Arm
- Ripeka Armstrong, Nga Kakano Foundation, Te Puke, Western BOP
- Ruth Smithers, Taranaki DHB, Planning & Funding
- Vicki Muir, Waikato DHB Provider Arm
- Louisa Erickson, Midland Region
- Rachel Dekel, Midland Region

## *Appendix 2 - Workshop Participants*

- Cathy Cooney, CEO Lakes DHB
- Chris Harris, GM Mental Health, Waikato DHB
- Connie Hui, Maori Health Portfolio Manager, BOP DHB
- Diane Irwin, Service Manager Mental Health, Tairawhiti DHB
- Eseta Nonus-Reid, HealthCare of NZ
- Gail Goodfellow, Mental Health Portfolio Manager, Lakes DHB
- Ginni Cashell, acting Service Manager Mental Health, Lakes DHB
- Graham Mellsop, Waikato DHB, Clinical School
- Janet Peters, facilitator
- Jean Mansner, BOP DHB
- Jeff Symonds, Waikato DHB Provider Arm
- Julie Fidoe, Pathway Trust Waikato
- Katherine Fell, Mental Health Portfolio Manager, Waikato DHB
- Owen Lloyd, Mental Health Portfolio Manager, Tairawhiti DHB
- Paul Ingle, Pathway Trust
- Paula Hakesley, Taranaki DHB Provider Arm
- Rachel Dekel, project manager
- Rajiv Singh, Clinical Director, Waikato DHB
- Rees Tapsell, Psychiatrist, Hauora Waikato
- Ripeka Armstrong, Nga Kakano Foundation, Te Puke, Western BOP
- Shahid Mehmood, Clinical Director, Taranaki DHB
- Sue Mackersey, Clinical Director, BOP DHB
- Suzy Paratene, Te Whare Whakaahuru, Taranaki
- Tess Ahern, Mental Health Portfolio Manager, BOP DHB
- Vicki Muir, Waikato DHB Provider Arm

## *Appendix 3 - List of Interviews*

| DHB | Provider | Meeting with | Date | Type |
|---|---|---|---|---|
| BOP | Portfolio Managers | Lesley Watkins; Connie Hui | 13 Mar 07 | DHB |
| BOP | Provider Arm | Sue Mackersy, Julie Woods | 20 Mar 07 | DHB |
| | | | | |
| Lakes | Portfolio Manager | Gail Goodfellow | 1 Mar 07 | DHB |
| Lakes | Provider Arm | Ginni Cashell, Jenny Collier (Te Ngako) , Vicki Lewis etc | 1 Mar 07 | DHB |
| Lakes | Richmond NZ, Rotorua | Jean Mansner | 1 Mar 07 | NGO |
| Lakes | Health Care NZ | Belinda Walker | 2 Mar 07 | NGO |
| Lakes | Rau O Te Huia Trust | Bill Yates | 12 Mar 07 | NGO |
| | | | | |
| Taranaki | Portfolio Manager | Ruth Smithers | 15 Mar 07 | DHB |
| Taranaki | Provider Arm | Paula Hakesley, Shahid Mehmood, Mike Broker | 22 Mar 07 | DHB |
| Taranaki | Te Rau Pani | Jo Van Leeuwen | 15 Mar 07 | NGO |
| Taranaki | Te Whare Whakaahuru | Paula Hakesley, Sue Paratene, Linda, Jo | 22 Mar 07 | NGO |
| | | | | |
| Waikato | Portfolio Manager | Larry Clarke | 28 Feb 07 | DHB |
| Waikato | Provider Arm | Eileen Hughes | 2 Mar 07 | DHB |
| Waikato | Regional Forensic | Vicki Muir | 30 Mar 07 | DHB |
| Waikato | Richmond | Cathy Holland | 19 Mar 07 | NGO |
| Waikato | Pathways | Julie Fidoe | 23 Mar 07 | NGO |

# *Appendix 4 – Notes of Meetings with Providers*

| | |
|---|---|
| **DHB:** | **BOP** |
| **Provider:** | **Provider Arm** |
| **Meeting with:** | **Sue Mackersey, Julie Woods** |
| **Date of meeting:** | **Tuesday, 13 March 2007** |

Intensive case management team – 3 FTEs in Tauranga and 1 in Whakatane. Part of the sector-team but also support each other. They are all nurses but can access other supports (i.e. OT) from the general team. This service works very well for the complex geography of the BOP, supporting people in own homes or in L4 and also liaise with prison, forensic and probation.

**Identified issues**

Workforce, especially support workers who are paid less than in other lower-paid jobs while the cost of living in BOP is very high.

Skills to support the high needs of H&C or ID – not all NGO L4 can cope with needs or are not interested in the difficult cases.

Lack of long stay beds in the community with rehab focus and access to inpatient beds, staffed by provider arm and NGO and with strong cultural input - ideally – 2 X 4 beds + ID

Can identify 10 H&C + 2 ID cases who fit the category

In practical terms it is difficult to differentiate between forensic and H&C. Perception that Waikato DHB forensic service is being "gate-kept" at the court by the forensic liaison and BOP have no access to forensic services.

**Regional**

Difficult to see how a regional service can work. Often a regional service benefits the DHB where it is located and provides fewer services to the other DHBs. Also – services should be closer to home and whanau.

| | |
|---|---|
| **DHB:** | **Lakes** |
| **Provider:** | **Richmond NZ, Rotorua** |
| **Meeting with:** | **Jean Mansner, Team Leader** |
| **Date of meeting:** | **Thursday, 1 March 2007** |

Type of service - High and Complex Community Living Support Service

Current clients - 2 treatment resistant, 2 dual diagnoses (MH/AOD), 3 dual diagnoses (MH/ID), 1 dual diagnosis (MH/HI). 4 residents are on the MH Act. They either go to the hospital to see their doctor or to their individual GPs.

Residents attend individual activities during the day including life skills at

- Beverly House (Contact Trust Rotorua) - provide activity-based rehabilitation/recovery service/day activity and living skills
- Te Aratu Trust – provide work rehabilitation/employment and educational support services
- IHC programmes at St Jades
- ACC rehabilitation programmes

Service has been in place since March 2006.

FTE funded – 6.4 clinical FTEs (7am to 11pm), one person on site at night. Staff is 80% Maori (3 male; 5 female), age similar to that of residents. Staff includes 2 RNs and one RN always on call.

One key worker per client. Work with client to develop a management care plan around the needs and activities they attend

Medications are in blister packs, given to residents by staff. Administration of the medication is not staff responsibility, rather of the residents themselves. Alcohol/ drugs not allowed on premises.

Residents pay rent (no need for resource consent because it is not a supported accommodation facility and each resident is in own unit). They regard the place as their home and they are not pushed to move at any stage. So far, one got married and moved out and one moved back to Turangi to live with parent, however was not ready and was treatment resistant.

Service also provides respite for 2 home-based clients

**Linkages with provide arm**

Work with provider arm community mental health (Te Ngako) and the Psychiatric Emergency Team (PET). Have open house policy with provider arm staff.

When major problem arises at night – call the PET who must respond within 1 hour

All staff are trained in risk assessment. Had only one admission to provider arm in the year.

**Identified issues**

Trained staff is always needed and also professional supervision.

Ability for a continuum of: 2-5 years in an independent living facility → home based support in the community → complete independence

| | |
|---|---|
| **DHB:** | **Lakes** |
| **Provider:** | **Rau O Te Huia Trust** |
| **Meeting with:** | **Bill Yates** |
| **Date of meeting:** | **Monday, 12 March 2007** |

Provide supported accommodation for 8 residents, male and female, + 1 respite on two sites.

Most are Level 3 and 1 is Level 4. All are DD (MH/AOD).

Residents stay for the long term and the next step for most will be independent living.

Current residents have been there for 4, 5, 5, 8 and 10 years.

Services are available 24 hours with 11 FTEs – all are support workers with qualification.

Residents attend day programmes in the community, rehabilitation and employment placement.

Support worker helps in the shared cooking and cleaning but often does most of it herself.

**Linkages with provide arm**

Work very well with community mental health and the Psychiatric District Nurses (PDN). Residents prefer to see Maori PDNs and are taken to the clinic 4 at a time.

Relations with inpatient not as great. Sometimes problems with adjusting medications – no consistency with psychiatrists in the hospital.

Very rarely need support at night. Medications are adjusted so that everyone is asleep at night. Crises arise usually during the day.

**Identified issues**

- Learn how to budget
- Sustain medication compliance
- Avoid drugs and alcohol
- Use tools without damaging

- Need for residential services in Taupo – there currently 4 residents from Taupo in Rotorua and probably another 4 from Taupo who will benefit from a Level 3 or 4 services

| | |
|---|---|
| **DHB:** | **Lakes** |
| **Provider:** | **Provider Arm** |
| **Meeting with:** | **Ginni Cashell, Jenny Collier, Vicki Lewis etc** |
| **Date of meeting:** | **Thursday, 1 March 2007** |

There has been more development in the NGO sector than in the provider arm in Lakes - need to ensure balance of funding to secondary level services.

Some resources were added into the dual diagnosis team.

Provider arm currently looking at service changes.

Jeff's regional position is providing support to staff and is working very well.

Consumers prefer to be close to home in accommodations that provide more freedom than the ward or a group home where they can live with people that have high tolerance to their behaviour.

**Identified issues**

A phase is missing between the Richmond Independent Living service and the provider arm providing a structured clinical service that NGO cannot provide – a 24/7 community-based clinical service where difficult patients who are ready to leave the inpatient unit can be placed if the NGOs are not ready for them.

Dual diagnosis – mental health and ID – often not identified early enough as ID until adult and get into the mental health system. No clear pathway available.

The child development service has no psychology input

| | |
|---|---|
| **DHB:** | **Lakes** |
| **Provider:** | **Health Care NZ** |
| **Meeting with:** | **Belinda Walker** |
| **Date of meeting:** | **Friday, 2 March 2007** |

Health Care NZ provides a range of services to people with H&C needs including:

- Home based support
- Independent living choices
- Flexible and planned respite
- Acute Solution in Pretoria Lodge – L3 and L4, crisis respite, community living transition

Referrals come from provider arm and other NGOs

10-15 clients per FTE based on acuity

Staff – social workers, psychologists, enrolled nurses, mental health support workers with certificate

Workforce development – training of core competencies by Eseta

Service mode' "Whatever it takes!"

**Linkages**

Other residential providers and provider arm. Monthly meetings

**Non-compliance**

Concerns with side effects and not enough explanation about the medications i.e. options, pros/cons

Family can help

Clients can see the difference in themselves when medications work

**Identified issues**

- More options in accommodation
- Team work
- Linkages between agencies
- Ability to identify early signs and a way to explain to clinicians
- A place for people with personality disorders and borderline

| | |
|---|---|
| **DHB:** | **Taranaki** |
| **Provider:** | **Te Rau Pani** |
| **Meeting with:** | **Jo Van Leeuwen** |
| **Date of meeting:** | **Thursday, 15 March 2007** |

Services are mostly meeting the needs of the clients and whanau because they are adaptable and linked to the social demographic needs of the populations.

- Integration between provider arm and NGOs
- Simple system that builds on adaptable model
- Communication through leaders and clinical directors

Service users are using the services as intended. Clients' pathways are very clear and there are tight screenings for movement of patients from the inpatient beds to L4.

Constrains:

- Clients are mobile across DHBs and regions and between accommodations
- Whanau are caught in the cross-fire when clients start offending, loose their accommodations or are in between providers

Risk management plays a big part in the process

Important to have a good case management model in place – currently the case managers are attached to geographically-based MDTs. Rate is about 1 to 9-10.

The providers in Taranaki are currently establishing a "virtual team" comprised of 1 FTE from Te Rau Pani and the 2 FTEs from the provider arm. They are the key workers that are attached to the MDTs. The purpose of the virtual team is to review case loads, discuss outcome measures and provide peer support.

Currently most H&C live in independent living arrangements, and only a few are in supported accommodation. The highest need is for mobile support.

We need a range of options, including a secure option.

Currently looking at home based treatment support service in collaboration between Te Rau Pani, provider arm and Pathways.

Interface with ACC / DSS is working well but requires much effort. Interface also with other sectors such as housing, WINZ, CYFS, providers in other regions/DHBs.

P&F should provide clarity of what they want providers to deliver.

**Service Model**

- ACT model was reviewed last year and resulted in FTEs allocated back to MDTs and not as one distinct team.

**Identified issues**

- Difficult to find trained and skilled workforce. Working with local polytech to promote mental health nursing.

- Need for peer support
- Need skill training for clinicians
- Non-compliance is often associated with the more transient group and those who have co-morbidities (i.e. addiction, ID, HD). Can be solved through working in partnership with consumers and whanau to achieve consent
- Transient→ co- morbidity→ less controlled behaviour → hard to get consent

| | |
|---|---|
| **DHB:** | **Taranaki** |
| **Provider:** | **Provider Arm** |
| **Meeting with:** | **Paula Hakesley, Shahid Mehmood, Mike Broker** |
| **Date of meeting:** | **Thursday, 22 March 2007** |

- Lack of clinical exerts within the NGO sector. The joint project allowed for the extension of the provider arm services to the community, the ability to support staff
- Rotation of provider arm nurses between inpatient unit and the community-based programme. Nurses rotate every 6 months on volunteer basis. Although its 24/7 work roster, the actual work is less intense than in the inpatient unit
- Capacity to bring back residents to the inpatient unit if needed but so far did not have to.

3 beds + 1 transitional bed for residents prior to moving into independent accommodation. None of the residents had to go through L3.

Advantage in provider arm working closely with a Maori NGO. The house is situated on Devon Rd by Bell Block, in a rural setting

There are no issues with neighbors or the police. One of the neighbors sits on the governance board of the service.

The service is working very well, costing less than what a bed in the inpatient unit costs. Will be good to have a similar facility for women in addition.

AOD - an AOD nurse coordinator from Provider Arm provides support

There are no difficult patients – staff works with the patient to find out what works for them as individuals

**Issues**

- Trained and skilled workforce is hard to find. Many level 3 or 4 providers are able to provide only custodial care for residents and are not rehabilitation focuses.
- Residential contracts don't specify what model of treatment needs to be available
- 70% of clients have co-morbidity
- Lack of short term stay – i.e. sub acute stage

**Community Mental Health Perspective**

- NGOs expect the provider arm's mobile teams/ key workers to take all the responsibility for the clients. No trained staff within the NGO to support or help in clients' rehabilitation
- Most of the mobile team's clients live at home, not in L3 or L4
- Jeff provides a lot of support to the staff
- No in-between the L4 and Forensic, i.e. secure 24/7 with rehabilitation focus. Although the numbers are very small (12-15 across the region) the very difficult people are impacting the most on resource utilisation.
- Any regional services should have all 5 DHBs involved in the governance

| | |
|---|---|
| **DHB:** | **Taranaki** |
| **Provider:** | **Te Whare Whakaahuru** |
| **Meeting with:** | **Paula Hakesley, Sue Paratene, Linda, Jo** |
| **Date of meeting:** | **Thursday, 22 March 2007** |

The current project is based on the experiences of the previous service that was existed.

Success based on the established working relationship between the provider arm and Te Whare Puawai – Te Pataka model – describing common ways of working for the two providers, established for the joint youth project.

What makes the service work – people with similar goals trying to achieve the same outcomes for consumers and not focusing on money.

**Staff**

Two separate rosters:

- One for the nurses (based on MECA, paid Provider Arm salaries) – 3 RNs (some work part time on the ward and part time at TWW
- One for the NGO's mental health support workers who work 12 hours shifts

Flexibility around funding – capacity funding.

Management committee includes managers from both provider arm and the NGO, clinical director and a business analyst – meet fortnightly.

The nurse takes the patients to the psychiatrist or the psychiatrist visits at the house – accessibility to direct clinical input or re-admission if necessary

Communication between team members is very important – team building days that include teaching sessions (i.e. next one is on rehab)

NGO has access to provider arm training and professional development opportunities

**Identified issues**

- WFD is the biggest challenge - there are currently no training in Taranaki for certification in support workers
- Nurses salaries are an issue
- Different definitions for rehab
- No services for women – most are borderline personality disorder. Often not safe for them to go back home but at the same time the inpatient unit is not appropriate as well
- Nurses at the provider arm prefer to work in mental heath than in other areas

Next steps- clarify rehabilitation outcomes

| | |
|---|---|
| **DHB:** | **Waikato** |
| **Provider:** | **DHB Provider Arm** |
| **Meeting with:** | **Eileen Hughes** |
| **Date of meeting:** | **Friday, 2 March 2007** |

Services provided:

- Acute inpatient unit – wards 34 and 35
- Community mental health services, as part of the general case load
- ACT team, 7 days, 13 FTEs (nurses, OTs, SW, clinical psychologists). They work with medical staff from community mental health, get referrals from the team, case load of about 10. Cover the Hamilton area.

1.5 FTEs based in the north and south areas of Waikato – rural services

- Clients are mostly in independent living arrangements

ACT team – moved from 100% to 2/3 nursing (now multi-disciplinary). Was difficult to recruit other disciplines.

- Mobile intensive team (part of community mental health) are restructuring to separate H&C from the general case load.
- 2004/05 - received additional $ for 3 FTEs to augment the existing teams. Was used for 1.5 FTE DBT and 1.5 FTE for rural services

**Identified issues**

- Concern with NGOs' moving away from supported accommodation to providing mobile support to people living in independent living and consequently reduction in availability of L3 and L4 supported accommodation in the community.
- Need better linkages within services in provider arm

| | |
|---|---|
| **DHB:** | **Waikato** |
| **Provider:** | **Richmond New Zealand** |
| **Meeting with:** | **Cathy Holland** |
| **Date of meeting:** | **Monday, 19 March 2007** |

A number of services are provided by Richmond in Hamilton including:

- 12 L3 adult
- 10 L4 adults
- 12 DD (ID/MH) adults
- 4 long term residential for youth <17
- 3 crisis beds for youth
- 2 respite beds for youth
- 20 clients in independent or home based

**Identified issues**

- Workforce – many are not qualified, and some are on flexible term contracts which allows staff to choose own shifts, resulting in need to continuously recruit more staff (sometimes casual) to supplement existing staff for weekend and nights.

Current staff includes 2 nurses, 3 social workers, 1 psychologist, few with national certificate

New staff are required to have a full driver license, either have existing qualification or current enrollment in national certificate programme, some experience in working in a residential facility

Staff needs to be able to conduct thorough needs assessment of clients and move away from the custodial care paradigm and focus on client needs and outcomes

- Funding – DSS more flexible funding arrangements than health
- Most have AOD problems and not receiving supports (i.e. AOD counseling)
- Mainly custodial care and not enough rehabilitation or recovery pathways
- Clients refuse to attend rehab services – often clients are referred to services that are available not necessarily to services that are appropriate for them
- Not using practice advisors as much as should
- Many clients stay in the same place for many years. Small number of success stories mainly of L3 clients who moved out to independent living

**Linkages**

- Funders – DSS (fund FTEs) and health (fund beds)
- Referrals come from provider arm and Hauora Waikato
- DHB provider arm –
    - All referrals for youth services come from CAMHS
    - Clients sometimes go to HBC and are discharged too early
    - Good relationship with CAT and the police

Developing new initiative in Hamilton – 14 single bedroom L3 flats, similar to the Rotorua model

| | |
|---|---|
| **DHB:** | **Waikato** |
| **Provider:** | **Pathways** |
| **Meeting with:** | **Julie Fidoe, Mike** |
| **Date of meeting:** | **Friday, 23 March 2007** |

High & Complex are defined by providers as "difficult to place"

**Identified issues**

- Lack of continuum between provider arm and NGOs
- Lack of sub-acute level
- Lack of acute alternatives to admissions
- Lack of cooperation with other sectors around funding mechanisms – i.e. WINZ, Housing - need flexibility

Pathways services in Waikato include L3, L3+, and L4 where services are tailored to clients needs – 5 complexes in Hamilton, 1 in Waihi and 1 in Thames.

Home based support is available during the day, and in Hauraki and Hamilton extended hours are also available.

The complex in Coromandel was recently closed and the service was changed into home based support – non clinical.

Pathway national contract will be devolved to the DHBs in 2008

No need for more beds but rather look for creative solutions – whatever it takes to manage people in their own communities

Most acute admissions can be picked by providers up to a week before a crisis occurs – however – admission criteria is such that it is not always possible to admit clients early

AOD – staff are trained

L4 – the sleepover requirement is redundant – very rarely is useful – should be possible to free up the resources necessary to comply with this contractual requirement for other services.

| | |
|---|---|
| **DHB:** | **Waikato** |
| **Provider:** | **DHB Provider Arm** |
| **Meeting with:** | **Vicki Muir** |
| **Date of meeting:** | **Friday, 30 March 2007** |

Waikato provider arm and Hauora Waikato are working together on the business plan for the five forensic beds through partnership overseen by a joint group comprised of Hauora Waikato's CEO and chair, Waikato forensic services manager, Graham Mellsop, P&F and a kaumātua.

The two providers are holding team meetings to review patients to determine which service is more appropriate – Tamahere or HBC.

The two providers are also working on formalizing governance of the regional forensic services to bring it to a higher level that only relationship.

The business case involves also re-design of existing wards

The provider arm is redefining its rehabilitation services moving from psychosocial model to a more suitable environment

## *Appendix 5 – Project Scope*

| Midland District Health Boards | **Project Scope** |
|---|---|
| **Title** | **Midland Region High & Complex Needs**<br>**Identification of Continuum of Care Options** |
| **Prepared by** | Rachel Dekel, Midland Region Mental Health and Addictions Strategic Planner |
| **Date** | 12 December 2006 |
| **Version** | Version 5.00 |

| | |
|---|---|
| **Project Statement** | This project will identify continuum of care options for services to adults who have high and complex mental health needs in the Midland Region. The identified options will inform DHBs' prioritisation process. |
| **Objectives** | To explore current national and international literature and best practice regarding continuum of care for adults with high and complex mental health needs, and to explore national best practice kaupapa models of care.<br>To examine the recommendations in, and currency of 'Midland Region Survey of Mental Health Consumers with Extreme and Complex Needs' conducted by Peter McGeorge during October-November 2004.<br>To map the current services available for people with high and complex needs in the Midland region, and identify DHBs' plans for funding additional services in 2006/07.<br>To quantify future requirements for services for people with high and complex needs in the Midland region based on the 2004 Mental Health Needs Assessment and other documents.<br>To identify gaps between current availability and future requirements.<br>To incorporate the information compiled by the Regional Mental Health Clinical Nurse Consultant pilot that aims to assess and support the needs of identified high and complex mental health service users in the region.<br>To recommend continuum of care options for people with high and complex mental health needs in the region, identifying a range of local and regional solutions. |
| **Strategic accountability** | The process of de-institutionalisation has accelerated the development of a policy direction that emphasises more and better community based support options available to people with mental health problems and high support needs. This has been embodied in the Mental Health Strategy Looking Forward 1994, Moving Forward 1997, the Mental Health Commission's Blueprint for Mental Health Services in New Zealand 1998 and Te Tahuhu 2005.<br>Parallel and closely linked to this process was the development of forensic services that aim to provide effective assessment, treatment and rehabilitation for people charged with criminal offences that have or may have a mental illness; offenders with a mental illness; and individuals whose potential danger to themselves and others is such that, adult mental health services (AMHS) cannot manage them safely.<br>Interface issues between the forensic system and general adult mental health services were identified relating mainly to the target population and core business of each |

| | |
|---|---|
| | service. These two separate but parallel systems have grey areas concerning who should provide inpatient services to whom. In addition, there are disincentive difficulties over transferring patients between AMHS and forensic services, outpatient follow-up, and access to community facilities and services for forensic service consumers.<br><br>These difficulties lead to the recognition that there is a group of service users, who currently may be using forensic services but without clear need for forensic care, or alternatively sit within the general adult mental health services which are at risk of future offending and therefore at risk of becoming forensic patients in the future. They present higher risks to themselves and others and are often more challenging to providers due to the lower compliance and effective engagement in appropriate treatment and rehabilitation programmes. Some of which via the Justice System end up in forensic services and due to their histories of "difficult to manage" are hard to transfer back into mainstream services.<br><br>Looking Forward (1994) focused on increasing specialist mental health services in the community, in the homes and in hospitals. The main priority areas were general adult population and their families, youth, and children and their families. There was neither the identification of the different levels and the complexity of needs that people with severe mental illness might have, nor the different level of services that are required.<br><br>Moving Forward (1997) identified specific needs groups and their services, including "people with the highest support needs". This group, defined as the 0.06% of the adult population, was targeted for assertive care management and a number of objectives and targets were identified.<br><br>The Blueprint (1998) went further to identify that people with ongoing severe and complex illness need access to a range of services within a framework which ensures continuity of care and follow-up. Similarly complex are the needs of those with mental illness with severe alcohol and drug disorders, eating disorders, head injury with compounding mental disorders, borderline personality disorders, mental illness with intellectual disability and 'mothers and babies'.<br><br>The Blueprint specified that hospital services (as an adjunct to community team services) providing medium-term and extended inpatient services must be available at the local level for those with high disability support needs whose complex symptoms and high support needs require 24 hour treatment and support.<br><br>Services have grown substantially since 1998. However it has become clinically apparent that while MHS in NZ are addressing a broader range of need than before, there are still a number of consumers whose needs are not being adequately met in terms of their being a risk to themselves and in some cases the public at large. |
| **Background** | Up until 1997, the Midland region was serviced by a large rural inpatient Mental Health facility, Tokanui Hospital, providing general Mental Health services including specialist services for the aged, adolescent and forensic populations<br><br>The expected closure of Tokanui hospital and lack of capacity in the community to provide forensic services and services for high risk patients and the interface between these and the general adult mental health services were a concern for the Midland RHA in the early 1990s. A base line survey was commissioned in 1993 resulting in recommendation for a service model that includes a number of components (i.e. acute inpatient unit with close intensive psychiatric care areas, sub acute intensive rehabilitation hostels, medium and long stay supervised accommodations, community based activities and rehabilitation programmes, substance abuse services and Mäori health services) and the establishment of a regional forensic services (medium and minimum secure facilities, community team, long stay/extended care units).<br><br>In mid-2003 discussions were initiated in the region regarding the potential impact that the implementation of the Forensic Framework will have on general adult mental health services for people with high and complex needs. It was decided to top slice $1.8m from the 2003/04 regional Blueprint funding and allocate proportionally to DHBs to increase local adult mental health capacity – packages of care and assertive community treatment teams – to support people with high and complex needs. |

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| | A concern was raised that not all needs will be met locally. It was agreed that regional solutions should be developed for medium to long term rehab options and for regionally agreed definitions of levels of needs and clients assessment, while retaining DHBs independence in developing local services. Consequently, a regional process was developed in late 2003 to identify the numbers and the specific needs of people whose needs could not be met by the existing local community services (i.e. assertive community teams and supported accommodation providers). It was envisioned that once the service users are identified by clinicians, a comprehensive assessment of their needs be undertaken. To oversee the process, a High & Complex Needs Expert Group was established and in April 2004 Dr Peter McGeorge was contracted by Waikato DHB on behalf of the Region to undertake a survey to identify the numbers of people involved, their risk profile, their needs and what services should be available to best address them.<br><br>Since the release of the report in mid 2005 a Regional Mental Health Clinical Nurse Consultant (RCNC) position was partially funded through the Blueprint regional top slice for a one year pilot. The objective of the position is to create expert capacity to assess and support the needs of identified high and complex mental health service users in the Midland Region. Data from the project will be available for the reference group. |
| **Approaches** | • The project will utilise sector's expertise through a competence-based reference group to develop continuum of care options.<br>• The project will include a number of key milestones:<br>• Establish a time limited reference group utilising MRG standard process, from a pool of sector nominations<br>• Conduct a robust literature search including best practice models of care for adults with high and complex mental health needs<br>• Examine the results and recommendations of 'Midland Region Survey of Mental Health Consumers with Extreme and Complex Needs' conducted by of Peter McGeorge during October-November 2004.<br>• Carry out a stock take of services currently funded for people with high and complex needs by the Midland DHBs and identify current models of practice utilised by these services<br>• Identify DHBs' plans for future funding of services for people with high and complex needs in their DAPs.<br>• Review the data currently being collected by the regional mental health clinical nurse consultant who is assessing the support needs of those identified through the survey.<br>• Utilise reference group expertise to identify continuum of care options for the region through workshops and discussions.<br>• Bring is additional experts (national or international) as identified by reference group to become familiar with existing and new models.<br>• Incorporate all knowledge obtained throughout the process to identify the best options for the region<br>• Present report to the Midland Region Mental Health Group<br>• Present recommendations to P&F GMs and CEOs Forums. |
| **The project will include** | Recommending continuum of care options for people with high and complex needs in the Midland region that can be utilised by DHBs when developing local funding plans. |
| **The project will not include** | Specific funding recommendations for individual DHBs. |

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| **Completion Criteria** | Report approved by the Midland P&F GMs and CEOs forums. | |
| **Internal Stakeholders** | • DHB Planning & Funding<br>• Midland Region Mental Health Group | |
| **External Stakeholders** | • Midland Region H&CN Reference group<br>• Service users<br>• Service providers in the Midland region | |
| **Implications for Maori** | Despite improvements in Maori health over the past four decades, social and economic disparities, particularly health disparities, still exist between Maori and non-Maori, and health status levels for Maori remain lower than for non-Maori across a range of health indicators.<br><br>McGeorge survey identified that out of the 95 consumers surveyed, Maori were over represented at 43% (41 individuals). The report indicated that the capacity of existing services to meet high and complex need of Maori should be more specifically determined, recommending that "ways in which Maori providers can be further and more precisely involved in the delivery of services for ECN consumers be identified and implemented". | |
| **IM Implications** | N/A | |
| **Resources and Project Structure** | • Project management and administration - Midland Region Mental Health and Addictions Strategic Planner<br><br>• Expert sector advise - Midland Regional High & Complex Needs Reference Group | |
| **Project relationships and linkages** | • *Midland Health Region Survey of Mental Health Consumers with Extreme and Complex Needs. October-November 2004.* Dr Peter McGeorge, Mental Health Horizons<br><br>• *Midland Mental Health and Addictions Workforce Development Plan 2005/06*<br><br>• District Annual Plans and District Strategic Plans for Bay of Plenty, Lakes, Taranaki, Tairawhiti and Waikato DHBs<br><br>• *Midland Region Mental Health and Addictions Strategic Plan. 2005-2015.* | |
| **Risk management** | **Risks associated with the project**<br><br>Process not receiving support from the sector/ not seen as a credible process<br><br>Lack of interest locally in applying regionally developed options to local services | **Risk Mitigation**<br><br>• Provide appropriate information to stakeholders on the process, progress and outcomes<br><br>• Involve experts through reference group and other appropriate mechanisms<br><br>• Link to other process in an out of the region<br><br>• Ensure DHBs continue to support the project and the added value of regional work |
| | **Risks we are exposed to if we do not proceed with the project.**<br><br>• Sector frustration with lack of progress on the non-inpatient based recommendations of the 2005 Peter McGeorge survey<br><br>• Increased level of need and the number of people with high and complex needs in the region<br><br>• Continuous sector uncertainty regarding Midland region's intention around funding bed-based inpatient regional service for people with high and complex needs. | |

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| **Project Opportunities** | • Improve relationships between stakeholders through better understanding of each others issues<br>• Enhance equitable, appropriate and timely access to services for residents of the Midland Region regardless of their residence<br>• Increase workforce development opportunities for people in the MH&A field who are interested in expanding their scope of work |
| **Assumptions** | • It will be possible to identify and to agree on continuum of care options<br>• The agreed options with be used by DHBs to inform their prioritisation process |
| **Constraints** | • Keeping to the defined time line might be hindered by competing deadlines/ obligations of key staff and stakeholders' response. |
| **Communication Plan** | • Project scope reviewed by Midland Region Mental Health Group and signed off by GMs<br>• Sector communiqué providing update to the sector will be distributed through the chairs of LAGs and regional forums to stakeholders once the reference group is established<br>• Progress reports to Midland Region Mental Health Group and GMs Forum (as part of Midland Region Mental Health Group report)<br>• Final report, once approved by GMs/CEOs, distributed to the sector and posted on the network's website. Key points/recommendation in the newsletter.<br>• Updates to the sector at key points of the project through the regional newsletter, the regional website and LAG updates. |
| **Evaluation** | Once recommendations are approved by GMs/CEOs forums:<br>• An evaluation form will be distributed to members of the reference group and to Midland Region Mental Health Group to evaluate the project<br>• Summary of the evaluation will be provided to participants once collated analysed and reviewed by GMs. |

## *Appendix 6 – Adult Level 3 and 4 Beds and FTEs in Midland*

| | | Volume | | | |
|---|---|---|---|---|---|
| | | Beds | | FTEs | |
| **DHB** | **Provider** | **Level 3/3+** | **Level 4** | **Clinical** | **Non-clinical** |
| **BOP** | Dalcam Company Limited | | 7 | | |
| **BOP** | Deo Gratias Trust | | 7 | | |
| **BOP** | Vincent House, Te Puke | 8 | | | |
| **BOP** | BOP Community Homes Trust | 14 | | | |
| **BOP** | Te Rau O Te Huia | 10 | | | |
| **BOP** | Te Tomika Trust | 12 | | | |
| **BOP** | Richmond Fellowship NZ Inc | 15 | 9 | | |
| | | | | | |
| **Lakes** | Mangakino Country Lodge | | 5 | | |
| **Lakes** | Pretoria Lodge Limited | | 2 | | |
| **Lakes** | Rau O Te Huia Trust | | 1 | | |
| **Lakes** | Richmond Fellowship NZ Inc | | 7 | | |
| **Lakes** | Te Aroha o Hinemaru Trust | | 7 | | |
| | | | | | |
| **Tairawhiti** | Richmond Fellowship NZ Inc | | 5 | | |
| | | | | | |
| **Taranaki** | Pathways Trust | | 11 equiv | | |
| | | | | | |
| **Waikato** | Ballymena Properties Ltd | 27 | 5 | | |
| **Waikato** | Guardian Heatlhcare Group Ltd | 2 | | | |
| **Waikato** | Hauora Waikato | 20 | | | |
| **Waikato** | Manaaki Trust | 15 | | | |
| **Waikato** | Ngati Maniapoto Marae Pact Trust Inc | 8 | | | |
| **Waikato** | Provider Arm ACT team | | | 10.0 | |
| **Waikato** | Provider Arm DBT | | | 1.5 | |
| **Waikato** | Richmond Fellowship NZ Inc | 22 | 6 | | 3.3 |
| **Waikato** | Te Awhi Whanau Charitable Trust | 20 | | | |
| **Waikato** | Te Runanga O Kirikiriroa | 7 | 8 | | |
| **Waikato** | Te Runanga O Kirikiriroa Adult Crisis Respite Programme | | | 2.5 | |
| **Waikato** | Te Runanga O Kirikiriroa Dual Diagnosis service | | | 3.0 | |

# *Appendix 7 – Results of Follow-up Interviews*

## What worked – Clinicians' perspectives

**All responses**

| | BOP | Lakes | Taranaki | Waikato | MR |
|---|---|---|---|---|---|
| Engaging with MHS | 12 | 9 | 11 | 30 | 62 |
| Supported Accomm | 0 | 0 | 8 | 15 | 23 |
| Multi-Agency Approach | 0 | 1 | 5 | 1 | 7 |
| Work/Transition | 0 | 0 | 5 | 4 | 9 |
| Medication | 11 | 5 | 4 | 30 | 50 |
| Family Dynamics | 4 | 1 | 3 | 8 | 16 |
| Meaningful Activities | 6 | 4 | 2 | 9 | 21 |
| Inpatient Services | 5 | 0 | 2 | 0 | 7 |
| Recovery Focus | 0 | 0 | 2 | 2 | 4 |
| PPPR Act | 0 | 0 | 2 | 0 | 2 |
| Close Monitoring | 0 | 7 | 0 | 0 | 7 |
| Counselling | 0 | 5 | 0 | 10 | 15 |
| Stable Accommodation | 9 | 4 | 0 | 0 | 13 |
| Motivation | 0 | 2 | 0 | 0 | 2 |
| Financial Support | 0 | 2 | 0 | 0 | 2 |
| Encouraging Autonomy | 0 | 2 | 0 | 0 | 2 |
| Respite | 0 | 1 | 0 | 2 | 3 |
| Cultural Input | 0 | 1 | 0 | 0 | 1 |
| Comprehensive Assessment | 0 | 1 | 0 | 0 | 1 |
| CCTO | 4 | 0 | 0 | 0 | 4 |
| D&A Follow-up | 3 | 0 | 0 | 4 | 7 |
| Stable Partners/relationships | 2 | 0 | 0 | 2 | 4 |
| Interagency Support | 2 | 0 | 0 | 0 | 2 |
| Health Assistance | 2 | 0 | 0 | 0 | 2 |
| Clear boundaries | 1 | 0 | 0 | 3 | 4 |
| Transition relationships Com/Inp | 1 | 0 | 0 | 0 | 1 |
| Package of care | 1 | 0 | 0 | 0 | 1 |
| Dual Diagnosis | 1 | 0 | 0 | 0 | 1 |
| Support Networks | 0 | 0 | 0 | 15 | 15 |
| Treatment Programme Compliance | 0 | 0 | 0 | 5 | 5 |
| Life Skills Assistance | 0 | 0 | 0 | 5 | 5 |
| Volunteer Work | 0 | 0 | 0 | 4 | 4 |
| Crisis inpatient Admission | 0 | 0 | 0 | 3 | 3 |
| Pathways Mobile Team | 0 | 0 | 0 | 2 | 2 |
| MHS Cultural Match | 0 | 0 | 0 | 2 | 2 |
| ECT | 0 | 0 | 0 | 2 | 2 |
| Abstinence | 0 | 0 | 0 | 2 | 2 |
| Transparency in processes | 0 | 0 | 0 | 1 | 1 |
| Taking Responsibility | 0 | 0 | 0 | 1 | 1 |
| HealthcareNZ | 0 | 0 | 0 | 1 | 1 |
| Financial Security | 0 | 0 | 0 | 1 | 1 |
| Education | 0 | 0 | 0 | 1 | 1 |
| Current Living arrangements | 0 | 0 | 0 | 1 | 1 |

**Top five responses for the Midland Region**

| | MR |
|---|---|
| Engaging with MHS | 62 |
| Medication | 50 |
| Supported Accomm | 23 |
| Meaningful Activities | 21 |
| Family Dynamics | 16 |

**Top five responses for Bay of Plenty DHB**

| | BOP |
|---|---|
| Engaging with MHS | 12 |
| Medication | 11 |
| Stable Accommodation | 9 |
| Meaningful Activities | 6 |
| Inpatient Services | 5 |

**Top five responses for Lakes DHB**

| | Lakes |
|---|---|
| Engaging with MHS | 9 |
| Close Monitoring | 7 |
| Medication | 5 |
| Counselling | 5 |
| Stable Accommodation | 4 |

**Top five responses for the Taranaki DHB**

| | Taranaki |
|---|---|
| Engaging with MHS | 11 |
| Supported Accomm | 8 |
| Multi-Agency Approach | 5 |
| Work/Transition | 5 |
| Medication | 4 |

**Top five responses for Waikato DHB**

| | Waikato |
|---|---|
| Engaging with MHS | 30 |
| Medication | 30 |
| Supported Accomm | 15 |
| Support Networks | 15 |
| Counselling | 10 |

## What did not work well – Clinicians' perspectives

**All responses**

| | BOP | Lakes | Taranaki | Waikato | MR |
|---|---|---|---|---|---|
| Accommodation | 3 | 0 | 1 | 8 | 12 |
| D&A Issues | 3 | 1 | 1 | 7 | 12 |
| Treatment Programme | 2 | 5 | 3 | 6 | 16 |
| Social Support | 1 | 1 | 1 | 5 | 8 |
| Family Dynamics | 4 | 5 | 4 | 4 | 17 |
| Physical Health | 2 | 2 | 1 | 4 | 9 |
| Insight | 2 | 0 | 1 | 4 | 7 |
| Restrictive Approach | 0 | 1 | 0 | 3 | 4 |
| Relationship with Keyworker MHS | 1 | 0 | 0 | 3 | 4 |
| Abdication of Responsibility | 0 | 0 | 0 | 3 | 3 |
| Dependence of MHS | 0 | 0 | 0 | 3 | 3 |
| Minimal intervention | 0 | 0 | 0 | 3 | 3 |
| Work Initiatives | 0 | 0 | 0 | 3 | 3 |
| Motivation | 1 | 0 | 1 | 2 | 4 |
| Counselling | 0 | 0 | 0 | 2 | 2 |
| Weight gain | 0 | 0 | 1 | 1 | 2 |
| Assistance with life skills | 0 | 0 | 0 | 1 | 1 |
| Financial Support | 0 | 0 | 0 | 1 | 1 |
| Relationships with others | 0 | 0 | 0 | 1 | 1 |
| Risk Management | 0 | 1 | 2 | 0 | 3 |
| MH Service Delivery | 0 | 0 | 1 | 0 | 1 |
| Stable Relationships | 0 | 0 | 1 | 0 | 1 |
| Independence | 0 | 2 | 0 | 0 | 2 |
| Safe Sex/Prostitution | 0 | 2 | 0 | 0 | 2 |
| Supported Accommodation | 0 | 2 | 0 | 0 | 2 |
| Access to services | 0 | 1 | 0 | 0 | 1 |
| Compliance with Medication | 0 | 1 | 0 | 0 | 1 |
| Confidentiality | 0 | 1 | 0 | 0 | 1 |
| Employment | 0 | 1 | 0 | 0 | 1 |
| Engagement with Work programmes | 2 | 0 | 0 | 0 | 2 |
| Informal Status | 1 | 0 | 0 | 0 | 1 |
| Inpatient Service | 1 | 0 | 0 | 0 | 1 |
| Transition between services | 1 | 0 | 0 | 0 | 1 |

**Top five responses for the Midland Region**

| | MR |
|---|---|
| Family Dynamics | 17 |
| Treatment Programme | 16 |
| Accommodation | 12 |
| D&A Issues | 12 |
| Physical Health | 9 |

**Top five responses for Bay of Plenty DHB**

| | BOP |
|---|---|
| Family Dynamics | 4 |
| Accommodation | 3 |
| D&A Issues | 3 |
| Engagement with Work programmes | 2 |
| Insight | 2 |

**Top five responses for Lakes DHB**

| | **Lakes** |
|---|---|
| Family Dynamics | 5 |
| Treatment Programme | 5 |
| Physical Health | 2 |
| Independence | 2 |
| Safe Sex/Prostitution | 2 |

**Top five responses for Taranaki DHB**

| | **Taranaki** |
|---|---|
| Family Dynamics | 4 |
| Treatment Programme | 3 |
| Risk Management | 2 |
| Physical Health | 1 |
| D&A Issues | 1 |

**Top five responses for Waikato DHB**

| | **Waikato** |
|---|---|
| Accommodation | 8 |
| D&A Issues | 7 |
| Treatment Programme | 6 |
| Social Support | 5 |
| Family Dynamics | 4 |

## What is needed - Clinicians' perspectives

**All responses**

| | BOP | Lakes | Taranaki | Waikato | MR |
|---|---|---|---|---|---|
| Stable Accommodation | 5 | 7 | 2 | 17 | 31 |
| Improving Family & Social Relationships | 6 | 4 | 3 | 16 | 29 |
| Meaningful & Healthy Lifestyles | 5 | 6 | 2 | 16 | 29 |
| Employment Opportunities | 4 | 4 | 0 | 19 | 27 |
| Counselling (D & A, Sexual) | 2 | 4 | 3 | 9 | 18 |
| Consistent approach by MHS | 3 | 2 | 0 | 8 | 13 |
| Financial Assistance | 1 | 0 | 0 | 7 | 8 |
| Cultural Input | 0 | 3 | 0 | 1 | 4 |
| Close Monitoring | 0 | 0 | 4 | 0 | 4 |
| Interagency approach | 2 | 0 | 2 | 0 | 4 |
| Respite Options | 0 | 1 | 1 | 0 | 2 |
| Sharing info | 0 | 2 | 0 | 0 | 2 |
| Clear diagnosis | 0 | 0 | 0 | 1 | 1 |
| Community Rehabilitation | 0 | 0 | 0 | 1 | 1 |
| Independence from MHS | 0 | 0 | 0 | 1 | 1 |
| Secure ID Facility | 0 | 0 | 0 | 1 | 1 |
| Funding Support | 0 | 0 | 1 | 0 | 1 |
| Transition Programmes | 0 | 0 | 1 | 0 | 1 |
| Dual Diagnosis support | 0 | 1 | 0 | 0 | 1 |
| Early intervention | 0 | 1 | 0 | 0 | 1 |
| Neuropsych assessment | 0 | 1 | 0 | 0 | 1 |
| Maternal Mental Health | 1 | 0 | 0 | 0 | 1 |
| Package of care | 1 | 0 | 0 | 0 | 1 |
| Use of MH Act | 1 | 0 | 0 | 0 | 1 |

**Top five responses for the Midland Region**

| | MR |
|---|---|
| Stable Accommodation | 31 |
| Improving Family & Social Relationships | 29 |
| Meaningful & Healthy Lifestyles | 29 |
| Employment Opportunities | 27 |
| Counselling (D & A, Sexual) | 18 |

**Top five responses for Bay of Plenty DHB**

| | BOP |
|---|---|
| Improving Family & Social Relationships | 6 |
| Meaningful & Healthy Lifestyles | 5 |
| Stable Accommodation | 5 |
| Employment Opportunities | 4 |
| Consistent approach by MHS | 3 |

**Top five responses for Lakes DHB**

| | Lakes |
|---|---|
| Stable Accommodation | 7 |
| Meaningful & Healthy Lifestyles | 6 |
| Improving Family & Social | 4 |

| | |
|---|---|
| Relationships | |
| Employment Opportunities | 4 |
| Counselling (D & A, Sexual) | 4 |

**Top five responses for Taranaki DHB**

| | **Taranaki** |
|---|---|
| Close Monitoring | 4 |
| Improving Family & Social Relationships | 3 |
| Counselling (D & A, Sexual) | 3 |
| Stable Accommodation | 2 |
| Meaningful & Healthy Lifestyles | 2 |

**Top five responses for Waikato DHB**

| | **Waikato** |
|---|---|
| Employment Opportunities | 19 |
| Stable Accommodation | 17 |
| Improving Family & Social Relationships | 16 |
| Meaningful & Healthy Lifestyles | 16 |
| Counselling (D & A, Sexual) | 9 |

# *Appendix 8 – Additional Financial Information*

## Taranaki DHB – Te Whare Whakaahuru

The following is the budget for Jan 2006 to Jan 2007 for the Community Based H&C Rehabilitation Service, located in Devon Road, New Plymouth.

BUDGET Jan 2006 - Jan 2007 - DEVON ROAD BUDGET - YEAR ONE ONLY

| | Description | | TPW | Month | TWPOTT | |
|---|---|---|---|---|---|---|
| **INCOME** | | | | | | |
| 1110.01 | Fee for Service | | | | | |
| 1110.02 | Contracted Funding | | 24268.48 | 43,800.00 | 19531.52 | Figure A |
| 1130.00 | Grants/Subsidies Received | | | | | |
| 1140.00 | Koha/Donations Received | | | | | |
| 1150.00 | Management Fees | | | | | |
| 1150.00 | Sundry Income | | | | | |
| 1160.00 | ACC Income | | | | | |
| 1170.00 | WINZ Benefits | | | 1,806.00 | 1,806.00 | |
| | **TOTAL INCOME** | | 24268.48 | 45,606.00 | 21337.52 | |
| | **Selling & Delivery Expenses** | | | | | |
| | Service Delivery | | | | | |
| 3140.01 | Hosting Expenses | | | 0.00 | 0.00 | |
| 3140.02 | Television Expenses | | | 90.00 | 90.00 | |
| 3140.03 | Recreational Activities | | | 10.00 | 10.00 | |
| 3140.04 | Residential Groceries | | | 1,419.00 | 1,419.00 | |
| | Client Health/Personal Services | | | | | |
| 3150.01 | Health Service Fees | | | 150.00 | 150.00 | |
| 3150.02 | Allowances | | | 313.04 | 313.04 | |
| | | | | 1,982.04 | | |
| | **Administration Expenses** | | | | | |
| 3210.00 | Bank Charges | | | 0.00 | 0.00 | |
| 3214.00 | Entertainment | | | 30.00 | 30.00 | |
| | Communication Expenses | | | | | |
| 3218.01 | Telephone & Tolls | | | 150.00 | 150.00 | |
| 3218.02 | Mobile Phone Charges | | | 150.00 | 150.00 | |
| 3218.03 | Internet/email | | | 0.00 | 0.00 | |
| 3218.04 | Courier & Postage | | | 6.00 | 6.00 | |
| | Consultancy Fees | | | | | |
| 3222.01 | Employment | | | 10.00 | 10.00 | |
| 3222.02 | Business Consultancy | | | 10.00 | 10.00 | |
| 3222.03 | Maori (Protocol & Terminology) | | | | | |
| 3226.00 | Equipment Hire | | | 100.00 | 100.00 | |
| 3230.00 | Fee, Licenses & Permits | | | 0.00 | 0.00 | |
| 3234.00 | General Expenses | | | 20.00 | 20.00 | |
| 3236.00 | Koha | | | 10.00 | 10.00 | |
| 3238.00 | Insurance | | | 25.00 | 25.00 | |
| | Leasing | | | | | |
| 3242.01 | Motor Vehicle Lease | | 0.00 | 0.00 | | |
| 3242.02 | Computer Lease | | 0.00 | 0.00 | | |
| 3242.03 | Photocopier Lease | | | 0.00 | 0.00 | |
| 3246.00 | Management Fee | 5.85% | | 2,562.30 | 2,562.30 | |
| 3250.00 | Membership/Subscriptions | | | 0.00 | 0.00 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Motor Vehicle Expenses | | | | | |
| 3254.01 | MV Repairs & Maintenance | | 100.00 | 100.00 | | |
| 3254.02 | Registration and WOF | 250 | 20.83 | 20.83 | | |
| 3254.03 | Petrol | | 200.00 | 200.00 | | |
| | Occupancy Expenses | | | | | |
| 3258.01 | Rent | | | 1,290.00 | 1,290.00 | |
| 3258.02 | Rates | | | 0.00 | 0.00 | |
| 3258.03 | Electricity and Gas | | | 350.00 | 350.00 | |
| 3258.04 | Security Monitoring | | | 0.00 | 0.00 | |
| 3266.00 | Printing/Stationery/Photocopying | | | 50.00 | 50.00 | |
| | Professional Services | | | | | |
| 3270.01 | Accounting Fees | | | 0.00 | 0.00 | |
| 3270.02 | Trustee Fees | | | 0.00 | 0.00 | |
| 3270.03 | Legal Fees | | | 0.00 | 0.00 | |
| 3270.04 | Admin/Management Support | | | 100.00 | 100.00 | |
| | Repairs and Maintenance | | | | | |
| 3278.01 | Computer Support | | | 10.00 | 10.00 | |
| 3278.02 | Plant and Equipment | | | 50.00 | 50.00 | |
| 3278.03 | Building | | | 0.00 | 0.00 | |
| 3278.04 | Small Asset Purchase (>$200) | | | 20.00 | 20.00 | |
| 3282.00 | Staff Development and Training | | 75.00 | 150.00 | 75.00 | |
| 3284.00 | Staff Supervision | | 0.00 | 0.00 | 0.00 | |
| 3286.00 | Travel and Accommodation | | | 10.00 | 10.00 | |
| 3290.00 | Wages and Salaries (+ Kaumatua) | 62% | 23795.60 | 38,199.03 | 14403.43 | 38% |
| 3294.00 | Depreciation | | 0.00 | 0.00 | 0.00 | |
| | | | | 43,623.17 | | |
| | | % | 0.40 | | 0.40 | % |
| | **TOTAL EXPENSES** | *53.05* | 24191.83 | 45,605.21 | 21414.17 | *46.96* |
| | **NET SURPLUS / (LOSS)** | | **76.65** | **0.79** | **-76.65** | |
| | | | | 45606.00 | | |

**ROSTER PROJECTION**
**Ns: Cyclic - 6 week, 4 on 2 off roster**

| | | | | | | | | | | | | | | RN Cost | RSW/ kumatua Cost |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RSWs: 12 hour roster | | | | M | T | W | Th | F | S | S | | | | | |
| C NL | General oversight/mgmt | RN | 16 hours per week/3ish hours per day | x | x | x | x | x | o | o | RN | | | 24000.00 | 0.00 |
| | | RN | 8 hour am shift | x | x | x | x | o | o | x | RN | | | 79600.00 | 0.00 |
| | | RN | 8 hour pm shift | x | x | x | x | o | o | x | RN | | | 75600.00 | 0.00 |
| | | RN | 8 hour night shift | x | x | x | x | o | o | x | RN | | | 75600.00 | 0.00 |
| | | RN On Call | | | | | | | | | | | | 0.00 | |
| | | RSW | 12 hour am shift | x | x | x | x | o | o | o | RSW | | | 0.00 | 72072.00 |
| | | RSW | 12 hour pm/nocte shift | x | x | x | x | o | o | o | RSW | | | 0.00 | 72072.00 |
| | | | | | | | | | | | Kaumatua | | | 0.00 | 8750.00 |
| | | | | | xs | | os | | | | AL | | | 30747.20 | 19947.20 |
| | | | | | | $24,000 | | | | | | | | 285547.20 | |
| 0.4 | 0.4 | | | RN | 0.4 FTE @ 60K | | | | | | | | | | 172841.20 |
| | | | | | | $58,000 | 0.4 | $21,600 | | | | | | **$23,795.60** | |
| | 1.4 | | | RN | 1 FTE @ 58K | | FTE | .00 | | | | | | | **$14,403.43** |
| | 1.4 | | | RN | 1 FTE @ 54K | $54,000 | 0.4 FTE | $21,600.00 | | | | | | 62% | 38% |
| | | | | | | $54,000 | 0.4 | $21,600 | | | | | | $38,199.03 | |
| 4.2 | 1.4 | | | RN | 1 FTE @ 54K | | FTE | .00 | | | | | | | Checked |
| | | | | | | $41,184 | 0.9 | $30,888 | | | | | | | |
| | 2.1 | | | RSW | 1.2 FTE @ 39K | | FTE | .00 | | | | | | | |
| | | | | | | $41,184 | 0.9 | $30,888 | | | | | | | |
| 4.2 | 2.1 | | | RSW | 1.2 FTE @ 39K | | FTE | .00 | $144,144 | | | | | | |
| 8.4 | | | | | | | | | | | | | | | |
| | | | | | | | | $126,576.00 | **$398,944.00** | | PER ANNUM | | | | |
| | | | | Approximate Staff Cost | | $272,368 | plus | | | | | | | | |
| | | | | Annual Leave/Sick Leave/Allowances | | | | approx | $50,694.40 | | 10% of above figure | | | | plus 0.2 FTE TDHB general overspend |
| | | | | Occupational Therapist input (0.5 FTE) | | | | approx | $0.00 | | nil at this point | | | | |
| | | | | RN On Call (equivalent to 0.2 FTE - 8 hours per week) | | | | approx | $0.00 | | | | | | |

| | | | |
|---|---|---|---|
| | x | | |
| Kaumatua Support (equivalent to 0.25 FTE) | appro x | $8,750.00 | |
| | | $458,388.40 | |
| | | **$38,199.03** | PER MONTH |

# Waikato DHB – Mental Health Concept and Cost Estimates

06-Jun-07

**SCR Project**

## Indicative Time Programme and Cash Flow to Implement

**Scope:**

| | |
|---|---|
| | Reconfigure 4 wards 30,31,32, 33 of |
| a | HBC |
| b | Construct a Whare nui within the existing precinct of HBC |
| c | Re-design the Front Entry of HBC (west side) |
| d | Construct a Recreation/Activity Centre within the existing precinct of HBC |
| e | Refurbish a building to house 5 step down patients - existing Day Centre |
| f | Fit-out part existing Cancer Lodge as an 11 unit Older Persons Inpatient Unit |
| g | Construct where appropriate, new courtyards and enclosures |

**The Draft Master Programme indicates the following key time lines**

| | From | To |
|---|---|---|
| ***Project Start Up*** | | |
| Unreserved acceptance by NCC | 12th June 2007 | |
| Site Master Planning | Complete | |
| Cancer Lodge Purchase | 01-Jun-07 | 01-Sep-07 |
| Identify decant location for Day Clinic | 01-Jun-07 | 01-Sep-07 |
| ***Design to be completed by*** | | |
| Concept | Completed | |
| Older Persons ex Cancer Lodge | 9th September 2007 | |
| Step Down ex Day Clinic | 9th September 2007 | |
| Whare nui | 2nd December 2007 | |
| Recreation Centre | 2nd December 2007 | |
| Henry Bennett Front Entry | 2nd December 2007 | |
| Ward Re-configuration & Courtyards | 2nd December 2007 | |
| ***Procurement*** | Various | |
| ***Construction*** | | |
| Older Persons ex Cancer Lodge | 15-Nov-07 | 01-Apr-08 |
| Step Down ex Day Clinic | 15-Nov-07 | 15-Jan-08 |
| Whare nui | 01-Apr-08 | 01-Oct-08 |
| Recreation Centre | 01-Apr-08 | 01-Oct-08 |
| Henry Bennett Front Entry | 01-Apr-08 | 01-Oct-08 |
| Ward Re-configuration & Courtyards | 01-Apr-08 | 01-Apr-09 |

**Cash Flow indications based on the above**

| | | |
|---|---|---|
| 2006 / 07 | $ | 200,000 |
| 2007 / 08 | $ | 2,736,685 |
| 2008 / 09 | $ | 3,722,645 |
| **TOTAL** | **$** | **6,659,330** |