

**Counties Manukau  
District Health Board**

**Mental Health and Addictions Services  
Health Services Plan**

**February 2008**

## 1.0 Current Services

Mental Illness accounts for 15% of the total burden of disease in the developed world, with depression set to become the second leading cause of disability in the world (similar to ischemic heart disease and COPD) by 2020. In New Zealand, at any one time an estimated 20% of the population have a mental illness and/or addiction and 3% are severely affected.<sup>1</sup>

The 2026 CMDHB mental health continuum of care framework is consistent with the strategic direction of CMDHB, international best practice and an acknowledgement at a national level that the way in which acute mental health services are currently delivered may not be the way forward for contemporary mental health services in New Zealand. It also recognises that for people to recover from mental illness or addiction, they need high quality, responsive primary care and mental health and addictions services and, most importantly, family, friends, work, housing, valued roles within society, and all the other aspects of life that are taken for granted by people without mental illness.

The framework responds to the challenges of the financial and workforce implications of current models of mental health and addictions services delivery, recognising that they will be ineffective in meeting the demands of the future population of Counties Manukau. This applies particularly to services for people whose mental health is deteriorating, or who are acutely unwell.<sup>2</sup>

Whilst acknowledging the need to deliver responsive specialist mental health and addictions services, the model recognises that a growing proportion of people experiencing mental health or addiction problems can receive the majority of their care in primary health and other community settings, with specialist secondary input for some more severe disorders. As we get better and quicker at responding to clients whose mental health is deteriorating or use of substances is increasing, the greater our chance of averting further deterioration, enabling recovery and hence minimising the subsequent care requirements.

The 2026 CMDHB Model of Care reflects and confirms a consistent progression towards providing the majority of mental health services in a wide range of community settings and in a way that is usually integrated with other healthcare delivery. This builds on a foundation of extensive development work and investment by the CMDHB Mental Health and Addictions Service Development Team and Planning and Funding approaches. These teams have been working hard to support the mental health and addictions sector to face our current reality and to involve everyone in designing new and improved services. Robust purchasing and support for service development within the mental health sector, and in wider intersectoral initiatives, has already resulted in the development of a substantial range of community services within Counties Manukau, including those provided by NGOs, by CMDHB and by/in partnership with other Government Departments/Agencies.

The direction of the future Mental Health and Addictions (MH&A) Model of Care for CMDHB is shaped by the following:

- Supporting Healthy Communities and other population health strategies that reduce the incidence and prevalence of mental health problems and substance misuse
- A whole of society approach to mental health and wellbeing
- Supported self/whanau care for people, regardless of setting
- Services provided mostly in natural community settings with many services operating across boundaries to support seamless service delivery
- Reduced boundaries between primary care practitioners and specialist mental health and addictions staff, facilitated by MH&A Specialist Staff working in Primary and Community Health Centres
- Some co-location of MH&A services with other specialist services (e.g. maternity services, youth

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<sup>1</sup> Te Kokiri: The Mental Health and Addiction Action Plan 2006-2015

<sup>2</sup> Acute Crisis: Towards a recovery plan for acute mental health services. Mental Health Commission 2006

- centres)
- Intensive and acute care available in the community settings, as well as the option of a brief acute hospital stay for acutely mentally unwell people for whom inpatient hospital care is the most appropriate therapeutic milieu

Whilst it is anticipated that the demand for acute mental health services will continue, the pattern of acute service utilisation will change as community based services, including acute alternatives to hospital based care such as home based treatment and respite care start to impact upon the length of stay and patterns of acute admissions.

## 2.0 Key Issues

Key influencing factors on future CMDHB MH&A development are:

### Policy Alignment

Recent NZ governments have identified Mental Health is a priority area for health outcome improvements and this has been supported by substantial targeted investment in the mental health sector through 'Blueprint' funding.

DHBs have been given specific responsibilities to achieve identified mental health outcomes in the next ten years.<sup>3</sup>

A national policy framework reflects a broadening policy interest in the mental health and wellbeing of all New Zealanders, whilst continuing the emphasis on ensuring that those people severely affected by mental illness can effectively access specialist services.

Te Tāhuhu<sup>4</sup> sets out the key challenges for the mental health and addictions sector for the next decade with a focus on improving whanau ora, recovery and wellness for people, families, whanau and communities affected by mental illness and addictions.

These key challenges are:

- Promotion and prevention
- Building mental health services
- Responsiveness
- Workforce and culture for recovery
- Maaori mental health
- Primary healthcare
- Addiction
- Funding mechanisms for recovery
- Transparency and trust
- Working together

Mental health is the number one health concern for Maaori, and successive governments policy and strategy documents challenge all health agencies and organisations, including DHBs, to work in a way that supports improving the mental health status of Maaori and Maaori whanau.

## 3.0 Trends and Future Directions

Since the closure of the large psychiatric hospitals in the late 1980s and early 1990s a New Zealand

<sup>3</sup> Te Kokiri: The Mental Health and Addiction Action Plan 2006-2015

<sup>4</sup> Te Tāhuhu: Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan

model of mental health and addictions care has been evolving. While the focus was on providing more mental health services in the community, no clear model was being followed. In the mid to late 1990s and consistent with wider international best practice models, a recovery-oriented approach began to gain traction within mental health and this focus on 'recovery'<sup>5</sup> has been the key philosophical driver of service development in New Zealand since that time.

- International and national studies and reviews have shown inpatient mental health units to be 'non-therapeutic' and contribute less to recovery than comparable services in the home and community, even for acutely unwell people.
- Recovery cannot take place in environments where people are isolated from their communities, where they are not given choices in their treatment, or they are not expected to get better.
- There is a growing availability of and demand for new, more complex and more effective pharmacological treatments.
- Respectful and trusting relationships between service users and their mental health or addictions workers, play a critical role in improving service effectiveness.
- There is emerging evidence regarding the importance of trauma-informed care to support recovery for the high percentage of people with mental illnesses who also have a history of trauma.

Given that the plan has a 20 year time frame, what is considered best practice today is likely to evolve and change over the coming years.

### **Changes in the Mental Health and Addictions Sector**

- New Zealand has committed to a community development approach to MH&A service development.
- Purchasing mental health and addictions services from community agencies that are Non Government Organisations is now a significant feature of the New Zealand mental health sector. In 2004 they utilised approximately 28% of the national mental health expenditure and in 2005 there were 365 NGOs delivering publicly funding mental health and addiction services.<sup>6</sup> Ongoing investment in NGO sector has been steadily increasing since that time. These agencies undertake varied activities in a wide range of situations often under contract to many different Government departments.
- Trends are towards further integration of the MH&A sector with other health services and wider social agencies etc.
- Active participation by Maaori in the planning and delivery of mental health and addictions services is incorporation of Maaori models of health and Maaori measures of health outcomes into the sector.
- The most significant cultural change to occur within the sector has been the growth of the service user movement which has been the principle driver of the recovery approach. Service user participation in the planning and delivery of mental health care and treatment is now a formal requirement of all New Zealand mental health and addictions services.
- Better informed service users (and family/whanau) of mental health and addictions services through increased access to information.
- There has been increasing demand from people who through misusing psychoactive drugs, exacerbate an existing mental illness, or develop a mental illness.
- Early intervention strategies are evolving through closer integration with personal health services.

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<sup>5</sup> The four key philosophies that enable recovery are: Autonomy/Self determination/Empowerment/Choice

<sup>6</sup> 2005 Landscape Survey undertaken by Platform

## 2.1 CMDHB Environmental Characteristics – Mental Health and Addictions

### Access to Services

Mental illness and addictions will affect more than 20% of adults and 10-15% of young people in any one year. In 2005 CMDHB overall access rates to adult mental health services was 2.19% of the adult population. This is approximately 83% of the rates being achieved across the rest of NZ, and below the national access target of 3%. Improving access to mental health care is one of the key strategies for CMDHB.

### Population Growth

**Table 1 Projected CM population from 2001 to 2026, by age group<sup>7</sup>**

	Year *						% change 2001-2026
	2001	2006	2011	2015	2021	2026	
15-44	174,400	191,110	198,230	207,380	219,700	231,800	33%
45-64	81,040	96,010	112,110	124,670	134,940	141,010	74%
65+	33,790	40,680	49,980	62,890	76,160	91,970	172%
Total	393,700	440,600	477,800	515,200	552,600	590,300	50%

As well as the substantial overall population growth in Counties Manukau there are a number of demographic factors that are anticipated to impact on the number of people experiencing mental disorders and substance misuse, and the demand for mental health and addictions services by 2026.

These are:

- A high current child and youth population moving into the adult age range.
- The high proportion of deprived people in CMDHB relative to other NZ DHB's.
- The diverse and changing ethnic population of Counties Manukau.

There is recognition at a national level that defined population groups within New Zealand experience significant health inequalities, based on their socioeconomic position and ethnic identity.

### Geographical Distribution

Changes in the shape of the geographical distribution of the CMDHB population are less significant, however much of the current mental health and addictions service need and development is centred on the more densely populated urban areas such as Mangere, Otara and Clendon.

Future service development must have the capacity and increased flexibility to meet the significant population growth in the Flatbush area. It must also respond to the steady pace of ongoing growth in existing services areas and increase the accessibility of mental health services to people in the southern and more rural areas of the Counties Manukau catchment area.

### Social Deprivation

The large proportion of deprived people in Counties Manukau relative to NZ as a whole is important as

<sup>7</sup> 2006-2026 SNZ data projected from 2001 Census-medium growth scenario, SNZ 2005

there is a strong association between socioeconomic factors such as low household income or area deprivation, and increased prevalence of mental illness, duration of illness, higher admission rates and longer admission durations.

Maaori and Pacific people are more likely to live in areas of high deprivation. Fifty eight percent of all Maaori in Counties Manukau and 78 percent of Pacific people live in decile 9 and 10 areas. This compares with European (17%) and Asian (22%).

Approximately 63% of the Counties Manukau population in contact with mental health services come from deprived areas as compared with 45% of the total Counties Manukau population. The more northern areas of the CMDHB catchment area in particular are identified as areas of high deprivation.

Indications are that socioeconomic factors are an important consideration as potential barriers to seeking help, prolonging the course of illness and impeding the effective coordination of service delivery. Schizophrenia in particular shows a strong association with deprivation.

Broad-based, intersectorial strategies are required within Counties Manukau to mitigate and change factors such as income, education, employment and housing for the population at risk of developing a mental illness. These need to be augmented by specific initiatives to improve access and early intervention for people developing a mental illness or addiction problem and there need to be mechanisms in place to address existing levels of need for those people already experiencing mental illness, and minimise their reliance on clinical services, support and interventions.

### Diverse Ethnic Composition

Counties Manukau has the most ethnically diverse population in New Zealand with Maaori accounting for 17% of the population, Pacific 21%, Asian 15% and European/Other 47%. However, this makeup will change over time, with growth in Asian and Pacific populations predicted to be much greater than for other ethnic groups.

Table 2 : CMDHB population forecast by ethnicity (2001-2026)<sup>8</sup>

	2001	2006	2011	2016	2021	2026	% increase 2001-2026
Maaori	69,230	76,010	82,640	89,700	96,600	104,300	52%
Pacific	78,550	90,410	102,100	114,470	127,790	142,290	81%
Asian	47,700	73,700	88,300	100,600	113,000	125,000	162%
Other	198,230	203,050	211,040	213,930	215,670	216,140	9%
<b>Total</b>	<b>393,710</b>	<b>443,170</b>	<b>484,040</b>	<b>518,700</b>	<b>553,780</b>	<b>59,000</b>	<b>50%</b>

Maaori and Pacific peoples experience both poorer health outcomes generally and specifically in relation to mental illness and addictions. They are more likely to experience severe mental illness and/or addiction and tend to access services at a later stage in the progression of their illness and with more severe symptoms than other population groups. *Te Rau Hinengaro* (2006)<sup>9</sup> reports the prevalence of mental illness for Maaori 29.5% and Pacific people 24.4%, whilst other ethnic groups experience a prevalence of 19.3%. Within Counties Manukau DHB, a high user group (accounting for 71% of all current inpatient bed days) has been identified. Maaori and Pacific people are over-represented within this group (28% and 22% of high users respectively). This over-representation is consistent with the *Te Rau Hinengaro* prevalence findings.

<sup>8</sup> 2006-2026 SNZ data projected from 2001 Census-medium growth scenario, SNZ 2005

<sup>9</sup> *Te Rau Hinengaro* The New Zealand Mental health Survey, 2006, Ministry of Health

## **Maaori**

There are indications that Maaori are twice as likely to require a mental health service as the general population. Recent research indicates Maaori are over represented in the moderate and severe dimension of experiences of mental illness, are more likely to have co-morbid conditions than non-Maaori, and they also tend to access services in the later stages of illness.

In 2006, 48% of the Maaori population in Counties Manukau was under the age of 15. This current cohort of young Maaori will make up a significant component of the growth in the adult age ranges over the next 20 years.

There has been significant progress nationally in the development of strategies and service models for Maaori and within Counties Manukau there are effective kaupapa Maaori clinical and NGO services already established in both the mental health and the addiction sector. These kaupapa Maaori models have already demonstrated the success of the service delivery style in engaging and sustaining effective care and treatment for Counties Manukau Maaori.

Future kaupapa Maaori service developments need to build on these successes, whilst mainstream service models also need to develop a workforce and service styles that can engage with and respond more effectively to the particular needs of Maaori whanau. All MH&A services for Maaori need to integrate and coordinate their service delivery more effectively with other providers in the wider health sector and also with agencies/services in the wider Counties Manukau communities, including iwi and marae based services. All need to engage with Maaori earlier in the course of any MH&A problems, develop interventions that are responsive to whanau needs and demonstrate better longer term outcomes for Counties Manukau Maaori, such as reducing hospitalisation rates and LOS.

## **Pacific**

The diverse Pacific population make up over 20 percent of the total population of Counties Manukau and currently almost half are under 20 years of age. It is projected that the Pacific population will continue to be the largest ethnic group of concern and by 2006 will have increased by 80% from 2001 census figures, requiring significantly more overall inpatient and outpatient services than other ethnic groups.

Youth 2000 data shows that Pacific youth have double the rates of suicide attempts and higher rates of depression than Europeans. Stress and adjustment disorders are also common presentations for Pacific youth.

*Te Rau Hinengaro* indicates that the rate of Pacific people in New Zealand receiving treatment is 35% lower than the rate for the total New Zealand population. In 2005 they made up only 14% of the unique clients seen by CMDHB adult services whilst making up approximately 20% of the total Counties Manukau adult population.

Counties Manukau Pacific male presentations are high in the under 45 years age group and they are the cohort who have the longest length of stay (21.3 days in 2005) in inpatient beds.

MH&A service delivery models for Pacific people within Counties Manukau (e.g. Faleola Clinical Team of CMDHB and Pacific NGO support services) are becoming established within the Pacific communities where their focus is on building strong liaison links within the various cultural networks and reducing the stigma and discrimination associated with mental illness and addiction problems. Extensive development is required to build services (and a workforce) that can operate within Pacific cultural models, or as mainstream services that are more acceptable to Pacific families, providing earlier and more effective interventions for the many Pacific communities in Counties Manukau.

## **Asian**

Between 2001 and 2026, Asian population growth forecasts are for growth of 162% by which time they

will make up 21% of the Counties Manukau population.

Asian people in Counties Manukau appear to have lower overall rates of mental disorders; however relevant data is currently limited. Issues of stigma and discrimination may be significant barriers to accessing mental health and addiction services, in many of Counties Manukau Asian communities.

Of Asians accessing CMDHB services, 44% were Indian and 24% Chinese. Unlike in most other ethnic groups, Asian female service users outnumbered males across most age groups.

Currently there are few services specifically for Asian people with MH&A problems. Some services have been established for specific groups (e.g. refugees and migrant communities) and are developing more understanding and expertise in the treatment of mental health problems e.g. Post Traumatic Stress Disorder, that are specific to these particular ethnic communities.

Currently there are specialist services (and individuals) emerging to respond to the specific needs of the various Asian communities. However over time, with the rapid growth in relative proportions of the Asian population, mainstream services will need to become more aligned and responsive to the specific needs of these communities.

### **Key Issues**

- *Significant growth in Asian and Pacific populations.*
- *High proportions of Maaori, Pacific and Asian in Counties Manukau necessitates Mental Health services being tailored to meeting the needs of the diverse ethnic communities.*
- *High proportion of deprived people in Counties Manukau drives the incidence of mental illness and substance misuse, prolongs the length of episodes of illness and substance misuse, and increases barriers to access and the effective use of mental health services.*
- *Maaori are over represented in the moderate and severe dimension of experiences of mental illness.*
- *Pacific peoples access rates for Mental Health services are lower and current services have more difficulty engaging with them in the provision of Mental Health services.*
- *Pacific people have high rates of severe mental health illness and longer average LOS in acute inpatient facilities.*
- *Limited expertise/models/integration of effective services for the diverse Asian communities.*

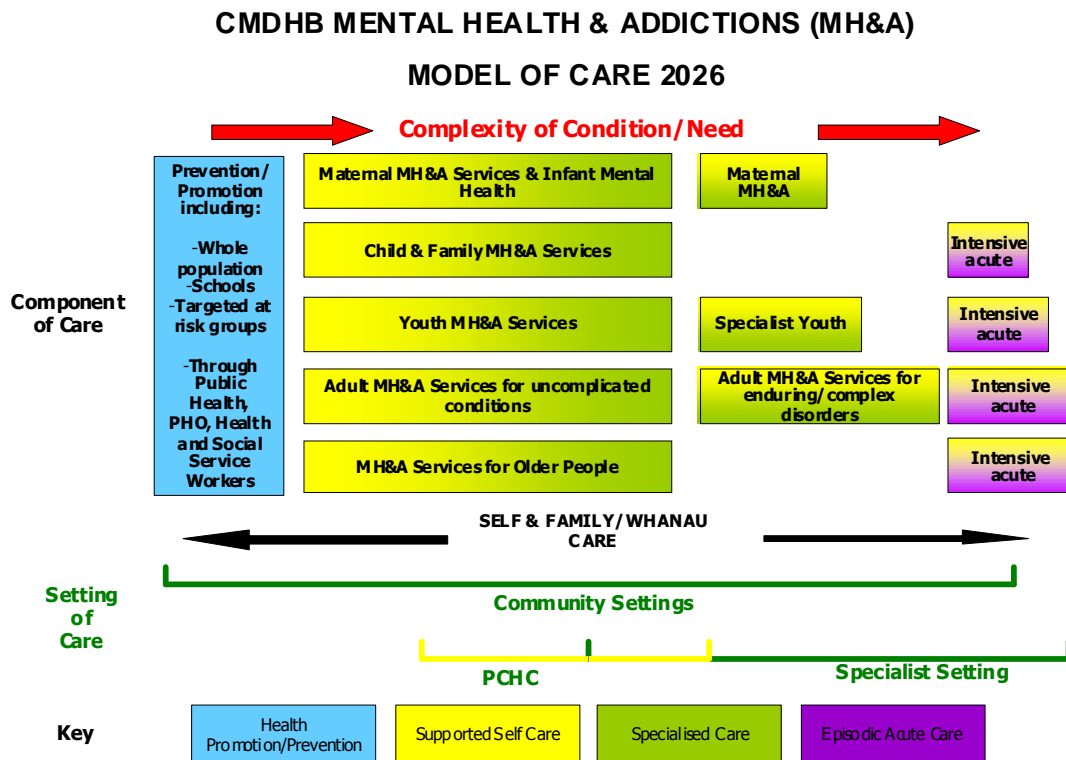
### **In response to these population trends, CMDHB will require:**

- *An intersectorial approach to support a reduction in deprivation and poor socioeconomic status that increases the risk and severity of mental illness.*
- *Improved access to an increased range of child and youth mental health services (including effective services to support carer-infant bonding in the first three years of life) to minimise flow-on effect into adult services.*
- *Capacity to respond with early intervention for adults.*
- *Service approaches that reflect impact of socioeconomic factors on rate/severity of mental illness.*
- *Services that reflect and respond to Counties Manukau's diverse cultural communities.*

### **The Future Model of Care**

The Model of Care for Mental Health and Addictions illustrates the application of a recovery orientation throughout the continuum and the shift in emphasis from service delivery in hospital and other specialist settings to services integrated into naturalised community settings and with other health services. This model itself, along with the quality of the services that are involved in implementing it, will be subject to continual review and redesign involving the whole mental health and addictions sector including people

who use the services and their families over the coming years. It is essential that the model continually improves and evolves. To facilitate this evolution, CMDHB will support the sector to develop a “Community of Learning” that can continually redesign our model of care.



## 4.0 Key Directions

The direction of the MH&A Model of Care for CMDHB is shaped by the following:

- ✓ *Supporting Healthy Communities and population health strategies that reduce the incidence and prevalence of Mental Health Conditions.*
- ✓ *A whole of society approach to mental health and wellbeing.*
- ✓ *Supported self/whanau care for people regardless of setting.*
- ✓ *Improved availability of information and education to support self/whanau care, and greater opportunity for people to exercise choice.*
- ✓ *Services provided mostly in natural community settings with many services operating across boundaries to support seamless service delivery.*
- ✓ *Reduced boundaries between primary care practitioners and specialist staff, facilitated by Mental Health and Addiction Specialist Staff working in Primary and Community Health Centres if these are established, but working closely with primary care from specialist settings if Primary and Community Health Centres are not established.*

- ✓ *Some co-location of Mental Health services with other specialist services (e.g. maternity, youth centres, general hospitals), with continued mental health clinical governance for all mental health services.*
- ✓ *Intensive and acute care and detoxification from substances available in community settings as well as hospital settings.*

#### **4.1 Health Promotion and Illness Prevention**

Good health and wellbeing is more than the absence of mental illness or addiction; it is vital to individuals, families and societies. Good health, well being and whanau ora are fundamental contributors to good mental health.<sup>10</sup>

The proposed model requires a shift in both strategies and resources towards prioritisation of mental health promotion for the community as a whole.

It is envisaged that whilst CMDHB may not be the service provider for health promotion activities it will need to actively ensure/promote the widespread development of healthy living skills within its community.

The home, school, marae, workplace and recreation spaces of Counties Manukau are all potential environments for ensuring that people develop the skills that contribute to better mental health outcomes, individually and as a community e.g. parenting and communication skills, drug and alcohol education, anger and stress management skills, destigmatisation and promotion of social inclusion for people with mental illnesses.

To achieve this, by 2026 there will be a wide range of activities that promote mental health and wellbeing, including:

- Community Education (for the population as a whole)
- Early intervention programmes for groups at moderate risk
- Targeted programmes for specific high risk groups

These programmes will include multi-agency initiatives, and will feature high levels of participation by NGO's, primary care, maternity services and well child services, as well as people/whanau who have experience of mental health and addiction issues. The initiatives will include nationally led initiatives with a local Counties Manukau component, and some locally developed initiatives and programmes with local community partners. Maaori and Pacific PHOs, marae/Iwi based services for Maaori, and Pacific NGOs (some as part of church communities) will have become significant as providers of prevention and promotion within a culturally relevant framework.

Expansion of new initiatives will be based on evidence of their effectiveness in reaching targeted population groups, increasing the mental wellbeing of the Counties Manukau population and minimising the incidence and impact of mental illness and addictions within the community.

#### **Key directions**

*CMDHB participate in, and where appropriate lead, local and national intersectorial programmes that:*

- ✓ *Promote an holistic approach to wellness, including increasing people's awareness of how to maintain mental health and wellbeing throughout different life stages*
- ✓ *Prevent and minimise substance misuse and addictions.*

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<sup>10</sup> Te Kokiri: The Mental Health and Addiction Action Plan 2006-2015

- ✓ *Provide information about those things that harm our own mental wellbeing and that of our families/whanau.*
- ✓ *Promote awareness of mental illness and the importance of social inclusion.*
- ✓ *Feature culturally relevant health promotion programmes that are shown to improve the mental health status of Maaori.*
- ✓ *feature culturally relevant health promotion programmes that improve the mental health status of the diverse ethnic populations of Counties Manukau.*

#### **4.2 Early Detection and Intervention**

CMDHB will develop and support local and national initiatives to raise community-wide awareness of the symptoms of mental illness and addictions, and to provide information about how to support friends or family who may be experiencing these symptoms. These programmes will be delivered via the media, in schools in workplaces and in training programmes such as those for the police and for staff of various agencies including healthcare providers. Our communities will demonstrate a high level of understanding and support for people experiencing mental health or substance misuse, and a high level of trust in local services including primary care and specialist mental health services.

People in recovery who have experience of mental illness or substance misuse will have assumed a lead role in raising awareness and providing a first point of contact for information and support, and will work within the community to assist people to recognise problems early on and connect with the services most relevant to their circumstances.

As a result of this, people will seek help much earlier than is the case in 2006. Primary health care practitioners, in a variety of community settings, will often be the first to identify and respond to early signs of mental health and addictions issues. Ongoing training, development and support from MH&A specialists integrated within primary care services and other specialist community health environments, will enable early detection and effective, safe management of mental health conditions. Where peoples' lives are temporarily disrupted by their condition, primary care providers will be able to authorize temporary support for day to day living. Being able to access a broad base of supports, at this early stage and in addition to clinical interventions, will prevent problems becoming more severe, enable people to be active participants in maintaining their own wellness and minimise the disruption to their daily lives.

By 2026, MH&A workers will have been some of the first specialist services to be integrated into the new primary health care services, and this will have proven very effective in reducing barriers for people presenting to primary care with MH&A issues. However, in areas/groups still serviced by smaller primary care practices e.g. rural areas and smaller ethnic communities, specialist MH&A teams may continue to operate separately while providing consultation liaison advice to these practices.

Whether co-located or not, primary care providers will be supported by accessible and responsive multidisciplinary specialist treatment services, including crisis resolution, based within the main population centres, in community based settings.

Specific holistic, culturally and clinically relevant early intervention programmes targeted at youth, in a range of community settings where young people in different communities (ethnic and other) gather, will still be a high priority within Counties Manukau. These initiatives rely heavily on the engagement of at risk groups through their peers and role models who have already experienced MH&A issues themselves.

People with severe mental illnesses will be able to access early intervention services that are mobile, have hours to suit people in school or working, are culturally enriching and clinically relevant, and that are excellent at engaging with people whatever their circumstances. These services will work as an integral part of primary healthcare services which will often have prior established links with the same people or

families. As a result of the early intervention services, the adverse impact of illnesses on peoples' lives will be significantly lessened and use of inpatient and residential care will be substantially lower than was the case for previous generations.

The efficacy of these approaches will have resulted in a gradual reduction in both the severity of presentations to CMDHB specialist services and in the subsequent impact on peoples' lives, particularly in the areas of depression and first episode psychosis. Pacific people and Asian people who are immigrants to New Zealand will be engaging with health services earlier on in the course of illness or addiction.

### **Key directions**

- ✓ *Building the capacity of all primary health care practitioners for early identification and intervention in mental illness.*
- ✓ *Specialist services integrated with primary health care providers to support timely and appropriate advice and safe intervention for mental health and addiction problems.*
- ✓ *A range of programmes that support Maaori, Pacific and Asian communities to present earlier with mental health and addiction problems.*
- ✓ *Clinical intervention combined with peer and other supports early in the onset of mental illness and addiction to prevent problems become more severe, wherever possible.*

### **4.3 Supported Self Care**

Supported self care is the foundation of recovery-oriented services for people with mental health and addiction problems. People who experience mental illness or addiction and their family and whanau need choices so they can access a range of timely, effective mental health services that respond to their specific needs and enable them to continue living meaningful and productive lives within their chosen community.

Information about self care will be much more freely available in pamphlets, DVDs and on the internet. People will have the option of attending educational programmes to assist them in recovery and maintaining wellness, in addition to education provided by the primary care provider or specialist mental health service.

Another option to assist people in developing their own recovery or wellness plan and driving their recovery will be the peer support specialist. People with lived experience of mental illness who are in recovery will have the option of training to become peer support specialists and to support others to achieve their own recovery. Peer support specialists will have been the most significant workforce group to increase within the MH&A sector and by 2026 will work actively alongside most primary care and specialist MH&A providers.

Mental health and addictions workers will be highly skilled in building trusting relationships and supporting people to steer and manage their own recovery.

As a result of these approaches, people with mental illnesses or addictions will play a significantly more active role in their own care and recovery from the time they first notice a problem. This will contribute to earlier resolution of mental health issues and substance misuse, fewer complications and less adverse impact on peoples' lives.

### **Key directions**

- ✓ *Increased availability of information to aid and support self care.*

- ✓ *Educational programmes to support self care and recovery.*
- ✓ *Peer support specialists to assist people to assume self care and take a leadership in their own recovery.*
- ✓ *Mental health and addictions workers who are well equipped to establish trusting relationships and support people to drive their own recovery.*
- ✓ *Promoting employment of service user peers within the clinical and NGO sector.*
- ✓ *Consumer/family/whanau networking and support: Initiatives that recognise the contributions that peer support can make to help people manage their own mental health issues and their impact on lifestyle choices.*
- ✓ *Improving the knowledge of the public, health consumers and the public of what is available to support people living in the community.*

#### **4.5 Specialist Mental Health**

Specialist Mental Health services will increasingly be provided in community based settings with hospital based care reserved for seriously ill patients where this is the most appropriate environment.

The assertive, early intervention for people with deteriorating mental ill health and the prevention of longer term disability will have reduced the number of people developing disabling mental illness and a high level of dependence on clinical services.

A model of integrated mental health and addiction service delivery with personal health services will be prevalent. The psychiatric liaison service at Middlemore Hospital and Kidz First will have been extended to also cover the Manukau campus services. This will ensure that people receiving hospital or other specialist interventions for medical, surgical or other physical health problems can also have mental health and addiction issues identified and dealt with as part of their overall care and treatment. Some services that have a significant number of people with MH&A issues e.g. Burns Unit and maternity services, youth health and health of older people will have MH&A specialists co-located with their treatment teams, both inpatient and within their specialist community teams.

MH&A specialists will be located/integrated in primary care facilities/teams serving defined geographical populations. This co-location will ensure that they are readily accessible to provide support to primary care clinicians e.g. GP's, Practice Nurses, Care Coordinators, and when combined with proactive involvement in team meetings and case discussions will enable primary care providers to identify and address MH&A needs within their population. Primary care teams will also include mental health workers.

The specialist mental health teams have a key role in the training and supervision of primary health practitioners in the identification/screening and management of early stage and uncomplicated addictions and mental disorders such as depression, anxiety, psychosis, eating disorders, effects of trauma and conditions associated with other major personal health problems and disabilities.

MH&A specialists will support primary practitioners to provide thorough initial assessments, with their assistance when required. Thorough assessment and identification of needs at this early stage will enable implementation of effective evidence based interventions including medication, therapy and wellness planning.

Treatments will focus on providing interventions and support for people to continuing living in their own

environment, wherever possible. Intersectorial initiatives and targeted community workforce planning will have seen the development of care coordinators within primary healthcare settings. These coordinators will have access to a wide range of community support services and agencies and will be able to support people, including those with MH&A problems to access childcare, emergency housing, financial supports etc in times of need.

For those with more complex disorders or where there are signs of these illnesses/addictions becoming more severe, MH&A specialists will be available to provide more specialised assessment, design individualised care plans and provide direct care. This includes interventions for crisis resolution (see Acute Care).

Effective consultation and liaison processes will ensure that specialists working with practitioners in the primary care environment have easy access to other MH&A specialist teams providing care to more specific population groups e.g. mothers with pre-existing mental illness, people with severe and complex disorders and Criminal Justice involvement, people with early psychosis, etc. These teams will be located in specialist centres, some specifically for MH&A issues but others in community based facilities that cater for youth, maternity needs etc.

Both evidence based and innovative treatment will be delivered in a way that is responsive to those being served and in a manner that is most likely to engage the service user and maintain that engagement for an appropriate length of time. For most people this will be a short, effective intervention from specialist MH&A clinicians. For others it may be appropriate to maintain longer term engagement with the service to ensure optimal treatment outcomes.

Whilst there will be a wide range of ethnic groups across the whole of Counties Manukau, some areas will have significant numbers of particular ethnicity e.g. Chinese community in Eastern Suburbs, Middle Eastern community in Otahuhu. It is an expectation that primary healthcare providers will both reflect the ethnic makeup of their community and deliver their healthcare in a manner that is culturally sensitive and wherever possible, appropriate. This will enable most MH&A interventions to be delivered safely to ethnic minorities with these mainstream services.

Maaori and Pacific PHOs will have developed a significant range of health related services within their communities. Their services address the mental health needs of their communities within their holistic cultural framework and MH&A specialist are integrated into and co-located with their broader, multidisciplinary teams.

There will also be specific cultural teams that are a mix of MH&A clinicians, cultural advisors and service users. These teams will be a resource for all the mental health specialists across Counties Manukau. They will often be utilised by mainstream services to support and advise in complex family/whanau situations where there are difficulties engaging with a service user and their family, particularly due to cultural issues. They will have strong liaison links with their specific cultural resources and will be active in ensuring that issues that impact on mental health in the community are addressed in intersectorial developments.

Important members of the specialist MH&A workforce are people who have lived experience of mental illness or addictions. All specialist MH&A services will have Peer Support Specialists appointed from the peer group of those people accessing the specialist service. The peer support specialists personal experience of illness or addiction and service will enable them to engage more readily with new service users, assist in their wellness planning and enable them to utilise the services available more effectively.

### **Key directions**

- ✓ *Increased coordination and integration between special mental health, addictions services and primary healthcare providers ensuring continuity and quality of care.*

- ✓ *Timely access to specialist mental health and addictions services that provide a range of evidence based approaches to care and therapies.*
- ✓ *Improving the knowledge of the public, health consumers and the public of what is available to support people living in the community.*
- ✓ *Most services provided in the community, all teams are multidisciplinary and include peer support specialists who assist people to live in communities and access services.*
- ✓ *Geographically based community specialist MH&A Teams providing support to MH&A specialist in primary healthcare settings and a range of specialist interventions including crisis intervention.*
- ✓ *The workforce in mainstream services reflects the ethnic balance of their community. Maaori and Pacific service users have access to specialised services that operate within their cultural frameworks.*
- ✓ *Sub specialist teams including Maaori and Pacific teams, maternal health, severe trauma complex psychosis, severe addictions. Some provide their service within a specific geographical area e.g. Mangere Pacific Youth Team, whilst others cover a wider geographical area.*

#### **4.4 Severe ongoing mental health and addiction problems**

In 2006, of the 3% of adults who experiencing severe mental illness or addictions each year approximately 20% had ongoing, severe and disabling mental illnesses or addictions. By 2026 it is anticipated that this percentage will have significantly decreased as a result of early intervention strategies combined with approaches aimed at supporting recovery.

Development and ongoing enhancement of the NGO sector, including the establishment of a consumer governed organisation will have been essential strategies for providing effective MH&A services to the people of Counties Manukau and reducing the size of the population of service users who experienced severe and disabling mental illness or addictions.

By 2026, people who continue to experience ongoing, severe and disabling illnesses or addictions will be those who do not engage well with health services of any sort. Therefore for many of the people in this group primary healthcare settings will not necessarily be the preferred option for the provision of ongoing care, treatment and service coordination. The aim is that these clients will eventually receive their care in a primary care setting. Good engagement with MH&A providers will be essential if people in this group are to achieve recovery.

In 2026 there will be mobile integrated MH&A services with a high level of flexibility to deliver services across CM, within the wider region and beyond and to be highly responsive in working with people to prevent relapses. These integrated teams will include peers, MH&A specialists and people providing a range of community living supports. In addition to those that are geographically specific, there will be some teams and centres that are culturally specific for Maaori and Pacific service users. Peers who have experience similar problems will be very helpful in assisting people in this group to regain control of their lives and prepare to manage their own futures.

These teams are likely to be based in several home-like settings close to the urban centres of Counties Manukau and have the capacity to allow for overnight stays when necessary, for short periods of time to prevent relapses. As a result of these centres, use of crisis, respite and inpatient care by people with disabling illnesses will have reduced.

For people in this group there will be strong linkages between a the MH&A team, the General Practitioner, the service user's own support network, other community resources and other agencies involved.

For people in this group who receive their care from a primary care setting, some NGOs will continue to be actively involved in the delivery of support services (e.g. housing, residential detoxification, employment, peer support, education programmes, advocacy, family support etc) where other agencies or the private sector have been unable to respond appropriately to the people with MH&A problems. However the main focus of NGOs will have shifted to become one of supporting people to access resources within the community and assistance in coordinating resources where necessary. NGOs will be active participants in intersectoral initiatives to ensure the needs of people with MH&A issues are met. As with DHB services, lived experience of mental illness or addictions will be valued when selecting staff and the workforce will increasingly reflect this.

Marae/Iwi based services and Kaupapa Maaori providers for Maaori, and Pacific NGOs (some as part of church communities) will have become significant as providers of support services within a culturally relevant framework. Their services will provide a lead in the provision of supports for family/whanau. NGOs will have mechanisms for financially compensating caregivers who have to take time of work to care for people with MH&A problems, and will provide additional home based support or short term respite for the service user, so that caregivers can take a break .

The presence of people with severe mental illness within the community and accessing community resources will have contributed to a significant reduction in stigma and discrimination within Counties Manukau which will now be seen as one of the most socially inclusive communities in New Zealand for people with mental illnesses.

As a result of reduced demand, the local NGOs will provide very few long term community based residential beds for adults, and these will tend to be used in the short term to address urgent housing needs while people are supported to find regular housing, and appropriate ongoing supports. The demand for a locked inpatient recovery-orientated environment will have dropped relative to the population size, and the LOS in Tamaki Oranga will have significantly reduced. The few people still requiring a secure environment will tend to be people who have disengaged from clinical services, exacerbated an underlying mental illness through the use of alcohol or drugs, may have involvement with the Criminal Justice System and need help to address a range of complex social issues. CMDHB will be re-visiting whether, with the right support from the regional forensic services, we could work toward a time where we no longer needed a locked inpatient rehabilitation service. Until such time as the demand for these services has been *proven* to no longer exist, CMDHB will need to retain Tamaki Oranga as a back-up option, as it is unlikely that alternative locations would be supported by the local Council should there be future further demand for these services.

### **Key directions**

- ✓ *People with severe and ongoing mental health and addiction problems are supported by their peers and a wide range of other workers who reflect the ethnic diversity of Counties Manukau.*
- ✓ *People with severe and ongoing mental health and addiction problems are supported to participate fully in the roles and responsibilities of community life.*
- ✓ *A wide range of initiatives that recognise, respond and support the specific needs of family and whanau of people with mental illness and addiction problems.*
- ✓ *Chronic mental illness is generally managed by specialist DHB and NGO services and primary services working in partnership with patients moving between specialist and primary based care in relation to their mental illness. Specialist mental health and addictions services promote the patient maintaining strong links with their General Practitioner to ensure that other health needs outside Mental Health are being met and to ensure continuity and quality of care.*

- ✓ *The role of NGO services within the Mental Health continuum of care increases and the emphasis shifts to enabling people to access community resources rather than direct provision of support.*
- ✓ *Specialist services support people to co-ordinate their health and social needs, ensuring community tenure and minimising acute inpatient episodes of care.*
- ✓ *Community workers include peer support specialists.*
- ✓ *Timely access to a range of evidence based approaches to care and therapies that are delivered within a culturally appropriate context.*

#### **4.6 Acute Care**

Acute care can be provided by Primary care (for less severe illness), by specialist services within the community, or by specialist services in a hospital setting.

##### **Crisis Response**

In 2026, there will be geographically based crisis services that ensure timely crisis resolution for people with immediate MH&A problems wherever they are located (in homes, police stations, primary care settings, in specialist settings e.g. Youth Centres, or at Middlemore Emergency Care).

The mobile MH&A clinical crisis teams will be supported by a range of acute care and treatment options to enable a range of responsive, flexible interventions aimed at crisis resolution, for people experiencing a MH&A related crisis.

The specialist staff will support the person and their family/whanau to get through their crisis by enabling access to a range of additional supports that will enable the person to keep themselves and others safe in the least restrictive environment possible. The intensity of crisis team input will depend on the person's environment, with the highest intensity being home based treatment (with multiple contacts in any one day). Wherever the person is located, additional pharmacological and/or brief psychological therapies will be used to support people to resolve their crisis and to make plans for their future, whilst also maintaining important relationships and contact with their usual healthcare providers.

##### **Community Options**

Community options that the crisis team can access will include crisis supports within the home at a day centre or a community based residential crisis support centre. Community based crisis support centres will be available in all high density areas of Counties Manukau. People living in the southern rural areas will have access to crisis support centre beds in two locations and will also be able to access the beds provided more centrally for specific cultural communities i.e. Maaori and Pacific.

Other residential alternatives for crisis resolution utilise youth emergency accommodation attached to youth centres that have a particularly strong health related focus. All residential crisis options will be provided by NGO or PHO providers.

The use of an acute inpatient facility is the least preferred option as a crisis resolution intervention.

##### **Inpatient Options**

Even with the comprehensive community crisis options described above, in 2026 there will continue to be times when an acute admission is required for people who may be engaging with services late in the course of their illness and who may have significant challenging behaviours that cannot be managed readily in other settings due to the risk of harm to self or others. To accommodate these needs, inpatient settings will need to have a Low Stimulus Area where people can be supported to deescalate when they

are feeling highly agitated.

It is difficult to predict changes to the inpatient model of care but it is likely that, for people with combined medical and mental health needs and those with complex conditions, inpatient care on a general hospital site is likely to continue to be the preferred option. For people without complex medical and mental health issues, alternative sites may be preferred.

On this basis, it will be necessary to have an acute inpatient unit on Middlemore site, with ready access to emergency, medical and other services for people who are mentally acutely unwell and may also have significant coexisting physical health issues (e.g. diabetes, respiratory conditions) that will need to be taken into consideration during their inpatient care and treatment.

In 2026, the community based integrated model of care will extend into the acute inpatient unit, with community clinicians taking a lead role in the delivery of inpatient care and treatment, and with peer support specialists assisting the person to formulate plans that will enable them to be discharged to an alternative, more appropriate setting as soon as possible. With continued pharmacological advances and community developments, stays within the inpatient unit are likely to be briefer than is currently the case.

The model of care provides for psychological, pharmacological and behavioural interventions to be delivered with a recovery orientation.

Specific client pathways will be in place to respond to the specific needs of Maori, with kaumatua and kuia on site and able to support Whanau Ora, for tangata whaiora and their whanau throughout an inpatient stay. Similar culturally specific pathways and supports will also be available to Pacific and Asian service users. These cultural supports will be available throughout admission and ensure culturally safe practices, particularly around food, physical contact and in the event of a death.

Although changes to the overall model of care are expected to reduce the need for acute inpatient care, it is not yet known the degree to which this will offset population growth.

In the event that the new model of care is not implemented (e.g. community options are not acceptable to the local community) or these strategies are insufficient to fully offset demographic growth, additional acute inpatient beds will be required. In 2001, the number of beds increased from 45 to 50 and even after the increase CMDHB had one of the lowest levels of acute beds in New Zealand. In 2006/07, CMDHB continues with only 50 acute inpatient beds for adults, and this remains one of the lowest levels in the country.

The maximum requirement for acute inpatient beds, based on projected population growth for adults, would be equivalent to 87 beds in 2026.

Only one wing of the current building on Middlemore Hospital site can realistically be modified to support the proposed more integrated model of care. For this reason CMDHB plans to reduce the number of inpatient beds on the acute hospital site to 20, with these beds being provided from an upgraded facility that better supports the integrated model of care. An additional inpatient unit (60 beds) will be built on the Manukau campus to provide a facility specifically designed to support the integrated model of care. This environment allows for greater flexibility in service options including usual primary care or specialist service providers being able to take the lead role in care and treatment during an inpatient episode and for partial hospitalisation options that retain strong connections with community based supports.

#### **Key Advantages of this Model:**

- Both facilities have access to medical services, if required e.g. life preserving, ECT.
- Both facilities are small enough to provide individualised recovery oriented environment and treatment.
- Opportunity for some resource sharing.
- Enhances relationship/integration with general health services.

- Provides alternative options for inpatient care, dependant on an individuals needs, including their risk management.
- Opportunities for further expansion or reduction of beds, if required.
- Increases accessibility.
- Philosophically aligned with international trend to smaller environments.

### Key directions

- ✓ *Responsive 24 hour crisis services with increasing range of community based options for people whose mental health is deteriorating including Home Based Treatment, respite options and community based crisis support centres.*
- ✓ *Increasing availability of emergency housing and other social supports for people who present at Emergency Department, or other primary and secondary services in social crises or when they are intoxicated.*
- ✓ *Integrated model of care extends into acute inpatient facility and community clinicians take a leading role in inpatient care and treatment.*
- ✓ *Two facilities (one on Middlemore Hospital and one on Manukau) aligned and integrated with community MH teams.*
- ✓ *Geographically aligned wards with their own Low Stimulus Areas.*
- ✓ *Peer support specialists to support a person through their inpatient experience.*
- ✓ *Culturally supports and sensitive cultural practices.*

### 4.7 Integration

Key assumptions for Mental Health services in addition to those in the core HSP Planning Principles, Assumptions and Enablers are:

- A strong focus of MH&A services is the continued development of community based services and intersectoral collaboratives to reduce the utilisation of inpatient hospital facilities.
- Expansion of community based services and facilities, including Community Mental Health Clinics and the use of PCHC's will be a key strategy to improve access through the development of local community based services.
- Purchasing MH&A services from the NGO sector will continue to be a significant feature of the New Zealand health environment.<sup>11</sup> Ongoing investment in NGO sector has continued increasing steadily since that time. These agencies undertake varied activities in a wide range of situations often under contract to many different Government departments.

In order to develop an overall picture of performance and service quality within this increasingly complex environment, and to enable lower level benchmarking between and within organisations, reporting mechanisms will need to be a mixture of inputs, processes, outputs and outcomes.

The early emphasis in the MH&A sector has been on resource monitoring using indicators developed to monitor the change and growth in services brought about by the Blueprint (1998)<sup>12</sup>.

The Ministry of Health's intention is to bring together all the performance, quality and information developments and to utilise a systemic approach with a coherent framework for the future. This work in

<sup>11</sup> In 2004 they utilised approximately 28% of the national mental health expenditure and in 2005 there were 365 NGOs delivering publicly funding mental health and addiction services NgOIT 2005 Landscape Survey by Platform

<sup>12</sup> Blueprint for Mental Health Services in New Zealand, 1998, Mental Health Commission

the area of performance and quality monitoring in the MH&A sector will be influenced by developments in the areas of:

- Greater information sharing between services
- Improved data quality
- Improved dissemination and use of information
- Advances in outcome measurement and reporting
- Introduction of a New Zealand casemix classification for mental health and addiction services

The Proposed KPI Framework for New Zealand Mental Health and Addiction Services<sup>13</sup> is one of a number of national initiatives currently underway in the MH&A sector. These initiatives will link with information processes and everyday clinical activities to improve the relevance and validity of locally collected data. This information will be made available to clinicians, operational managers and service planners and will have the potential to be used to inform benchmarking processes and policy developments at local, regional and national levels.

CMDHB is currently in the process of implementing HCC, an electronic clinical record system that is being developed and implemented regionally, providing a springboard for future clinical information sharing within and the MH&A sector and beyond.

#### **4.8 Workforce**

The provision of high quality mental health services within Counties Manukau, depends on the recruitment and retention of a diverse workforce able to deliver the type and volume of services required in the sector. Significant growth is indicated in CMDHB's mental health workforce to keep pace with the demands of local population growth and aging.

In 2005 the New Zealand government released *Tauawhitia te Wero: Embracing the Challenge*, the national mental health workforce development plan. The document outlines a framework of five strategic imperatives necessary for a systemic response to address issues of supply and demand as well as workforce skill and mix.

Over the medium term, the focus of mental health's workforce development, is to implement DHB requirements signalled in the national plan emphasising sustainable development across the local sector (mental health provider arm and non-government organisations).

The provision of high quality services within Counties Manukau requires the recruitment and retention of a diverse workforce that can deliver effective, recovery oriented services for Maaori, Pacific peoples, Asian peoples, children and young people, older people and people with addictions.

Indications are that growth in the CMDHB mental health workforce numbers will not keep pace with the demands of population growth and ageing, utilising current workforce skill and mix profiles.

Current issues with general workforce shortages and workforce diversity are likely to be exacerbated by:

- An aging workforce
- Difficulties in attracting the younger generations into careers in health or mental health
- Ongoing under-representation of Maaori and Pacific peoples in the mental health workforce, particularly in the clinically trained workforce.
- Persistent skill shortages in specialist areas e.g. child and youth.

#### **Other significant issues are:**

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<sup>13</sup> 'Report on The Proposed KPI Framework for New Zealand Mental Health and Addiction Services' March 2007

- Highly regulated industrial relations environment within the context of national multi-employer bargaining.
- Increasingly stringent requirements for health registered professionals.
- Growing gap with rapidly expanding non regulated workforce sector.

### **Workforce Development**

CMDHB workforce development strategies associated with a changed delivery environment will include:

- Competency development (knowledge, skills, values and attitudes) of current and potential workforce.
- Recognition of:
  - traditional MH clinical workforce
  - growing NGO sector
  - service users taking an increasing role in workforce
  - providers of other clinical services at the expanding interface
  - e.g. primary care
- Recruitment and retention e.g. parity in pay and conditions (particularly training and development opportunities) with DHBs.
- Preparing current workforce for working in a changed delivery environment.
- Infrastructure capacity to support workforce diversity within changed delivery environment.

### **Quality Improvement**

## Appendix One: Acute Inpatient Options

<b>Option One : All Adult Acute Services at Tiaho Mai</b>			
<b>Inpatient</b>	<b>Advantages</b>	<b>Disadvantages</b>	<b>Comments</b>
Development of all inpatient services on site at MMH with potential expansion of current unit to 80 beds by 2026	<p>Major advantage is economies of scale for the workforce (operational and financial). This could be of some advantage with anticipated ongoing workforce shortages.</p> <p>Infrastructure and support functions relevant to Mental Health services are on the MMH site and part of larger infrastructure services able to be provided economically on a large site</p> <p>Planned development provides the opportunity to increase capacity while staging redevelopment of the existing facility.</p> <p>Offsite relocation of MHSOP or Rehabilitation Services would make available areas for redevelopment into Mental Health offices/ support staff.</p> <p>Optimises ability to support Psychiatric Liaison Service to ED and medical wards within MMH.</p>	<p>Existing facilities need significant investment to meet modern standards of care.</p> <p>Current facility may have limited scope for significant increase of bed numbers.</p> <p>Impact on service delivery during development phases would be significant. Careful programming would be critical to maintain adequate bed numbers .</p> <p>Limited capacity of Middlemore site to support a highly integrated mental health service with significant numbers of community based staff who are also required to carry out work within inpatient facility.</p> <p>Tamaki Oranga would remain as a stand-alone unit at Bairds Road with increasing operating and capital challenges associated with infrastructure at the Bairds Road site.</p>	<p>Collocation and integration of mental health services with other health services is consistent with national policy direction.</p> <p>This would not support the initial organisational focus on reducing total hospital bed numbers on the MMH site.</p> <p>Does not support enhanced integration of mental health services within communities of focus.</p>

<b>Option Two : Relocation of Mental Health Services to Bairds Road</b>			
<b>Inpatient</b>	<b>Advantages</b>	<b>Disadvantages</b>	<b>Comments</b>
Development of inpatient Mental Health services on Bairds Road (site alongside Tamaki Oranga) following the relocation of the Spinal Unit to Manukau.	<p>Opportunity to create a dedicated Mental Health inpatient facility at Bairds Road with co-located secure adult rehabilitation facility.</p> <p>Tiaho Mai would become available for other purposes or demolition</p>	<p>Duplicated and extensive infrastructure would need to be developed particularly in relation to security and parking</p> <p>Bairds Road would need to provide ECT facilities with additional capital required and associated operational inefficiencies of splitting ECT across both the Manukau and MMH sites</p> <p>Timely access to emergency medical services response would be difficult to achieve.</p>	<p>Need to confirm that there are no resource consent issues</p> <p>Models of developing stand-alone Mental Health facility are inconsistent with national and</p>

		<p>Full inpatient bed capacity would need to be developed (80 beds by 2026) rather than only the additional beds (50 to 80). This would increase significantly the capital investment required.</p> <p>An enhanced psychiatric liaison service would be required to support EC presentations to MMH, medical and surgical services on both MMH and Manukau sites.</p> <p>Currently Mental Health Management and large numbers of clinicians are located on MMH site. If these staff remain in their current accommodation they would be disconnected from any part of the Mental Health service delivery system which would be highly undesirable. Extensive capital (buildings and parking) would be required to relocate these staff to Bairds Road.</p>	international mental health service delivery trends.
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<b>Option Three : All Acute Mental Health Inpatient services located at Manukau</b>			
<b>Inpatient</b>	<b>Advantages</b>	<b>Disadvantages</b>	<b>Comments</b>
Development of inpatient Mental Health services on the Manukau site.	<p>Opportunity to create a modern dedicated Mental Health inpatient facility.</p> <p>Economies of scale for the workforce (operational and financial). This could be of some advantage with anticipated ongoing workforce shortages.</p> <p>Co-location with relocated MHSOP would provide some operational efficiency.</p> <p>Access to Manukau theatres for ECT, with the infrastructure levels available at Manukau generally supporting Mental Health Services</p> <p>Improved access for community based clinicians.</p>	<p>Additional infrastructure development would be required at the Manukau site (parking, engineering services, hotel services) for a 80 bed service. These would be volume increases, rather than the development of new types of infrastructure.</p> <p>Full inpatient bed capacity would need to be developed (80 beds by 2026) rather than only the increased bed numbers required to expand Tiaho mai. This would increase significantly the capital investment required.</p> <p>Careful programming would be required to maintain adequate bed numbers during staged development.</p> <p>Currently Mental Health Management and support staff are based at MMH. If these staff remain in their current location they would be disconnected</p>	Tiaho Mai would become available for other purposes or demolition

		<p>from <i>any</i> part of the Mental Health service delivery system - highly undesirable. Further capital investment (buildings and parking) would be required to relocate them to Manukau or another community based facility.</p> <p>In the absence of on-site Acute Mental Health services at MMH, robust on-site services would need to be developed for patients presenting to EC requiring inpatient Mental Health assessment and/or admission to an Acute Mental Health bed.</p>	
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<b>Option Four : Acute Mental Health Inpatient Services split between Manukau and Taiho Mai</b>			
<b>Inpatient</b>	<b>Advantages</b>	<b>Disadvantages</b>	<b>Comments</b>
<p>Development of inpatient Mental Health Units at two sites. This would involve a remodelled and reduced size Taiho Mai at MMH and a new inpatient unit at Manukau site at a date in the future.</p>	<p>The development of 60 additional beds at Manukau (maintaining the 20 beds at MMH) would avoid the higher capital investment associated with building 80 new inpatient beds</p> <p>The size of both units would be consistent with optimal model of care for contemporary mental health services.</p> <p>This model would provided optimal support for an integrated model of care , with both sites having the capacity to accommodate visiting community staff .</p> <p>Two separate units would provide the opportunity to have different service focus at each unit eg Tiaho Mai may provide higher levels of containment.</p>	<p>Some inefficiencies associated with operating two inpatient units across two sites, particularly after hours.</p> <p>The geographical distance between the two sites is relatively small and offers minimal access advantage to clients. As Mental Health services are increasingly community based, Mental Health access issues are more appropriately focused on delivering community-based services in Community Mental Health Clinics, PCHC or domiciliary.</p>	<p>Commissioning of beds at the Manukau site could be scheduled in such a way as to reflect growth in demand when impact of new community based alternatives to acute inpatient admission has become clearer and more accurate predication of bed numbers is possible.</p>