

## **New Zealand Notes**

### **Introduction:**

In February and early March 2005 I attended the a meeting of the international initiative on mental health leadership (IIMHL) which consisted of a site visit to the Counties Manukau district health board (Auckland) and then an international meeting in Wellington involving clinicians, administrators and consumer leaders from New Zealand, Australia, England, Scotland and the US, as well as small delegation from Canada.

What follows are observations and reflections on the mental health services and the health care environment in New Zealand, recognizing that my reflections are limited by the relatively short time period I spent there. The visit did confirm Tom Peters' notion of management by wandering around, in that some of my observations would not be discernable by simply reading reports on New Zealand.

"Turn your face to the sun and the shadows will fall behind you." A Maori saying.

### **Health Care Reform**

In 2001 NZ restructured their health care system into 21 district health boards (DHB's), based on hospital catchment areas. Unlike the LHINS in Ontario DHB's are both purchaser and provider. In mental health, the provider side has a manager, as does the purchaser side of the DHB. DHB population size ranges from 40,000 to 400,000. The smaller DHB's are having problems providing a full range of services. As well there are regional services with the funding pooled among DHB's and one DHB takes the lead on managing a regional service, e.g. Forensic. The Ministry of Health funds and monitors DHB performance based on legislation, and the government still directly provides standards and the public health functions. The current model is fueled by population based funding which takes into account social inequities, and is seen to be an improvement over the previous model, which tried to introduce a competitive market mindset into the provision of health services. NZ faces similar challenges to Canada's of trying to contain hospital-spending growth, which is running at 7-8%, when health-funding growth is less than 2%.

The have just begun primary care reform and will be moving away from a fee for service model to a capitated model. This is seen as an opportunity to increase culturally competent services to the Maori and Pacific Islander populations and improve integration of mental health services. They are also moving to a disease management model for diabetes and other illnesses.

### **Mental Health Services**

Mental Health services have been expanding since 1998 with over \$400 million added to DHB budgets based on the 1998 Blueprint, which established priorities and service targets. A new national mental health plan will be released in June. Currently mental health funding is ring fenced (cannot be allocated to other areas of health spending) but there are concerns that ring fencing may end and some DHB's are trying to "jump the fence".

Mental health funding and DHB funding takes social deprivation into account. This has led to significant funding increases for the Counties Manukau DHB. Despite this, there is variation in the ability of DHB's to meet the mental health performance target of serving 3% of the population in a three-month period (3% represents the percentage of the population who experience serious mental illness). For example Counties Manukau is at .7%. The northern region of which they are a part should be serving 26,727 people, but now serves 16,524, a shortfall of 10,204.

Although they have increased funding, they are experiencing shortages of skilled staff in DHB managed services and some of their NGO are not able to meet Blueprint standards. There area also problems with fragmentation/ coordination of services. By 2010 the regional plan aims to reduce the FTE blueprint gap from 37% (2004) to less than 20% and implement agreed on clinical pathways and workforce development with the NGO sector.

Counties Manukau have used surpluses in year-to-year Blueprint funding to realign clinical programs and develop partnerships with the NGO sector in Auckland. They have taken a systems view and have funded a mental health development team to lead the change process in both hospital and community services. There is also leadership from clinicians (psychiatrists and other mental health clinical staff) who work closely with the mental health development team.

There is evidence of the shift to community focused mental health services. In 1971 New Zealand had 300 beds per 100,000 population. Across the country this has declined to 50/100,000. In Counties Manukau (one of four DHB's serving Auckland) the ratio is 29/100,000. They currently have 53 beds per 100,000 for rehabilitation and 5.6/100,000 forensic beds. Counties Manukau is starting to develop supportive 60 housing units and wrap around service packages in partnership with the NGO sector to move people out of rehab beds and reduce pressure on hospital beds. They are shifting services to more of a community focus. Out patient programs are being realigned as community mental health centers and coordinated with local NGO services. The DHB has two ACT teams and an early intervention program.

New Zealand has made progress meeting the mental health needs of Maori, who comprise 18 % of country's population. 58% of Maori are under 25. Maori are 2-3x more likely to enter mental health services through the justice system. In Counties Manukau there is a Maori service network in the NGO sector, a reference group of Maori service users and a Maori ACT team. There is a shortage of Maori mental health professionals, (there are only 3 Maori psychiatrists in NZ). As a result DHB services employ Maori cultural workers who work alongside clinical staff and provide cultural support. There is a separate Maori addictions service led by one of the other DHB's serving Auckland.

Counties Manukau has also started to develop mental health services targeting Pacific islanders who are a heterogeneous group. There are now more Pacific islanders in NZ than in some of the Pacific islands. 40% of their population is under 15. Counties Manukau has difficulty recruiting professionals from the Pacific islands staff, but has been able to recruit some nurses and social workers. They are also liaising with traditional healers. By 2030 it is estimated that Maori and Pacific islanders could comprise more than 40 % of the population in Auckland, so the development of culturally relevant mental health services will continue to require attention. Work is beginning on how to meet the needs of Asian immigrants to NZ.

### **The NGO Sector**

New Zealand has a vibrant NGO sector of 400 organizations that receive about 30% of mental health funding. They (the NGO's) would like to see this double. The NGO sector has developed in response to unmet community needs ("pills and pillows aren't sufficient"). The sector provides housing, employment and other community mental health services and includes Maori and consumer organizations. Some managers of NGO's are consumer leaders in the sector.

NGO's range from small to large, e.g. Pathways, which received \$30 million per year to provide community, support services across the country. Some NGO's have developed services for hard to serve clients such as DBT. Partnerships with hospital based services are starting to develop. The supportive housing (60 units) and wrap around service package projects (individualized funding) with the Counties Manukau DHB are examples.

While NGO's do hire mental health professionals, such as nurses, occupational therapists and social workers DHB providers see them as lacking clinical skills. Partnerships are beginning to change these perceptions and build trust.

Pathways has developed a client record system that meets the MOH reporting requirements and allows consumers to check their files on line. The DHB and NGO sectors have separate MIS and client record systems but this is beginning to change.

The consumer sector in NZ has a strong recovery focus and varying tolerance for treatment services. There is a strong push by consumers to end outpatient commitment, use of seclusion and increase the employment of consumers in mental health services.

There are a number of strong and well-known consumer leaders such as Mary O' Hagan of the NZ Mental Health Commission who publicly and privately prod the system to implement a recovery paradigm.

DHB's such as Counties Manukau have developed consumer advisory committees and created consumer staff positions to advise the management team, but performance has been variable. The DHB is now using consumer advisors to develop and carry out research/ evaluation projects and have a small health systems research unit that is measuring model fidelity and outcomes.

There is little evidence of strong family involvement at the system level, although family (wahanau) involvement figures prominently in Maori and Pacific islander services.

### **Reflections and Implications**

Mental health reform is a long-term process that requires managerial, clinical, consumer and family leadership and partnership between the institutional sector (hospitals) and the community sectors locally, (provincially) and nationally. It is important to find common ground across sectors in order to forge partnerships. Supporting the development of sector specific services and supports such as ethno specific services (Maori and Pacific islander services in NZ) and consumer led NGO's are also important features of a recovery focused mental health system.

Development of culturally competent mental health services in both mainstream and ethnoracial service organizations is critical and should receive funding attention from federal, provincial and territorial governments. The Maori experience developing mental health services in NZ can inform the development of services in aboriginal communities in Canada, and can also inform the development of services for immigrants and refugees.

Mental health reform will take at least a generation. Governments need to see this as a long-term project, and provide for policy leadership, funding enhancement and protection in order for change to occur. Population (needs) based funding that takes into account social deprivation should be used to develop services in addition to service funding based on national or provincial targets.

Targets and funding are critical to keeping the process moving. At the same time discord and problems in the system can create opportunities for change. Health authorities in Canada need to develop and fund local projects that encourage systems thinking, service realignment and partnerships with the community (NGO) sector, such as the Mental Health Development Team in Counties Manukau (Auckland)

Primary care reform creates opportunities to improve integration between mental health services and primary care.

Strategies to improve measurement of program and system performance and knowledge transfer (such as health systems research units at the DHB or Health authority) can support the change process.

Steve Lurie  
23-03-05