

Partnerships in Development: developments in mental health service provision in New Zealand. A case study

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Abstract

It is estimated that 46.6% of the population of New Zealand will experience some form of mental disease or disablement over their life time. (MOH, 2006 p.xix). Of these about 3% will have severe mental health conditions, and a further 5% will have moderate/severe needs. Services for those experiencing severe mental illness are delivered through varying patterns of partnership between District Health Boards (DHBs) (clinical care) and non-government organisations (NGOs) (community-based support services). The nature of these partnerships has changed considerably over the past twenty-five years, as paradigms of mental health care and provision, and conceptualisations of illness and recovery have also changed. Using our experience of one District Health Board (hereafter WDHB) as an illustrative case study, we trace key changes in partnership concepts from de-institutionalisation to the present day, and explore the implications of such changes for partnership relationships. This paper will trace some of the key changes in mental health provision in the light of these contextual changes, and explore the human resource development implications of our analysis on the dynamic relations amongst clinical providers, NGOs and consumers.

The case study briefly highlights steps taken in the past eighteen months to build partnership between clinical and community services, to strengthen the capacity and capability of the NGO sector, in order to redress in small part the imbalance of power between the statutory (clinical) and community support services, in order to overcome the fragmentation on services and to achieve a more systemic approach service integration, and the development of consumer-directed pathways towards recovery.

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It is estimated that 46.6% of the population of New Zealand will experience some form of mental disease or disablement over their life time (MOH, 2006 p xix). Of these about 3% will have severe mental health conditions, and a further 5% will have moderate/severe needs. Services for those experiencing severe mental illness are delivered through varying patterns of partnership between District Health Boards (DHBs) (clinical care) and non-government organisations (NGOs) (community-based support services). The nature of these partnerships

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has changed considerably over the past twenty-five years, as paradigms of mental health care and provision, and conceptualisations of illness and recovery have also changed. Using our experience of one District Health Board (hereafter WDHB) as an illustrative case study, we trace key changes in partnership concepts from de-institutionalisation to the present day, and explore the implications of such changes for partnership relationships. Across the board staffing shortages, internal competition for scarce resources and anticipated changes in the financing of mental health services in the future challenge capacity and capability in both DHBs and NGOs. We examine the systemic implications of these changes and the particular impact they may have on workforce development and mental health service delivery.

The complex and changing partnership between statutory and non-statutory agencies within Mental Health has to be understood in the context of major health reforms in New Zealand since the mid-1980s. Changing attitudes towards mental health outcomes; changing patterns of service provision in terms of the capacity as well as capability of the various agencies to respond effectively to the range of mental health needs in the community and changing public attitudes towards those experiencing severe mental illness, and the emergence of the consumer movement, with its focus on recovery and empowerment rather than passive receipt of treatment, bring further dimensions to partnership relationships. This paper will trace some of the key changes in mental health provision in the light of these contextual changes, and explore the human resource development implications of our analysis on the dynamic relations amongst clinical providers, NGOs and consumers. Figure 1 expresses a simplified statement of these relations.

Figure 1: Relationships between the different parties



Figure 1. Triangular relationships in mental health service provision

Changing workforce relationships - a national historical perspective

De-institutionalisation of mental health services began in the mid-1980s as part of wider radical economic reforms in New Zealand. The large psychiatric hospitals were progressively closed and 'former patients' were 'discharged' back to their communities. Driven by fiscal, rather than health policies, the process of 'de-institutionalisation' meant that mental health residents' experienced wide-ranging problems once they exited from the hospitals. Insufficient community health infrastructure and support networks made it difficult for them to fully participate in community living and maintain wellness.

Alongside these health sector changes, a Department of Social Welfare (DSW) review in the late 1980s identified the need to develop capacity within communities to contribute to the provision of social services. This provided opportunity for a range of community focused nonprofit mental health organisations to be established which offered alternative health care for those afflicted and marginalised by mental illness. Many of these organisations were set up by charismatic leaders with a passionate commitment to support services (beyond the medical paradigm) that linked those experiencing mental illness into community networks and local solutions, contesting, through their actions, if not directly, the dominant medical paradigm of mental illness, and the value of community relationships and support as part of the progression to wellness.

Extensive Health Sector reforms took place during the 1990s, first with the creation of the Health Funding Authority (HFA) and introduction of the 'purchaser-provider split'; creating quasi-market competition in the sector. Statutory and NGO providers had to compete amongst themselves for contractual dollars. The worst exigencies of the Health Reforms were modified in 1993, but the climate of competition for contracting has had a long legacy in the NGO sector, undermining early collaborative initiatives and community responses and pitting the NGO sector against statutory (clinical) services and other NGOs.

Significant change took place in mental health provision between 1994-97. The National Mental Health Strategy *Looking Forward* (Ministry of Health 1994), defined mental health as a national priority, placing emphasis on the need for *more* services. It also signalled a commitment to develop community based services, leading to further development of the NGO sector. A review of mental health funding (The Mason Report) in 1996, concluded that funding of services was insufficient to meet the needs of people with severe mental illness. Taking up this challenge, The National Mental Health Implementation Plan *Moving Forward* (Ministry of Health 1997) emphasised the need for more and *better* services. A year later, The Mental Health Commission Blueprint (1998) set the benchmarks to put *Moving Forward* into action and 'ring-fenced' funding for mental health for ten years, since when the sector has experienced phenomenal growth. The Health Funding Authority (HFA) recognised that support services were better placed in the community and not within hospital or clinical services. NGOs within the disability sector were already providing services for the majority of their clients in the community and the philosophy of normalisation was moving from disability into mental health. Mental Health NGOs became increasingly aware of the need to address the larger determinants of health and develop relationships with other sectors such as housing, welfare, education and justice.

Under the HFA, community-based mental health services had been shaped by prescriptive contracts, and standardised training within service groups (social workers, nursing, OT), reinforcing occupational segregation of experience. The sector was further shaped along referral pathways - NGO support services were regarded by clinical providers as somewhere to refer service users *to*. The contractual climate resulted in a multitude of specialist teams and a range of support services that were fragmented, and seldom well aligned. Many people (service users, families, as well as staff) found it difficult to navigate their way through all the different services as each component had their own entry criteria and referral pathways as Figure 2 illustrates.

Figure 2: The different services

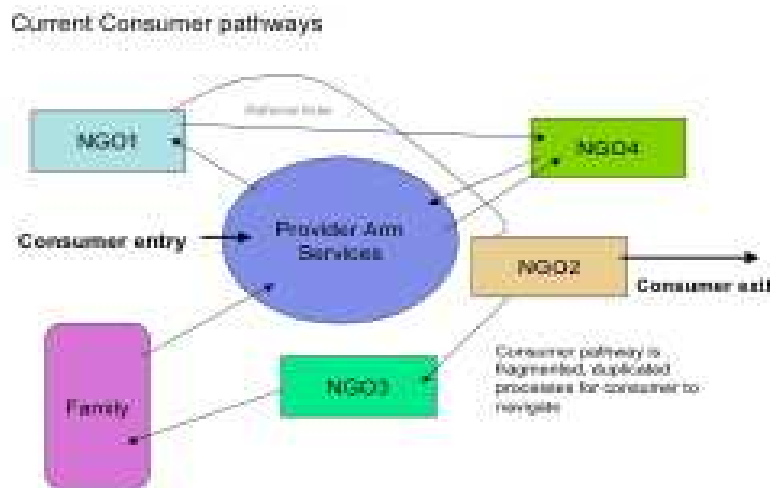


Figure 2: Current Consumer Pathways
Source: Adapted from a 2008 presentation to MCHB (Mental Health Review Board)

Contractual arrangements standardised work in the various agencies. The funder made the assumption that the needs of the service users could be addressed through detailed service specifications and contract requirements for each different type of support service within a 'level of care' structure (i.e. this is what we do in residential rehabilitation services for Level 3 or 4) therefore a standard approach to service delivery was warranted, negating attempts to provide local solutions for local situations and conditions.

Population-based regional funding was re-introduced by the Labour Government in 1999, establishing 21 District Health Boards (DHB) in place of the Health Funding Authority. Under DHBs, the Funder/provider split was removed: clinical provider and funder arms within the same DHB were established and NGOs were again in competition for funding. However, by 1998 NGOs accounted for 23% of mental health funding. By 2001 this had risen to 28%. In 2008 this appears to have plateaued and NGOs in New Zealand receive just under 30% of the national mental health budget (\$863 million in 2004-05). Integration of mental health into the broader health system was articulated in policy and strategic

documents developed by the Ministry of Health such as The New Zealand Health Strategy (2000), the New Zealand Disability Strategy (2001), the Primary Health Care Strategy (2001) and *He Korowai Oranga* Maori Health strategy (2002), *Te Tahuhu: Improving Mental Health 2005–2015* (2005), and *Te Kokiri* The Mental Health and Addiction Action Plan 2006-2015 (2006) developed in conjunction with the DHBs. Importantly, these policies recognise the emergence of the ‘non-registered’ workforce (in contradistinction to registered clinical staff eg psychiatrists, MH nurses, psychologists etc.) as valued contributors to mental health provision, not merely adjuncts to medical practice. The integration of mental health into the national health strategy has strengthened calls to reassess partnership relations between clinical staff within the DHBs and support work staff in the NGOs.

Our discussion so far has traced the shift in paradigms of mental health provision from institutionalisation to clinical/community partnership largely from the clinical perspective. We turn now to further examination of the development of mental health practice and partnerships, from the perspectives of the NGOs and the consumer movement (see Figure 1), highlighting in particular the emergence of new kinds of work, and attendant new areas of knowledge, skill and expertise contained within the non-registered support workforce and the consumer peer workforce.

Paradigms and partnerships

NGO support work has evolved from early unpaid and voluntary work through carer/support positions, which often trapped service users in dependency relationships, to increasingly professionally qualified and recovery-focused career positions. Earlier concepts of the ‘paid friend’ (used when CSW was first established) describing well-meaning but often patronising ‘help’ (of the meeting-for-coffee-type) are in sharp contrast to current practice of intentional goal-directed support that enables people to work towards their personal aspirations. With the gradual demise of funded community residential services and social activities, NGOs have increasingly turned their attention away from residential rehabilitation to meeting the needs of individuals through personalised ‘packages of care’, delivered by community support workers (CSWs) and the development of consumer peer support networks. Within this paradigm, service users work, in partnership with their community support workers, towards pre-agreed goals and definitions of their own wellbeing. Support workers work within a particular service philosophy and require appropriate training.

The formal introduction of Community Support Work Services in 1995 marked a significant development for NGO support work as it provided options for service users to receive support work in their own home. The introduction of this new service model was guided by staff induction programmes and training specific to the service model. The approach was significantly different from the existing practice of Residential Rehabilitation services in creating independence and choice for the individual consumer. Initial standardised training for Support Worker staff across different NGOs assisted in defining the support worker role in relation to clinical and other allied health staff involved with the service user.

The development of a National Certificate for Community Mental Health Support Work assisted in articulating a set of core competencies and scope of practice for community support work and was readily adopted as the minimum entrance criterion for the growing so called non regulated workforce. The National Certificate in Community Mental Health Support Work continued to strengthen and develop the support work role through the phenomenal growth of the NGO sector in the last ten years.

As attitudes to mental health have changed over the years, so too has appreciation of the NGO sector. Clinicians have shifted their suspicion and disdain of what the role of the NGO was, or could possibly be, to growing recognition of what NGOs actually contribute. NGOs are now regarded as an increasingly significant part of the mental health sector. Though professionals within the formal health system were initially suspicious and threatened by the emergence of an independent workforce, the increasing professionalisation and development of the academic profile of the support work force has now led to wide acceptance within the sector of this emergent ‘non-registered’ workforce.

Whilst community organisations challenged dominant paradigms of mental health provision throughout the last 20 years, the experience of recovery by many people who have successfully overcome the disabling effects of severe mental illness has challenged traditional medical paradigms of mental illness even further. Recovery, as a philosophy— defined as “Living well in the presence or absence of mental illness and the losses that can be associated with it” (Mental Health Programmes 2006) — asserts the active role that people experiencing mental illness can have in their own progress towards wellness, and the importance of inclusion, choice, self-determination and hope in living with mental illness and its consequences. The shift in paradigm from institutionalisation to community service provision has been mirrored by changes in definition of service users: from passive recipient/patient to active participant in charge of own recovery pathways: from ‘patient’ to ‘te tangata whaiora’¹ – people seeking wellness. A growing and maturing international consumer voice is also active in New Zealand. Mary O’ Hagan, Consumer Advocate within the Mental Health Commission, has provided strong leadership through her participation in NZ and Australasian Conferences and the development of documents such as *Kia Maori Tau* (Lapsley, Nikora and Black 2002), *The Recovery Competencies* (MHC 2001) and *Our lives in 2014* (Mental Health Commission, 2004a) and most recently, *Te Hononga – a picture of mental health and addiction services in 2015* (MHC 2007). Increased recognition of family and whanau² involvement has also challenged traditional therapeutic practices.

By recognising the wider determinants of (mental) health, and the need for partnership between clinical, support and consumer services, the Mental Health sector has increasingly embraced the need for a whole of government approach, and wider community services involvement. These movements have impacted on Ministry of Health (MOH) policy. In 2005 MoH revised its National Mental Health Plans (Te Tahuhu/ Te Kokiri, 2005) establishing

¹ Maori are over-represented in all mental health statistics. The term ‘tangata whaiora’ has been adopted by many service users and service providers as more accurately reflecting the journey they seek.

² In the Maori language ‘whanau’ refers to the extended network of family connections and obligations which form the basis of tribal relationships. Whanau provide many support services that in western cultures would be provided through community (no-kin based) organisations.

recovery as the philosophical basis of the national vision, and setting consumer rights to inclusion in community life as a central focus for mental health. New Zealand is the first country to formally position recovery in this way.

Within this policy framework, two consumer workforce development initiatives are developing: the first is emergence of 'consumer owned and run' Peer Support Services which continues to strengthen an independent consumer voice; the second is recognition of the knowledge and expertise those with lived experience of mental illness bring to the paid mental health workforce, as nurses, CSWs, clinicians or managers. Thus it is hoped that "By 2010 people with experience of mental illness will be a skilled, powerful, pervasive and openly identified part of the mental health workforce in New Zealand" (MOH 2005).

It is of course, one thing to encapsulate bold policy and aspiration in national planning documents – quite another to see such policies put into action. The sector appears to be responding to these developments (especially the emergence of the Peer Support Workforce) as they did to the Support Workforce. Negative responses include suspicion, safety concerns, fear and professional protectionism, including from the established Support Workforce itself, despite the espoused commitment to Recovery as the philosophical basis for practice. Furthermore there are different perspectives on recovery paradigms amongst support and clinical staff (and even within clinical professional groups). This can create tension in the development of a consumer focussed recovery plan where the potential polarisation of the consumers' needs versus symptom reduction and risk management are inherent. Models of recovery which inform respective practices are different and at times in tension with one another (Lapsley, Nikora & Black, 2002). Partnership between clinical, support, and community services is essential if the vision of recovery and social inclusion is to be realised. Clinical provision, on its own, is unable to provide the social, community and personal support services that individuals require for their unique journeys towards health. The burden of fostering professional relationships with other (clinical) disciplines whilst establishing the position and scope of practice of mental health support work within the sector seems to fall most heavily on the NGOs and is an ongoing dynamic. However, anticipated changes to the funding of mental health across all DHBs challenge the mental health sector to work in partnership within one another. The potential risk for ring-fencing of mental health funding to cease in June 2009, would leave mental health agencies to compete for funding against all other demands in public and population health. Under this regime, the future of mental health service provision, and the NGOs in particular, is vulnerable, particularly in competition for, and retention of, appropriately skilled staff.

A summary of the evolving relationships in the mental health sector from 1980s to the present day is presented in Table 1

Table 1: Changing Partnership Relations between Statutory and non-government Mental Health providers

Date	Ministry of Health	Clinical Provider Services	Interface/ partnership relations	NGOs	Consumers
1980s	Area Health Board	Institutionalised psychiatric care ('asylum' and forensic)		Concerned and affected family members providing self help support within the community/concern over hospital treatment of patients	'Patients' very few rights 'Discharged' into community
Late 1980s	AHBs	De-institutionalisation process accelerated, psychiatric institutions closed		Embryonic, some agencies providing residential and rehabilitation services, some community support Ministry contracts high prescriptive	Many patients unable to cope in the community, lack of access to appropriate support, stigmatisation within the community at large.
1991	Health Reforms (Regional) Health Funding Authority	Purchaser –provider split, Crown Health Entities (CHEs) originally competition with one another Expert (doctor)	Clinical referrals to..... Clinical services protocols for referrals, clinical pathways for clients	Rise of NGOs to meet identified MH needs in the community – community support services, accommodation, support for families and self-help groups – eg Schizophrenia Fellowship, Richmond Fellowship, AMHS, WALSH etc. NGOs as 'benevolent caretakers'	'Patient referrals' – transfer of individuals along referral pathways from hospital to social and community services Recipients of care
1993	Auditor General concern over MH provision	Lack of adequate provision for a severe mental health situations	Clinical referrals to... Medical model still predominant	Growth of NGOs with diversity of services, some funded by other agencies – Housing and Social Welfare.	
1994	Mental Health Strategic Plan 'Looking Forward'	Provision on for 3% population with severe mental health problems	Quantity and Choice – improvements in clinical provision; Mirror contracts specifying inter-face protocols	Rising standards of provision, greater accountability required for funding	
1997	Implementation plan 'Moving Forward' De-Stigmatisation programmes	Medical expertise still disdainful NGO services	'well-meaning volunteers'	Mainly dependent on Mental Health contracts for funding – increasing relationships with other agencies: Housing Social Welfare, Justice, Education	Consumer voice and consumer movement gathering momentum
1998	Mental Health Commission 'Blueprint' for service provision and funding – MH funding 'ring-fenced'	70% funding for MH received for hospitals and district health boards		30% funding - Recovery philosophy gaining ground, divergent of therapeutic models – eg Strengths based, Boston, etc. Increased employment of consumers in influential positions (Mental Health Foundation etc.), consumer representation accepted in organisations at all levels – staff and Trustees.	Increasing client/consumer access to services

2000	District Health Boards replace HF	Huge growth in MH spending, increased quality and access	Some collaboration Provider arm contracts cease replaced by price/bed occupancy rates etc.	NGOs as 'service providers' available to consumers	Growth of the consumer movement
2005	Mental Health Plan revised, institutionalises philosophy of Recovery	Policy of community inclusiveness	Collaborative environment, working with NGOs	Enacting policies of community inclusiveness – still community resistance (NIMBY)	Consumer led provision , peer support, Recovery focus, 6
2009?	Removal of MH ring fenced funding; competition with all other health claims	Competition with other clinical services – Mental Health very low political appeal	Strategic alliance between clinical and support services? Advocacy to Boards, agreed strategic planning for minimum MH services by locality?	Exploration of other funding sources? Alliances and complementary services? Shift to relationships with Private Health Organisations (PHOs/GPs)?	Campaign for the normalisation of mental health – growing number of population affected, at least in mild to medium forms, on-going advocacy for de-stigmatisation and community inclusion in all aspects of living.

Case study

These national trends provide the backdrop for our case study. The Waitemata District Health Board (WDHB), one of four DHBs in the greater Auckland Region in the North Island of New Zealand, is both funder and provider of clinical mental health and addictions services for a population of around 500,000. Fourteen non-government agencies contract to provide a range of mental health and addiction services for the Waitemata District.

A Mental Health Commission (MHC) review of mental health services in the Auckland Metropolitan area in 2002 concluded that through the preceding ten year period of rapid growth:

1. resource allocation, funding and planning decisions were being undertaken without proper engagement with service providers,
2. there was a failure to deliver an integrated continuum of services,
3. there was a lack of procedures for coordinating care of individual people with experience of mental illness across the service spectrum;
4. the level of resourcing was inadequate
5. roles, responsibilities and relationships amongst clinical teams, NGO staff, support services and primary care were insufficiently defined.

Responding to this situation, and the national expectation that DHBs would consult and involve local communities in the planning of health services, the WDHB Mental Health Programme Manager/Funder recognised the need to ‘future-proof’ mental health services against the impact of changes identified above, and in particular to build better relationships between WDHB clinical and NGO support service providers. Funding changes will impact clinical and community support services alike, and on those with severe mental illness, most particularly.

This case study briefly highlights steps taken in the past two years to build partnership between clinical and community services, to strengthen the capacity and capability of the NGO sector, in order to redress in small part the imbalance of power between the statutory (clinical) and community support services, in order to overcome the fragmentation on services identified by the MHC review and to achieve a more systemic approach service integration, and the development of consumer-directed pathways towards recovery.

To this end, formalised inter-agency meetings, workshops and service development forums were set up which also served to stimulate dialogue and collaboration amongst the NGOs themselves. This process of facilitating dialogue and relationship was further enhanced through development of

- a District Provider Forum
- a District Provider Executive Group
- a local Stakeholder Network
- Shared Vision Community Mental Health interest groups in each locality, and
- a consumer network within each locality.

Several issues have still to be addressed within these forums.

First, the imbalance of power and resources in favour of the statutory services has to be acknowledged. Past relationships of disdain on the part of the DHB clinical providers towards local NGO Support Service providers has given way to increasing valuing of the work of the NGOs and their capacity to adapt to new paradigms of mental health and recovery. The rise of professionalism amongst NGO service providers, and leadership from the current cohort of newly appointed CEOs in the larger agencies challenges earlier clinical assumptions of standards of care and practice. Critical issues of staffing however still remain, as DHB clinical services can provide much higher salaries and conditions of employment (especially in the form of generous study leave) than the NGOs. The loss of key experienced staff from the NGOs to positions within the DHB seriously impacts on the development of Support Services, through loss of experience. Clinical providers, however, are in no position to provide the sorts of community services that NGO have pioneered, so it is certainly in the DHB Funder's interests to see that a robust NGO sector is maintained.

Resourcing issues point to the urgent need for a systemic approach to mental health planning in the district and clear recognition of the inter-dependency that in fact exists between the two provider arms (clinical and community support services). The continued operation and sustainable growth of the NGO sector now demands a course of development to enable appropriate structures, processes and procedures to be introduced and implemented. Workforce development, salaries and conditions, and on-going competition for appropriately qualified staff are key resource challenges across the sector.

Systemic development needs to be two-pronged: envisioning and planning for future service delivery, and developing the capacity and capability of the agencies concerned. Both have been attempted within the WDHB. This was formalised in the WDHB in 2006 as a Collaborative Partnership Agreement between the clinical and support service providers.

From stakeholder networks and District Provider Forums a set of district wide change goals is being developed to give shape to a vision and plan for the future of mental health service provision which recognises the unique characteristics of local communities in different corners of the district. Clinical services and NGO support services are now working towards greater alignment and configuration of services based on local community needs and resources. Over one hundred middle and senior managers engaged in debate over the prioritisation of future mental health services for the 2007-8 funding round, resulting in a much more coordinated planning and prioritisation process. This dialogue also had the effect of raising the level of managers' capability (towards a much greater strategic perspective) and encouraged stronger relationships and integration between NGO and clinical staff.

The history of NGO's in the district started with small residential facilities for people from the large institutions. In 1995 the then HFA introduced Community Support Work to support people living in their own homes. The consumer voice continued to strengthen and develop. New service models and the collective consumer voice triggered one another to continually develop towards flexible and individualised service solutions suitable for the specific needs of each individual. Within the Waitemata District the resulting 'Packages of Care' service model provided service users with alternative options suitable for unique individual needs. The challenge for NGO support work is to adapt from prescriptive service delivery and practice towards defined core roles with freedom to exercise discretion within bounds of ethic, practice

standards and mission values. Staff need to use their discretion within the scope of support work practice to provide individualised support options for service users. The service delivery system therefore needed to change from prescriptive services where service users are referred towards an integrated system that is responsive to service users needs (across clinical and support services). This requires quite major changes in staff practice, workforce development strategies, organisational infrastructure and support systems and the way organisations and staff of different agencies interface and collaborate with each other.

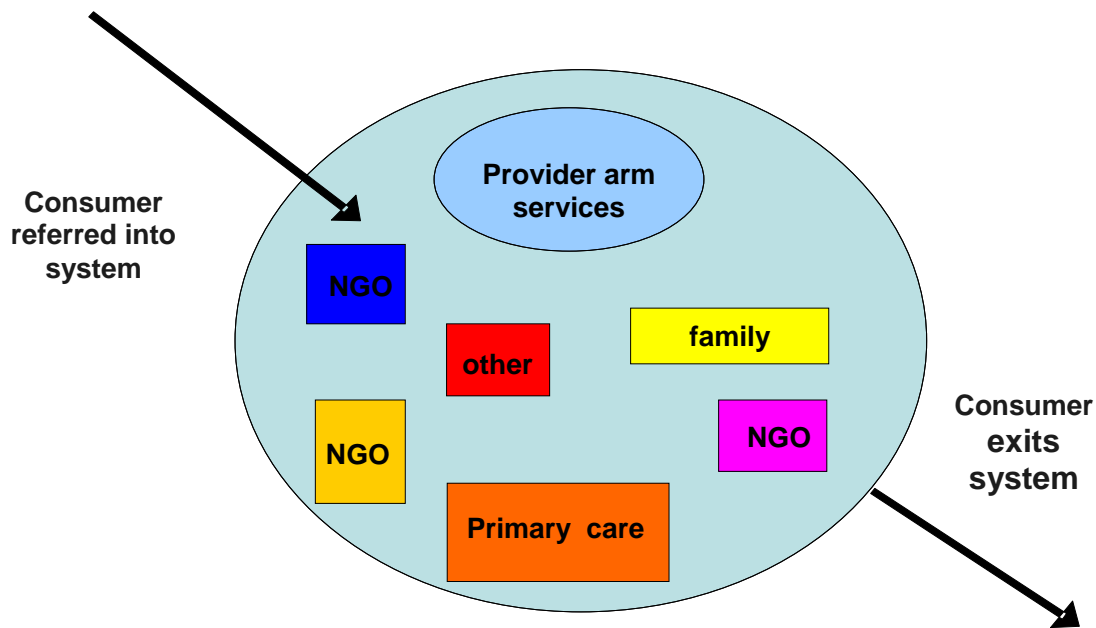
As we saw in the national developments, the driver for recent change has been the increase in the consumer voice. The WDHB mental health funders have been instrumental in showing how consumer-driven changes can be achieved at a district level. Two separate NGO projects were funded to address the lack of ability or resources to ensure organisational development, infrastructure and sustainability were given due priority. The first was an *Organizational Health and Capacity Audit* (OHCA) for each of the fourteen agencies providing contracted services to WDHB. Areas of organisational infrastructure needing attention were identified and recommendations made to overcome specific risk and compliance factors. The second was an organisational development initiative with the contracting agencies. A series of *Building Capacity and Capability* (BCC) workshops introduced agencies to the Levels of Work model developed by Jaques (1991, 1994) and Stamp (1993) (McMorland, 2005). The workshops provided some conceptual tools for the NGO sector to consolidate, develop and strengthen their organisational viability, providing an organisational/ growth and survival focus to counterbalance attention given to service development as well as developing a shared 'language' with which to address different levels of complexity and engagement within the sector, and across institutions. Facilitated follow-up with each agency helped translate the conceptual model of work at each organisational level into the practicalities each agency was facing in preparing for, and responding to change.

The OHCA and BCC projects were introduced to help the NGO mental health sector change the way services are delivered and how organisations engage with service users, the community, and each other. Such changes need to be embedded in practice at all levels of the sector, from policy development to service delivery and practice. Each organisation, (and the system as a whole) needs to adapt to be able to remain responsive to the unique and individual needs of service users

The OHCA and BCC projects also gave the district funder a clearer picture of the individual viability and capacity of each of the agencies as well as an overview of collective capacity and capability of the district mental health sector to develop a responsive and consumer focused mental health system within the Waitemata District (Bennett, 2006; McMorland, 2006).

A key outcome sought by the Funder from these initiatives is an enhanced capacity on the part of NGOs to provide flexible and responsive services within each locality, bringing clinical and community support services into a clear, integrated consumer recovery pathway. District wide change and the reorientation of services according to consumer pathways, rather than referral pathways, will require targeted and specific organisational change and development intervention at each level of the mental health system. Figure 3 shows an idealised model for such a pathway.

Figure 3: District wide model of consumer-directed pathway for service delivery.



Source: B. Kukler, WDHB presentation to District Provider Forum 2006

The pathway assumes strong collegial networking, and open access across services. It also recognises implicitly that consumers may seek to access multiple services through the course of their journey to wellness, moving between clinical and community services as the acuity of their mental disablement changes.

Dialogue is still needed between practitioners as there is no universal understanding of recovery within the sector. Different practitioners (service providers) will continue to interpret recovery from their own perspectives, and adopt roles in relationship to consumers accordingly. Contestation of service paradigms identified in Figure 1 above still continues, but with a different, and perhaps more subtle, face. The value of the district forums that bring diverse practitioners together is that practice differences can be discussed more openly. The possibly inevitable tension between managing risk and promoting recovery — sometimes played out as conflict between practitioners from the provider arm and support staff — can in fact be viewed as bringing into dynamic engagement different, but legitimate, issues. Doctors' concerns for clinical safety and risk-management mitigate support workers' over-enthusiastic advocacy for consumer independence and autonomy. The consumer/recovery focus of the support workers reasserts the right of the service user to be respected as a partner in decision-making, countering excessive medical control. In this way too, the interests of the public at large are addressed, if not removed: there will always be some risk that consumers might harm themselves or others, but, as with the risks of driving cars, these are not managed by draconian constraints, but through education, destigmatisation and trust – in systems of governance that enable people to live well together, and in individuals themselves and their right to hope and self-determination. In Waitemata, the framework for inter-agency dialogue has been informed by the Levels of Work (McMorland 2005). This can be shown in two tables: the first (table 2) shows the translation of

National policies into action as different levels within organisations; the second how recognition of appropriate levels of engagement can be effective for inter-agency co-ordination.

Table 2: Inter-relation of policy levels from National Policy to Service Delivery

Level	Agency/Policy	Theme of work	Practices
6	Ministry of Health Health Priorities	VALUES PHILOSOPHY	Sets national direction, priorities, standards, mental health spend
5	Regional or DHB Annual Plan	STRATEGIC INTENTION	DHB priorities, budget, integrated service planning, RFPs, contracts
4	Agency / NGO Three Year Strategic Plan	STRATEGIC DEVELOPMENT	Agency purpose, vision, outcomes, priorities and developments. Who we are and why we exist
3	Agency Annual Business Plan	BEST PRACTICE	Culture, services, budget, work deployment, review, systems, capacity building. What we will do
2	Service Annual Business Plan	SERVICE IMPROVEMENT	Programme, goals, budget / resourcing, staffing. Capability building, compliance. How to do things.
1	Daily, weekly, quarterly objectives	EXCELLENCE OF PROVISION	Daily coordination, continuous improvement, team/ individual performance management.

Source: Wade and McMorland, (2005) Building Capacity and Capability, unpublished workshop materials, Northland DHB, Gemini Partners Ltd. Adapted from Jaques and Clement 1994; Stamp and Stamp 1993).

Short, medium and long term intervention will be required to facilitate and direct changes in the interface between and amongst NGOs and clinical services, as well as in the planning and delivery of mental health services. These different time frames are captured in Jaques’s model of the Levels of Work (Jaques and Clement 1994). There are also illustrated in the following Table which identifies different levels of engagement between DHB (as provider) and NGO providers. Consumer interests are not yet addressed at all levels, though the Mental Health Commission does serve these interests at Levels 4 and 5.

Table 3: Showing examples of levels of interaction between WDHB and NGOs

	DHB	Meetings	NGOS and community
6	National policy abstract and conceptual, difficult to translate into operation realities within funding constraints, current practice and fragmentation of services	<ul style="list-style-type: none"> • National Advisory Committee 	<ul style="list-style-type: none"> • Different models of recovery across disciplines and institutions
5	Workforce development in train Regional and District Strategic planning	<ul style="list-style-type: none"> • Platform – NGO • Working Parties for Policy Development (eg Workforce Planning) 	<ul style="list-style-type: none"> • scarcity of skilled workers at all levels • remuneration differences • lack of NGO strategic positioning
4	Service managers/ CEO's, district annual planning process, collaboration/ partnership agreements, development of operational protocols/ interface agreements, service planning through Changing personnel in DHB	<ul style="list-style-type: none"> • District Wide Forum • Provider Executive Group 	<ul style="list-style-type: none"> • success in greater dialogue between upper levels of organisations and DHB
3	Changing personnel in DHB, loss of key people and fragile network of personal contacts falters. Paradigms of cost accounting still apparent	<ul style="list-style-type: none"> • Service Managers meetings 	<ul style="list-style-type: none"> • Lack of strategic positioning and imagination for the future – • trust in consumer capability for self care and peer care.
2	Team leader and service coordinators, locality meetings with local providers (both clinical and NGO) local stakeholder networks/ shared vision forums.	<ul style="list-style-type: none"> • Team leader training 	<ul style="list-style-type: none"> • Team leaders beginning to conceptualise responsibility for service development

The steps taken in WDHB to create a more integrated mental health service have been encouraging within the DHB and the NGOs, but there is still much work yet to do. Development of a district-wide strategic intent in mental health has proved problematic. Senior managers and policy makers/funders conceptualise in broad abstract terms that mean little to service providers working with consumers on a daily basis. There is still much ‘talking past’ one another when people working at different levels fail to understand the salience of the others’ perspective, or fail to take time to translate the conceptual into practice.

There is also much change to celebrate. The establishment of DHBs saw the beginnings of changing relationships within the mental health sector. Consumer leadership and participation in management and service delivery, created further changes in how organisations were run. The changing relationships between service users and staff were defining changes in practice for both clinical and support staff. The funder – provider relationship changed from a contractual business relationship to one based on consultation, collaboration, transparency and a population health focus. Service planning and needs analysis were based on district population needs. Within the Waitemata district a strategic framework was developed focussed on providing local services for the local population. This required extensive restructuring of clinical services and integration of services at a locality level. The work of a localised stakeholder network was also instrumental in promoting collaboration, and opportunity for input in service planning and design from a wide range of stakeholders (consumers family and whanau, Maori, Pacific, clinicians, managers, and support staff throughout the district).

Concluding Observations

Fundamental change has been happening across the mental health sector over the past twenty-five years that has changed the configuration of relationships between providers and services users in dramatic ways. Though the statutory funders still play a major part in shaping provision, through the contracting of services, NGOs and consumers alike have shaped the outcomes and values of the service.

The non-government sector has contributed enormously to mental health reform, innovation and as change agents in how mental health services are provided in New Zealand. This ability to be innovative, creative, to ‘box beyond one’s weight’ has arguably been a key element of NGO survival. The development of NGOs, however, is at a crossroads. The passion, commitment, vision and determination which earlier leaders articulated established a sector which now receives nearly 30% of the mental health budget. However many NGOs now find themselves in the position of having to adapt to new forms of leadership: on the one hand, balancing the passion for service with pragmatism and business acumen, on the other seeking to anticipate new forms of service delivery and the attendant requirement for a changing profile of service workers, and changing forms of organisational arrangement. Increasingly sophisticated human resources strategies will be needed to address staffing shortages and retention, putting additional burden on lean organisational capacity and under-funded services.

NGO support work has developed a ‘whole of life’ approach to supporting service users in maintaining (mental) wellness in the community. Normalisation has evolved to Social Inclusion as a fundamental principle in NGO support work. Community development, building of natural

support systems and personal efficacy have become the fundamental tools for support work where previously focus was on needs assessment, service coordination and risk management. Staff require the ability to consult, liaise, facilitate, collaborate etc with other agencies and departments in supporting service users dealing with all factors that impact on (mental) wellness. This has become part of core competencies in working with service users. Development of the consumer workforce has brought both benefits and challenges for NGOs. While greater connectedness with service users is most desirable, NGOs have to ensure sustainability in the consumer workforce for it to be effective and build in additional capacity into their own organisational arrangements to make reasonable accommodations and provide flexible support to that workforce.

The National Mental Health and Addictions Workforce development plan (Te Awhihiti, MOH, 2006) has recognised the need to develop and maintain a workforce that is equipped to respond to the changes in National funding policy as well as in the NGO sector itself. Enhanced and extended contemporary mental health and addictions service provision will include more community based, mobile and flexible service options. The emphasis of the plan is to build a knowledgeable, skilled, competent and recovery focused mental health and addictions workforce, and to foster a culture amongst service providers that is “person centered, culturally capable and delivers an ongoing commitment to assure and improve the quality of services for people” (MOH, 2005). Rapid progress is needed in the registration of qualified and competent support workers if contractual demands for ‘qualified mental health professionals’ are to be met. Current contract requirements for professional (practitioner) qualifications are difficult to meet, and harp back to earlier definitions of mental health service provision. If Mental Health policy and contractual requirements cannot not be aligned more effectively then the sustainability of NGO contracts is significantly threatened over the next 5-10 years.

Within this context, smaller NGOs are particularly vulnerable to collapse if they cannot identify specific niche contributions to the sector, which will allow them to compete for contract opportunities and funding. Larger organisations have greater capacity to build organisational resilience, and can garner more resources with which to stay competitively innovative. Increased advocacy amongst and on behalf of tangata whaiora/consumers will continue to shape the provision of services and definitions of mental illness and wellbeing.

As lead change agents in the development of community based mental health services, some (larger) NGOs feel they have been forced to bear the brunt of statutory authorities’ resistance to change, and poor change management practice within the wider health service. At the policy level however, NZ Mental Health strategies are world leaders being the first to embrace recovery as a national policy. Within the public sector generally, there is increased recognition of the value of NGOs in service provision, innovation and advocacy for change. The role played by NGOs in New Zealand mental health services is greatly admired – if not envied – in many countries around the world.

This paper has canvassed some of the changes that have taken place in the evolution of mental health service provision from de-institutionalisation to provision of consumer-directed, needs driven packages of care, and from relationships of antagonism and suspicion between statutory (clinical) and community (support) service organisations to partnership and more mutual respect. Waitemata District Health Board Mental Health Services division has pioneered ways to enhance

interaction and confidence in the possibility of a systemic, integrated approach to mental health care. We trust that the joint authorship of this paper will in its own way contribute to a deepening of relationships across the sector, and to the continued identification and addressing of organisational impediments to the effective provision of services for those who live with mental illness.

“Recovery happens when we regain personal power and a valued place in our communities. Sometimes we need services to support us to get there”

Our Lives in 2014: A recovery vision from people with experience of mental illness (MHC, 2004: 15).

We hope that the leadership Waitemata DHB has shown through imaginative funding, and the energy, passion and commitment of health workers in both the DHB and the NGOs will mean this can happen long before 2014.

References

Bennett, H. (2006). Recommendations for District-Wide Capacity Building Initiatives developed from the Organisational Health and Capacity Assessment. *Unpublished report for WDHB Funder.*

Jaques, E. and Clement, S.D. (1991). *Executive Leadership: A Practical Guide to Managing Complexity.* (reprinted 2002). Falls Church: Carson Hall & Co Publisher

Lapsley, H., Nikora, L. and Black, R. (2002). *Kia Maori Tau; Narrative of Recovering from Disabling Mental Health Problems.* Wellington: Mental Health Commission

O’Hagan, M. (2001). *Recovery Competencies for New Zealand Mental Health Workers.* Wellington: Mental Health Commission

Mason, K., Johnston, J. and Crowe, J. (1996). *Inquiry Under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services.* Report for the Ministerial Inquiry to the Minister of Health, Hon. Jenny Shipley. Wellington: Ministry of Health

McMorland, J.C.I. (2005). Are You Big Enough for Your Job? Is Your Job Big Enough for You? Exploring Levels of Work in Organisations. *University of Auckland Business Review.* 7(2): 75-81

McMorland, J.C.I (2006). The NGO Development Initiative: Reflections on Work Carried out for the WDHB Funder. *Confidential unpublished report for WDHB.*

Mental Health Commission, (2002). *Review of the Continuum of Mental Health Services.* Funded by the District Health Boards in the Auckland Region. Wellington

Mental Health Commission, (2004). *Our Lives in 2014: A Recovery Vision from People who Experience Mental Health Illness*. For the Second Health Plan and the Development of Health and Social Services. Wellington.

Mental Health Programmes, (2006). *Te Awhihiti: National Mental Health and Addictionsn Workforce Development Plan*. For, and in support of, Non-Governmental Organisations 2006-2009. Auckland: Mental Health Programmes Limited

Minister of Health (2000). *The New Zealand Health Strategy*. Wellington

Minister of Disability Issues (2001). *The New Zealand Disability Strategy: Making a world of Difference: Whakanui Oranga*. Wellington: Ministry of Health

Minister of Health (2001). *The Primary Health Care Strategy*. Wellington: Ministry of Health.

Minister of Health and Associate Minister of Health (2002). *He Korowai Oranga: The Maori Health Strategy*. Wellington: Ministry of Health

Minister of Health (2005). *Te Tahuhu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addictions Plan*. Wellington: Ministry of Health.

Minister of Health ((2006). *Te Kokiri: The Mental Health and Addictions Action Plan 2006-2015*. Wellington: Ministry of Health.

Ministry of Health. (1994). *Looking Forward: Strategic Directions for Mental Health Services*. Wellington.

Ministry of Health (1997). *Moving Forward: The National Mental Health Plan for More and Better Services*. Wellington

Ministry of Health (2006). *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington

Stamp, G. and Stamp, C. (1993). Wellbeing at work: aligning purposes, people, strategies and structures. *International Journal of Career Management*. 5(3).