NORTHERN DHB SUPPORT AGENCY LTD

NORTHERN
REGIONAL MENTAL HEALTH & ADDICTIONS PLAN
2003 - 2004

(Final Draft)

Prepared for the four northern region District Health Boards (DHBs):
Counties Manukau DHB (CMDHB)
Auckland DHB (ADHB)
Waitemata DHB (WDHB)
Northland DHB (NDHB)

by the Northern Regional Mental Health Funding Team
and the Northern Regional Mental Health Network

June 2003

Waitemata District Health Board *Te Wai Awhina*

AUCKLAND DISTRICT HEALTH BOARD *Te Toka Tumai*

COUNTIES MANUKAU DISTRICT HEALTH BOARD *A Community Partnership*

Northland Health
Hauora o te Taitokerau

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THE PLANNING CONTEXT

In early 2002 the Chief Executives of the Northern Region DHBs agreed a two-year allocation model for the additional Blueprint mental health funding applied in the northern region[1]. The allocation was based on three funding principles:

- Achieving intra regional equity in relation to funding per head of population
- Allocate remaining funding on a population basis
- Address the total lack of any local extended care beds in Northland

That allocation informed the 2002/03 Northern Regional Mental Health Plan, which determined priorities and allocations over the period July 1 2002 –June 30 2004. This plan addresses the second year in that period, is based on the work undertaken for the earlier plan, and acknowledges those significant environmental and other variations which impact on the earlier plan.

In particular, the earlier plan was built on expectations of the availability of the full $10.7 million in year 2002/03. A decision by the Ministry of Health subsequently reduced that funding by $1.7 million. The likelihood of reduction had been acknowledged in appendices to the plan.

The 2003/04 plan bases its funding allocation on the principles outlined in the earlier plan. The Government has made commitments to enhanced mental health funding in the Northern region, particularly metropolitan Auckland, as a result of the Mental Health Commission Auckland review. The 2003/04 plan therefore takes a conservative approach to the allocation of new funding, recognising that a proportion of that funding will also be allocated to the Midland region.

District Health Boards indicated during the 2002/03 planning cycle, their wish and intention to carry out the detailed district level planning in consultation with their communities. Accordingly, the 2003/04 plan reiterates earlier high-level regional priorities and identifies those additional priorities that could be met in light of proposed additional funding. It leaves the detailed allocation of capacity to the local DHB funding and planning processes. That detail will be reported in their District Annual Plan. This provides for a level of consultation to specifically inform local detailed planning.

The Mental health Commission review of Auckland's mental health services has been a significant and extraordinary event in the 2002/03-year. Implementation of the review findings will lead to changes in funding and service delivery in the Northern region. The high level approach taken to planning in the current document provides ample opportunity for detail variation as the review begins to be implemented. It should be noted that the review process has demanded significant analytical capacity from the regions DHB Planners and Funders, and the NDSA funding team. In future years, it is desirable that that capacity is utilised to the full

[1] Memo re Mental Health (Blueprint) Funding Allocation 2002/03/04, NDSA, 8 February 2002

extent to ensure the most timely and well-informed regional mental health planning cycle.

The establishment of local and regional mental health stakeholder networks during 2002 has provided the opportunity for enhanced planning input. The terms of reference for the Regional Mental Health Network include:

> The main focus of the RMHN will be to ensure regional consistency in planning, based on what is know to work best in achieving positive outcomes for people who use mental health services. The RMHN will deal only with issues that have implications regionally. Its key functions will be:
>
> 1. The sharing of information between stakeholders and the regional funders
> 2. Collaborative planning for mental health services (with the funders) at a regional level[2]

Timing constraints in the current planning cycle have caused some limits on the participation of the Regional Mental Health Network in the development of the plan. Feedback during the planning process has also been critical of the available time for the process, and the opportunity for input. It is hoped that the section of the plan below called Future Directions sets out a timetable and process for increasing that involvement in future years, as well as highlighting many of those issues which the networks would have considered in more detail, if timing had permitted.

The NDSA has sought feedback on the 2002/03 Regional Mental Health Plan through a consultation document released in December 2002. That feedback comprising close to thirty submissions confirmed the broad vision and direction of the plan.

Following the acceptance of the first draft of this plan, it has been further reviewed by the Regional Mental Health Network, and presented to each of the local mental health stakeholder networks for further input and feedback.

We acknowledge the valuable input to the plan from both the local and Regional Networks, and seek to maximise this in future. Networks provide the communications pathway to ensure the widest range of voices is heard during the planning cycle. Participation by Union representatives, and GMs of both DHB and NGO providers has helped deliver a diversity of opinion and strategic thinking to the planning process.

[2] Northern Region District Health Boards, Mental Health Stakeholder Networks, Terms of Reference and Establishment Process

OUR VISION FOR MENTAL HEALTH

> Our long term vision for mental health[3] is of well informed communities, able to protect and preserve the mental health of their residents, able to recognise when help is needed and where to go for that help, and able to support people with serious mental health or addiction problems to achieve recovery.
>
> Our vision is of a time when there are no longer health disparities for Maori and Pacific peoples, people who are socio-economically disadvantaged, or any other group within our communities

What our vision will mean:

From the time their disorder is first identified, people diagnosed as having a severe mental health disorder will have access to highly effective services that minimise disruption to their lives as a result of their disorder. These services will equip people with severe and ongoing disorders to manage their own illnesses well, so that they are able to live full lives in their community needing only infrequent though regular support from primary care providers and/or mental health specialists. Where communities and other agencies are not supportive of people's wellness and/or recovery, services will make a special effort to engage and educate those communities and enhance their contribution to recovery and wellness.

Other people with mental health needs and/or drug and alcohol problems will be able to rapidly meet these through a competent primary care team that includes/works closely alongside people with specialist mental health and drug and alcohol expertise.

People of all ages and ethnicities will be able to access services that are appropriate to and respectful of, their age specific needs and their culture.

We will know the outcomes people are achieving and these will be equally good for all people, regardless of ethnicity or socio-economic background.

Wherever a person is in the northern region, they will have access to the same range and level of service, and the same demonstrably effective technologies (although these may vary in nature on the basis of local characteristics). Services in this region and around New Zealand will work together to ensure the highest standards are maintained and that new and effective approaches are adopted throughout New Zealand as they emerge.

Maori will be able to choose between services that are Kaupapa Maori and mainstream services, and - whichever they choose - these services will be culturally competent and will make available treatments, therapies and supports that are recognised as effective.

Pacific people will be able to choose between mainstream services and services specifically for Pacific people, and - whichever they choose - these services will be

[3] "mental health" includes the absence of drug and alcohol problems

culturally competent and will make available treatments, therapies and supports that are recognised as effective.

Our Commitment to the Treaty of Waitangi

The northern regional mental health funding team includes representatives of both treaty partners (MAPO and DHBs/NDSA). The funding team is committed to practically applying the three principles of the Treaty of Waitangi: Partnership, Protection and Participation. In doing so each team member will work together in good faith, valuing equity, honesty, integrity, cooperation and reciprocity.

The Purpose of the Regional Plan

While this plan is primarily focused on the priority setting and allocation of additional funding for specialist mental health and addiction services, it is important to remember why we are planning in the first place. Specialist mental health services make up only a small part of health services. Primary health makes a huge contribution to the mental health of the populations covered by this plan, both those who access secondary services and those who do not.

Mental health is only one aspect of the health of the individual and the community. While we focus on delivery of specialist mental health services we must always remember that we make a small but important contribution to a person's health within their lifetime. It is easy to focus on our services to the exclusion of other aspects of health, particularly where we are planning within a limited context. As the District Health Boards focus more and more on the health of the populations they serve, and the resourcing of those services, planning will become broader based.

Service users remind us that the service we provide is not, and nor should it be, the whole focus of their lives. Service users are citizens, seeking to exercise their full citizenship within the communities in which we all live. As such, their needs are no different to those of their fellow citizens. Mental health services must use the least restrictive means possible, in partnership and collaboration with the service user, to deliver a valued service that enhances the service users capacity to live the life they want to live. Anything less is no longer acceptable. It is hoped that this plan goes some way towards meeting that goal.

THE PLANNING PROCESS

Role of the DHB – Annual Plan

District Health Boards are required by the Government to submit a District Annual Plan, which includes their funding and planning intentions for the year. The Plan is the key annual accountability document between the Board and the Crown, and forms the cornerstone of the planning cycle. It is to be submitted to the Ministry of Health by April of each year.

Regional Mental Health and Addictions Plan

The Regional Mental Health and Addictions Plan, upon its acceptance by each District Health Board, informs the District Annual Plan, along with District level mental health planning and funding information. The regional mental health funder network and the regional mental health stakeholder network work together to prepare the Regional Mental Health and Addictions Plan. The plan is an annual plan, and its objective is to identify regional mental health priorities, and set out the allocation of additional mental health funding across the region.

Other Regional Planning

The Regional Mental Health Plan 2002-03 plan identified the need for the development of both Maori and Pacific Regional Plans to address the specific mental health needs of those populations on a regional basis. Both plans are due for completion shortly, and will be submitted to District Health Boards for their approval.

Local DHB Planning and Consultation

District Health Boards will make local level decisions about the detailed allocation of additional resources, in line with the broad priorities outlined in this regional plan. Consultation and the participation of local networks at the district level will inform that detailed development.

PLANNING PRINCIPLES

While the 2003/04 Regional Mental Health and Addictions Plan is based on its predecessor, the Northern Region Mental Health Plan 02/03, the planning process for this year has identified a set of principles for use in guiding future planning.

- ***Understand what we do now***

DHBs are committed to the ideal that we routinely analyse what we do and continue to work to improve our data collection and analysis.

- ***Work toward an equitable position***

While a degree of equity between DHBs within the region will be achieved within the timeframe of this plan, the region remains substantially behind the Blueprint targets. Equity between regions remains some distance off. It is important that the region

retains a solid focus on improving its position from 57% of benchmark targets in 2001 to match the 75% of the Central and Southern regions[4]. It is unacceptable that the region remains at a similar level of comparative disadvantage while each region moves forward at the same pace. Recent funding decisions have begun to remedy this inequity. The Northern region has the highest population growth rate in the country, therefore the focus on closing the funding and service gap is doubly important.

- ***Plan for the achievable***

Identified priorities tell us what we need to do, however workforce capacity and provider infrastructure development may be limiting factors in delivering on those priorities in the short term.

- ***Work towards better services, rather than just more of them***

With the Northern region so far behind the Blueprint benchmarks, it would be easy to concentrate solely on delivering more capacity within the sector. However, additional resources provide a strong development impetus for better services, as well as more services. Prioritising new services in accordance with our vision will help us develop services, which better meet the needs of services users.

- ***Develop regionally where advantage exists***

Regional service development runs a risk of lagging behind district level development. Where clear advantages, such as economies of scale or the development and retention of specialist workforce exist, regional development should be supported.

[4] Memo re Mental Health (Blueprint) Funding Allocation 2002/03/04, NDSA, 8 February 2002

CURRENT FUNDING ALLOCATION AND SERVICE DELIVERY

How the Northern Region Compares Nationally

The Northern region (like the Midland region) has been endeavouring to reach the point of equitable funding with southern parts of the country for some time. In 2001/02 the comparative performance against Blueprint benchmarks was as follows:

Comparative Regional Performance against Blueprint Benchmarks 2001/02

North	57.70%
Midland	57.00%
Central	74.60%
South	74.80%

2002/03 indicative two-year allocation of additional Blueprint funding

	2000/01	2002/03 addn	2003/04 addn	Total 2 yr increase
North is on	$240.5[5]	$10.7	$8.7	$19.4
Midland is on	$124.7	$5.0	$4.1	$9.1
Central is on	$140.8	$1.6	$1.3	$2.8
South is on	$166.4	$1.5	$1.2	$2.7

Even with the substantial additional funding identified at that point, the northern region remained some way behind the central and southern regions in respect of Blueprint targets.

Comparative Performance against Blueprint Benchmarks 2003/04 (on 02/03 allocation)

North	62.40%
Midland	61.10%
Central	76.20%
South	76.00%

To close the equity gap in 3 to 5 years from 2002/03 will require a greater funding commitment than that planned for in 2002/03. The Ministry has indicated that the commitment will include an additional $10 million (GST inclusive) split between the Northern and Midland regions in the ratio 13/7.

Comparisons of Funding within the Northern Region

The following tables identify current mental health expenditure within the northern region at an aggregate level. The first set details the expenditure by high-level service category and ethnic group[6]. 2002/03 figures are based on the Regional Mental Health Plan allocations. Percentage figures reflect the distribution between the various service groupings.

[5] All figures in this table are $millions

[6] The service is either identified as specifically for members of the ethnic group, or is a service delivered by members of the ethnic group for members of that group under a specific cultural framework, for example Kaupapa Maori services.

Mainstream

	2001/02	2002/03	Total	Dist
	$000's	$000's	$000's	%
A&D	22,689	119	22,808	10%
Community	88,356	7,050	95,406	42%
Community Residential	30,939	798	31,737	14%
Forensic	19,139		19,139	9%
Inpatient	55,603		55,603	25%
Other (Monitoring)		400	400	0%
Total	216,726	8,367	225,093	

Maori

	2001/02	2002/03	Total	Dist
	$000's	$000's	$000's	%
A&D	2,394		2,394	12%
Community	10,840	237	11,077	54%
Community Residential	4,377		4,377	21%
Forensic	500		500	2%
Inpatient	2,085		2,085	10%
Other (Monitoring)			0	0%
Total	20,196	237	20,433	

Pacific

	2001/02	2002/03	Total	Dist
	$000's	$000's	$000's	%
A&D			0	0%
Community	7,435	396	7,831	88%
Community Residential	547		547	6%
Forensic	500		500	6%
Inpatient			0	0%
Other (Monitoring)			0	0%
Total	8,482	396	8,878	

Total

	2001/02	2002/03	Total	Dist
	$000's	$000's	$000's	%
A&D	25,084	119	25,203	10%
Community	106,631	7,683	114,314	45%
Community Residential	35,863	798	36,661	14%
Forensic	20,138	0	20,138	8%
Inpatient	57,688	0	57,688	23%
Other (Monitoring)		400	400	0%
Total	245,404	9,000	254,404	

A summary of current expenditure on community services gives the following proportions of expenditure:

Summary (excl. Inpatient & Forensic)

	2001/02	2002/03	Total	Dist
	$000's	$000's	$000's	%
Mainstream	141,984	7,967	149,951	85%
Maori	17,611	237	17,848	10%
PI	7,982	396	8,378	5%
Total	167,577	8,600	176,177	

Current service expenditure by age groups is as follows:

Expenditure by Age Groups

	2001/02	2002/03	Total	Dist
	$000's	$000's	$000's	%
Child & Youth	27,134	0	27,134	11%
Adult	209,537	8,123	217,660	86%
Older People	8,734	137	8,871	3%
Non specific		740	740	0%
Total	245,405	9,000	254,405	

Finally, the proportion of expenditure between the DHB and NGO sector is as per the following table:

Proportion DHB/NGO

	2001/02	2002/03	Total	Dist
	$000's	$000's	$000's	%
NGOs	64,638	798	65,436	26%
DHB Provider Arms	180,767	7,802	188,569	74%
DHB Funder Arms (Monitoring)	0	400	400	0%
Total	245,404	9,000	254,404	

Detail of 2002/03 Funding Allocation

District Health Boards have determined the final detail allocation of additional funds in the 2002/03 year. The following table sets out the actual allocation of funds in the 2002/03 year.

Priority	**Service Type**	**DHB**	**Provider Type (NGO/ DHB)**	**Annualised Dollar Value (GST Excl)**
People with a serious mental health disorder (who have been recently diagnosed)	Early Intervention teams	WDHB	Provider Arm	$790,835
		ADHB	Provider Arm	$395,991
		CMDHB	Provider Arm	$81,901
		NDHB		
People with a serious mental health disorder (who are the most unwell, have the highest needs, and are reluctant to use services)	Mobile Intensive Teams Community Support Teams	WDHB	Provider Arm	$410,000
		ADHB	Provider Arm	$911,025
		CMDHB	Provider Arm	$1,470,008 $753,546
		NDHB	Provider Arm	$85,913
People with a serious mental health disorder (in crisis)	Crisis Respite	WDHB	Provider Arm	$343,395
		ADHB		
		CMDHB	Provider Arm	$444,452
		NDHB		
Maori	Maori Services Kaupapa Maori Services	WDHB		
		ADHB		
		CMDHB	Provider Arm	$245,544
		NDHB		
Pacific	By Pacific For Pacific Services	WDHB		
		ADHB		
		CMDHB	Provider Arm	$409,240
		NDHB		
Maternal mental health	Maternal Mental Health Services	WDHB		
		ADHB	Provider Arm	$145,460
		CMDHB		
		NDHB		
Eating disorder services	Regional Community ED Service	WDHB		
		ADHB	Provider Arm	$107,325
		CMDHB		
		NDHB		
Consumer networks	Consumer Networks	WDHB	Provider Arm	$118,618
		ADHB	Provider Arm	$115,164
		CMDHB	Provider Arm	$89,309
		NDHB		
Family engagement	Family Engagement	WDHB	Provider Arm	$57,582
		ADHB		
		CMDHB		
		NDHB		
Regional forensic services	Inpatient Beds Prison Liaison FTEs			

Priority	Service Type	DHB	Provider Type (NGO/ DHB)	Annualised Dollar Value (GST Excl)
Monitoring	Monitoring	WDHB ADHB CMDHB NDHB	Funder Arm	$130,237 $110,195 $115,000 $42,517
People who have alcohol and drug problems and high and complex needs (with opioid dependency)	GP Methadone Places Specialist Methadone Places (Regional)	WDHB	Provider Arm-Regional	$118,850
		ADHB		
		CMDHB		
		NDHB	Provider arm/NGO	$105,551
People with a serious mental health disorder (who have ongoing support needs)	Service Coordination	CMDHB	NGO	$850,000
People with a serious mental health disorder (who have intermittent relapses and use acute inpatient or respite services)	Specialist Community Mental Health Services	WDHB		
		ADHB	Funder Arm	$3,538
		CMDHB		
		NDHB		$478
People with a serious mental health disorder (able to maintain their health using available treatments) and other people with a clearly identified mental health disorder	Primary or specialist community mental health services/ Primary Care capacity Initiatives	WDHB		
		ADHB		
		CMDHB		
		NDHB		
Older Adults	Improve access Home support Comprehensive assessment and treatment Integrated care continuums Evaluation			
People with a serious mental health disorder	Community and Residential Support	WDHB	NGO	$548,060
		ADHB		
		CMDHB		
		NDHB		

THE ADDITIONAL NEEDS WE WANT TO MEET IN 2003 –2004

PRIORITISING DEVELOPMENTS FOR BLUEPRINT FUNDING

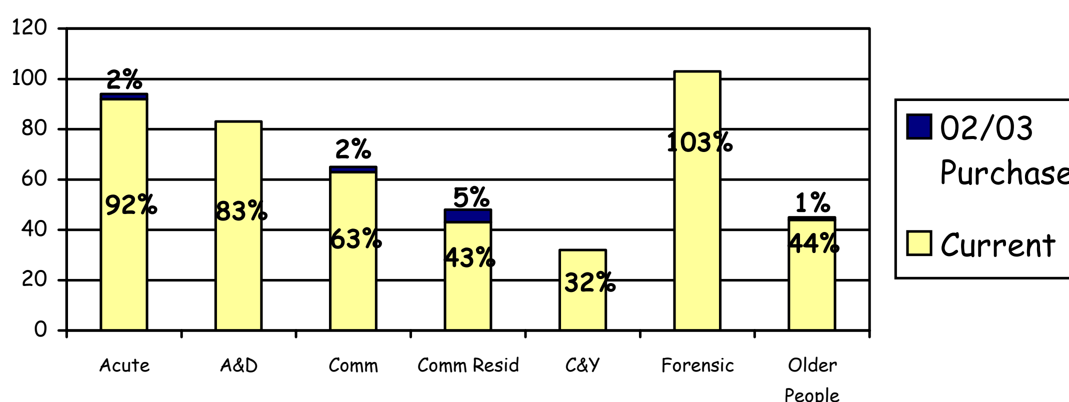
We recognise that this region is well behind Blueprint benchmark service levels and that the funding in the 2003/04 financial year still does not significantly close this gap.

Priorities were established at two levels in 2002/03. The current plan endorses those priorities and is based on the view that sufficient additional funding will be available within the 2003/04 year to meet them. It also identifies those additional priorities that will be targeted with further additional funds as these become available.

Identifying Priorities

The previous section provided detailed information on the allocation of current resources across the region. Matching those resources to Blueprint targets provides one way of identifying those service delivery areas that require priority attention. The following graph shows the current level of resource delivery against service benchmarks[7] in the region, plus the effect on these of recent additional funding.

Percentage Gap to Blueprint Benchmark



Several things are worth noting in respect of this information. Firstly, Child and Youth mental health services remain the most distant from benchmarks, in spite of recent funding increases. This is consistent with the findings of the Ministry of Health and Mental Health Commission mental health funding Ringfence Review (2002). An inability to recruit sufficient additional child and youth workers is a key constraint to the further development of these services and is an issue DHBs will actively address in the coming year.

[7] Note that the figure of 103% for forensic services reflects the original benchmark established in the Mental Health Commission Blueprint. More recent work by the Ministry of Health incorporating the growth rates in the New Zealand prison population has adjusted the forensic resource levels to better meet this growth rate.

Child and Youth mental health services clearly must remain a priority for additional development. Additional resources of approximately $55 million are required to reach benchmark levels. While recruitment of additional staff remains a significant constraint to the further development of these services, workforce and infrastructure development projects must seek to resolve this shortfall.

Older people's services, while accounting for a comparatively small overall share of Blueprint resources, are still delivered at a level below 50% of the benchmark. To achieve benchmark levels for services for older people would require on the order of $11 million. Arguably, a greater focus on increasing older adult service levels could be achieved in the region without significantly delaying development on those areas requiring substantially more resource.

Priority setting at the District level

As previously noted this plan has focused on high-level priorities in order to enable each of the District Health Boards to focus on the specific planning details at the local level. Some over arching issues may help DHBs in their decision making at that level. They include the strategic direction arising from the Maori and Pacific Regional Mental Health Plans, and the issue of service equity between districts.

Maori and Pacific Services were specifically identified as regional priorities in the 2002/03 plan. Both of these priorities were initially addressed through a strategic planning process, culminating in the development of both the Maori and the Pacific Regional Mental Health Plan. Those plans are both in their final stages of completion, and should be referred to for detailed information regarding service development. The following table reproduces the strategic priority areas from the Draft Northern Region Maori Mental Health and Addictions Action Plan.

Priority Area	Action
Changing the Balance	Moving towards a better balance between gaining wellness and managing illness.
Shifting the Paradigm	Moving from individualised western models of care to collective holistic models of care.
Awhi, Manaaki and Tiaki	Ensuring high quality, safe, effective and efficient services are provided to tangata whaiora and their Whanau.
Whanaungatanga	Supporting robust, relevant and co-operative relationships within the mental health sector, the health sector and across other sectors.

Pacific strategic objectives for the three-year period 2003-05 are set out in the Draft Northern Region Pacific Mental Health and Addictions Action Plan as follows:

	Goals
1.	To improve access for Pacific peoples to Mental Health services
2.	To develop partnerships with organisations, communities, families and service users, which will maximise opportunities for Pacific peoples involved with Mental Health and Alcohol and other Drug services.
3.	To develop a competent and qualified Pacific Mental health workforce that will meet the needs of Pacific peoples
4.	To ensure that information and research on Pacific Mental health will inform policy planning and service development
5.	To improve the Quality of Mental Health services
6.	To develop Pacific primary Mental health services[8]

Both plans provide DHBs with a guiding framework to improving the development and delivery of mental health services to Maori and Pacific peoples.

Workforce Development

The Northern region DHBs are aware of significant issues facing the mental health workforce, a problem reflected nationally also. A number of high-level strategies have been produced regarding mental health workforce development, but the Northern region has never had an agreed regional approach to assist us to develop the mental health workforce in a planned, co-ordinated and efficient manner.

Therefore, the Northern DHB Support Agency (NDSA), on behalf of Auckland DHB, Counties Manukau DHB, Northland DHB and Waitemata DHB have commissioned the preparation of a Northern Region Workforce Development Action Plan.

The key objective that has been considered in the formation of this Action plan is:

" How do we ensure the right people are doing the right job in the right place so clients receive the best recovery focussed services?"

In order to answer this question, the Northern region is of the view there are a number of actions that can be taken. These actions are summarised below, and ,ore fully discussed in the body of the Action Plan.

1. Establish what our workforce looks like (numbers, locations, skill mix).
2. Complete a stocktake of what workforce development initiatives have been supported over the last 5 years, and how effective have these initiatives been in supporting our key objective. This will include gathering data on Northern regions access to local, regional and national initiatives
3. Identify the key issues that influence our workforce, to ensure we have a sustainable, competent[9] and high quality workforce
4. Identify the plans do we have over the next 3-5 years to ensure ongoing investment in workforce development initiatives meet our regions needs (linked to

[8] Will be further clarified and defined as the Pacific plan is finalised
[9] Using the Recovery, Nursing, Alcohol and other Drug, Mental health Support work and competency guidelines

priority areas, new service developments and population needs, and ultimately building capacity in the sector).

This Action Plan has been informed by current strategy and policy documents, current national workforce development initiatives, and builds on work completed to date. The document should be considered, as a starting point to assist us to better plan for the future needs of the Northern region Mental Health workforce.

Intra District Equity

The issue of intra district equity at the service level has been raised and discussed during the 2003/04 planning process. Different District Health Boards provide different standards and quantities of services, particularly within metropolitan Auckland. Services for older people, mothers with babies, and other groups may be quite different between districts. While this may reflect the diversity of needs and make up of the different district populations, it may also lead to inequities of access, and service user migration across district boundaries to access particular services. District Health Board funders and planners may wish to consider the effects of such differences, and factor increased equity between services into their priority setting.

Regional Priorities

The Northern Regional Mental Health Plan 2002/03 identified the following priority developments:

Priority Developments 2002-03 Plan[10]	
1: Highest Priority Developments -	**Target Dates June 30 2004**
People who have a serious mental health disorder	1. improved equity of access to early intervention services 2. mobile intensive treatment and coordination services available 3. equitable access to crisis respite
Maori	1. option to access Maori services, where possible Kaupapa Maori services[11] 2. equitable levels of Kaupapa Maori services, by Maori population 3. improved collaboration between Maori and mainstream services
Pacific people	1. option to access Pacific services 2. equitable levels of Pacific services, by Pacific population

[10] For detailed information on these priority developments, refer to Northern Regional Mental Health Plan 2002-2003, pages 6 - 15

[11] Maori services are defined as those services that specifically target the Maori population. Within those services, a subset comprises Kaupapa Maori services, those services delivered within a Maori framework and governance structure.

Maternal mental health	1. equitable access to maternal mental health services, by births/DHB
Eating Disorder services	1. increase access to regional service
Consumer networks	1. resource areas without specific network resourcing
Family engagement	1. pilot engagement and peer support services, particularly Maori and Pacific
Whanau and Pacific Family engagement[12]	1. pilot engagement and peer support services
Regional Forensic Services	1. increase service provision in line with MOH direction 2.
Monitoring	1. fund DHBs to monitor

2: Other Priority Developments

People with A&OD problems and high and complex needs	1. 50 additional methadone places
People who have a serious mental health disorder	1. increase access to service coordination (target June 30 2005) 2. improve specialist community mental health service capability 3. improve access to choice of primary services
Other people with a clearly identified mental health disorder	1. increase equity of access to services 2. build primary care capacity

As a result of the consultation and planning processes which have led to the development of this plan, the following priorities are proposed in addition to those outlined in the 2002-2003 plan:

3: Additional Priority Developments

Consumer Networks	1. Pilot consumer for consumer service development 2. Consumer workforce development
Eating Disorder Services	1. Increase regional capacity

[12] Feedback from Maori and Pacific groups indicates that Family in a mainstream context is notadequately inclusive of the differences between Maori, Pacific, and mainstream family structures. Whanau and Pacific families may require different styles of engagement and peer support, as determined by Maori and Pacific planning processes.

Maternal Mental Health	1. Inpatient or equivalent services available
Older Adults[13]	1. Improve access to services 2. Support older people to live at home 3. Comprehensive assessment and treatment 4. Integrate continuums of care – care plans, care packages and caregiver support 5. Evaluate so improvements in services and outcomes will be measured
Child and Youth	1. Improve access to services 2. Integrate continuums of care – care plans, care packages and caregiver support 3. Workforce and infrastructure development projects must seek to address recruitment and retention issues and build service capacity
People who have a serious mental health disorder	1. improve access to community and residential supports regionally 2. Integrate mental health service provision with primary care chronic care management approaches 3. Improve access through single regional 0800 number 4. Review and reconfigure service delivery in the Social and Recreational services area to align models of delivery within a care continuum
People with A&D problems and high and complex needs	1. 50 additional methadone places 2. improve access to after hours treatment 3. pilot family engagement and peer support 4. Increase capacity for Children and Young People 5. Increase capacity for Older Adults
Regional Forensic Services	1. Improve capability of adult mental health services 2. Increase capacity to address regional prison growth 3. Access to specialist provision for people with an intellectual disability and challenging behaviour
Research and Development	1. Fund regional approach to R&D
Workforce development	1. Implement Regional Workforce Development Action Plan

While many of the regional priorities will be resourced in detail at the District level by each of the DHBs, those services which are accessed or delivered regionally will

[13] Priorities consistent with those identified by Project Members, Regional DHB Mental Health Service for Older People Core Group and "Mental Health Services for Older People in the Northern Region"

require regional decisions regarding their funding allocations. These range from the need for additional community and residential support, which is resource intensive and well below benchmark, to the provision of tertiary specialist level services.

Regional Projects

Phasing of new funding in the 2002/03 financial year allowed for the development of a number of one-off projects. The Regional Mental Health Team has initiated and funded a number of these key regional projects.

Projects have been prioritised based on identified priorities within the Regional Mental Health Plan 2002/03 and the regional work plan, and the ongoing need to develop mental health infrastructure for the region.

Identified priority areas in the Regional Mental Health Plan include service developments for:

1. People with the most severe mental illness and highest need
2. Maori
3. Pacific
4. Regional Forensic services
5. Consumer networks
6. Family engagement

Forensic Framework

The region completed a Forensic Services Plan in 2002/03 setting out its intentions in implementing the forensic framework. Negotiations between the Ministry of Health and Waitemata DHB have agreed on additional service delivery as follows:

5 additional Prison Liaison FTEs
10 additional Kaupapa Maori Medium Secure Forensic beds
5 additional secure beds to replace those relocated to the Midland region.

The Regional Forensic Plan identifies a range of other issues and service improvements, including strengthening adult general mental health service capacity to address risk.

Infrastructure

Identified priorities in relation to infrastructure include

- workforce development
- information and outcomes measures and
- quality and monitoring developments.

Service re-configuration and equitable access to regional services are both priority areas.

The following table lists the projects and the progress achieved to date on these.

Project[14][1]	Lead Organisation	Progress	Completion Date
Regional Coordination	WDHB	Final Draft Completed, Sector Presentation	May 2003
Governance	NDSA	Development of both local networks and Northern Regional Mental Health and Addiction Network complete	January 2003
Maori	ADHB	Needs Analysis and Draft Plan Completed, Manawanui service development plan proceeding	Mar/Apr 2003
Pacific	CMDHB	Plan Completed and ready for printing	March 2003
Older Persons	ADHB	Phase 1 completed, phase 2 commencing	June 2003
Alcohol & Drug	ADHB	Competency based training pilot, phase 1 complete	November 2002
Forensic	WDHB	Planning and agreement with MOH for additional services complete	Ongoing
Acute Services	NDSA	Final Draft completed, Sector Presentation	February 2003
Workforce	NDSA	Draft plan and feedback completed	February 2003
High Complex Needs	NDSA	Planning underway	TBA
PBF/ Pricing	NDSA	Regional Group	April 2003
MHINC	NDSA	Continuing Regional Involvement	Ongoing
PHO	NDSA	Participation in Regional work	Ongoing
Quality Monitoring	NDSA	Contract to develop framework, audit projects	June 2003

Research and development

DHBs in the Northern Region are committed to the development of a Regional research and development programme. This approach is designed to support infrastructure development at a regional and local level, encourage local innovation and build a research and service development culture. The approach will align with National, Regional and local priorities it will enhance and strengthen planning, service delivery and outcomes for service users. A Regional research and development approach will build upon current key regional and local projects commenced in the 02/03 year, further it will assist in the implementation of the MHC review recommendations now and into the future.

Additional projects that could be funded during the 2003/04 year include:

Project	Rationale
Improving integration of Mental Health and Alcohol and Other Drug services	Service users with both mental health and drug use problems are becoming more common in both mental health and drug and alcohol services. Changes to drug usage within society also impact on both services. Enhanced cooperation and collaboration between the services is necessary to improve the delivery of service to the service user, and ensure that they have timely access to the service s that they require.
Primary care integration, particularly addressing populations being served and geographic overlap	As mental health services move into service delivery to greater numbers of service users with episodic requirements for secondary treatment, improved integration with the primary care sector becomes critical, to ensure service users maintain their

	primary health relationships, and do not become “over –serviced” by the specialist services.
Consumer Care Pilot	In spite of increasing resources, the adult acute services continue to experience difficulty meeting demand for inpatient and crisis services. Alternate methods of service delivery, based on collaborative approaches with service users may reduce reliance on inpatient solutions as the primary response to risk.
Asian population growth and service needs	With the growth rate of the Asian population in the region, the nature of that population, including the ethnic mix and age profile of different sub groups, will need to be clearly understood to plan effective, culturally competent and responsive services for the future

As referred to in the introduction section of this document the MHC review of Auckland services has been a significant and extraordinary event in the 2002/03 year. DHBs have moved rapidly to commence implementation of the review recommendation and have appointed a Regional Director Mental Health Services (RDMHS). The Regional Directors role is a key role in the mental health sector and is intended to provide a single accountability for the overall clinical direction, leadership and oversight of Auckland mental health services. In doing so, the Regional Director will provide a sense of a shared vision and leadership for the mental health sector as a collaborative system of care. The primary responsibility of the RDMHS is to ensure the provision of a co-ordinated mental health service and a seamless continuum of care for service users in the Northern region. Through the Regional Director and the yet to be formed Regional Service Coalition DHBs in the Northern region will also commence implementation of the review recommendations at a service delivery level.

PROPOSED FUNDING ALLOCATION 2003/04

OUR VISION FOR PLANNING AND FUNDING

We will achieve our vision by all four DHBs working collaboratively with the Regional Director Mental Health, their agents the NDSA, their MAPO partners and with local and regional stakeholder networks and the proposed Regional Service Coalition to plan services, to agree on needed improvements, and to implement those improvements.

We will also work in partnership with our local communities and will encourage others in health and related sectors to develop strategies that will support the achievement of our vision for mental health[15].

In December 2001, the northern regional mental health funding team worked collaboratively using the best information it had at the time in order to recommend a split to their District Health Boards. The division was based upon converting all service gaps relative to Blueprint benchmarks into equivalent Community FTEs per 100,000 population. A two-step process was then used to divide the money:

1. Using national prices for a Community Clinical FTE, a share of the indicative two year Blueprint funding was apportioned to each DHB except the DHB with the highest service levels, in order that each DHB would then have the same level of gap from Blueprint benchmarks
2. The remainder of the additional funding was shared between DHBs based on their share of the northern region population

At the end of this process, it was agreed that Northland (the DHB with the most services) would withdraw from using regional extended care and intensive supported rehabilitation as of July 01 2002, and would receive an appropriate share of the new money in recognition of this change in access. Should Northland use these particular Auckland Metro services in the future, it will pay for this use.

The proposed division of funding for the 2003/04 year is based on original allocation as agreed by the DHB CEOs, and used in the 2002/03 Regional Mental Health Plan. That starting point is as shown in the table following:

Original Allocation as per Board Paper

	NDHB	WDHB	ADHB	CMDHB	TOTAL
2002/03	426,563	3,308,354	2,451,021	4,514,062	10,700,000
2003/04	346,831	2,689,970	1,992,886	3,670,313	8,700,000
TOTAL	773,394	5,998,324	4,443,907	8,184,375	19,400,000

[15] see page 1 (note "mental health" includes the absence of drug and alcohol problems)

The first principle agreed by the CEOs was that of working towards intra-regional equity (that is, an equivalent level of resourcing per head of population within each District). The indicative (and final) funding for 2002/03 was insufficient in itself to achieve intra-regional equity.

Intra Regional Equity Calculation – Two Years 2002-2004

	NDHB	WDHB	ADHB	CMDHB	TOTAL
Relative equity		3,636,123	2,378,396	6,149,512	12,164,031
Population based split	773,394	2,362,201	2,065,511	2,034,863	7,235,969
Total	773,394	5,998,324	4,443,907	8,184,375	19,400,000
Population projection used[16]	10.7%	32.6%	28.5%	28.1%	100.0%

However, as is evident from the preceding table, two years of additional funding have provided sufficient funds to achieve equity on the basis of the original formula.

The final allocation of funding for 2002/03 was reduced by $1.7 million. The end result is that the three metropolitan DHBs all still fell some way behind the equitable position at the commencement of 2003/04. The following table identifies the amount of money each DHB required to achieve equity with its fellow DHBs in the region.

Final Allocation (after $1.7m reduction) (as per Regional MH Plan 2002/03)

	NDHB	WDHB	ADHB	CMDHB	TOTAL
Dollars received 2002/03	234,459	2,517,577	1,788,698	4,459,266	9,000,000
Plus – Value of regional services (as per RMH Plan 2002/03)	11,408	237,269	193,993	(442,670)	0
Net value	245,867	2,754,846	1,982,691	4,016,596	9,000,000
Relative equity (as per above table)	0	3,636,123	2,378,396	6,149,512	12,164,031
Balance of equity allocation	0	881,277	395,705	2,132,916	3,409,898

Blueprint funding of $8.7 million has been made available for the 2003/04 year as previously noted. The Ministry of Health has more recently indicated an intention that the Northern region should achieve an equitable position with the rest of the country within five years. The Ministry of Health has also indicated that additional funding will be available to the region as a result of the Mental Health Commission review of Auckland acute services. That funding has now been indicated as totalling $10 million dollars, inclusive of GST, with $3.5 million of it expected to meet the needs of the Midland region.

Additional funding 2003/04

Amount	Source
8,700,000	Blueprint 2003/04
5,778,000	Additional dollars Auckland Review (excl GST)
14,478,000	Total

[16] population projection for 2002 drawn from the 1996 census (as per original CEO paper) as a detailed analysis of the 2001 census was not available at the time.

Allocation of the Blueprint funding in 2003/04 is firstly targeted at completing the remaining equity issues arising from the 2002/03 formula. The remainder of that funding is allocated to address improved equity information as well as population split.

DHBs have determined the regionally equitable split of the additional $5.778 million. That split has been informed by work undertaken to develop an Inter District Flow methodology. The split recognises that the purpose of the funding has been to address issues raised by the Mental Health Commission Auckland Review, and as such is allocated between the urban DHBs. As such, a proportion of the funding has been allocated to regional services and their further development.

Additional packages of care have begun to relieve the acute service pressure that has impacted on the region in the past 18 months. Additional funding to implement the recommendations of the Mental Health Commission Auckland Review is being utilised as referred to earlier in the plan.

Blueprint allocation 2003/04

Allocation Summary of 2003/04:	**NDHB**	**WDHB**	**ADHB**	**CMDHB**	**TOTAL**
New Blueprint 2003/04 (as previously agreed) and advised to the MoH	345,828	2,688,508	1,975,950	3,689,714	8,700,000
Additional $5.778m					
- Equity ($4.448m)		596,218	2,473,062	1,379,609	4,448,889
- Regional ($1.328m)		855,532		473,357	1,328,889
	0	1,451,750	2,473,062	1,852,966	5,777,778
Total 2003/04 Dollars	**345,828**	**4,140,258**	**4,449,012**	**5,542,680**	**14,477,778**

Below is the summarised table of the allocation of 2003 – 2004 blue print funding allocation per DHB.

These priorities and volumes are indicative only, DHBs reserve the right to adjust the priority and volume according to local and regional service needs.

Schedule of Proposed New Services 03/04

				FTE /Volume				
Priority Area	**Service type**	**PUC**	**Unit**	**CMDHB**	**ADHB**	**WDHB**	**NDHB**	**Total**
Locally based community services								
People who have a serious mental health disorder	Community MH Service Early Intervention	MHCS06A	FTE	3.00				3.00
People who have a serious mental health disorder	Community MH Service - mobile intensive teams	MHCS06A	FTE	18.70				18.70
People who have a serious mental health disorder	Crisis respite - Adult	MHRE02	FTE		1.00			1.00
People who have a serious mental health disorder	Crisis respite – Child and Youth	MHRE02	FTE		1.00			1.00
People who have a serious mental health disorder	Crisis respite – Older persons	MHRE02	FTE		1.00			1.00
People who have a serious mental health disorder	Specialist community mental health services	MHCS06A	FTE		4.50	5.50		10.00

People who have a serious mental health disorder	Specialist community mental health services	MHCS06B	FTE	1.00 (SMO)	.30			1.30
People who have a serious mental health disorder	Specialist community mental health services	MHIS03	Beds	4				4
People who have a serious mental health disorder	Primary or specialist community mental health services/Primary care capacity initiatives	MHCS06A	FTE		2.00	1.00		3.00
People who have a serious mental health disorder	Primary or specialist community mental health services/Primary care capacity initiatives		FTE	1.50				1.50
People who have a serious mental health disorder	ICU – Intensive care inpatient beds	MHIS09	Beds			2		2
People who have a serious mental health disorder	General hospital liaison service	MHCS07	FTE	1.50	1.00	2.00		4.50
People who have a serious mental health disorder	Community and residential support – Asian services		FTE		2.00			2.00
People who have a serious mental health disorder	Social and rec – vocational services	MHCS14C	FTE	3.50			1.00	4.50
Maori	Maori services – adult community teams	MHCS19	FTE	1.00				1.00
Maori	Maori services – adult community teams	MHCS06A	FTE			1.00		1.00
Pacific People	Pacific services	MHCS06A	FTE	2.50	3.00	1.00		6.50
Pacific People	Pacific services		Packages of care		4			4
Maternal Mental Health	Maternal Mental Health Services	MHCS28	FTE	1.50	1.00			2.50
Consumer Networks	Advocacy / peer support - consumer	MHCS21	FTE	4.00	2.00			6.00
Family Engagement	Advocacy / Peer Support - Family	MHCS21	FTE		2.00			2.00
Family Engagement	Advocacy / Peer Support - Family	MHCS22	FTE			1.50	.50	2.00
Child and Youth	Child and youth - medical	MHCS08B	FTE		1.00			1.00
Child and Youth	C&Y community service	MHCS08A	FTE			2.00		2.00
Child and Youth	Residential support		Packages of care		4			4
Older Adults	Community Service older people	MHCS18	FTE	3.30				3.30
Regional community services								
Refugee Services	New migrant services -Asian	MHCS27	FTE		2.00			2.00
People who have a serious mental health disorder	Community and residential support – Asian services		FTE		2.00			2.00
People who have a serious mental health disorder	Community and residential support		FTE	6.90			1.50	8.40
People who have a serious mental health disorder	Community and residential support		Packages of care		4			4
People who have a serious mental health disorder	Dual disability			1.50				1.5
Eating Disorders	Eating disorder services	MHCS09	FTE	1.2	3.00			4.20
Eating Disorders	Eating disorder services	Flexifund	FTE		2.00			2.00
Regional access residential services								
People who have a serious mental health disorder	Level 4	MHCR04	Beds			3.72	2	5.72
People who have a serious mental health disorder	Flexible residential and rehab options		Packages of care	6.5		6		12.5
Metropolitan Auckland Addiction Service								
People with AoD problems and high and complex needs	Drug and Alcohol – Methadone places	MHCS29.2	places			138		138
People with AoD problems and high and complex needs	Drug and Alcohol		FTE	1.50				1.50
Other planned Projects				√	√	√	√	
Pilot reconfiguration of residential rehab services					√			

Monitoring of services			√	√	√	√	
Regional Director/ coalition			√	√	√	√	

FUTURE DIRECTIONS

The 2003/04 planning process has highlighted a number of issues that have the potential to improve future regional planning processes.

Improving our information

Planning will be enhanced by improved information. Access to utilisation data, the measurement of outcomes and effectiveness, are key to improving the quality of service delivery across the region. Much of the work currently under way including the development of the Mental Health Information National Collection will provide that improved information. Work by the District Health Boards to develop inter district flow information, and the application of the Population Based Funding Formula, will help improve the future allocation of mental health funding.

Issues that need to be addressed in future information management include greater understanding of the differences between population groups, and the impact these have on resource use. Cultural and age differences are reflected in current resource allocation, but the differences in need are as yet inadequately understood.

Piloting new services

There is a range of innovative ideas across the sector, which can get lost within the focus on providing a greater volume of services. Well-planned pilot projects with strong evaluation frameworks can provide additional information on service improvement methodologies.

Need to develop infrastructure and build capacity

The emphasis on capacity building must include the investment in the development of stronger infrastructure. This is particularly the case where the option of Kaupapa Maori or Pacific-by-Pacific or Consumer-by-Consumer services is being promoted.

Critical to infrastructure development is an improvement in clinical relationships. The Northern DHBs are addressing this in various ways. The appointment of the Regional Director Mental Health, together with clinical participation in the Service Coalition, will help ensure a strong regional focus on clinical issues and concerns. DHBs have begun:

- to increase capacity in core clinical services to reflect growth in community based NGO services.
- to enhance relationships between NGOs and community services
- to reduce fragmentation and improve service delivery to service users

Planning cycle for 2004/05

Planning for the 2003/04 financial year has taken place against a backdrop of new developments, the establishing of the local and regional mental health stakeholder networks being perhaps the most significant. It has also been influenced by the Auckland Review process, which has both absorbed a great deal of the regions mental health analytical capacity and provided new resources and structures that will effect future planning.

Participants in the current planning cycle identified the need to commence the planning cycle early, in order to maximise the input from the sector. A proposed planning timetable for 2004/05 follows, recognising that the implementation of the Auckland Review will alter the decision-making processes surrounding the development of the next Regional Mental Health and Addictions Plan.

The regional and local mental health networks will be key to the successful consultation process for the 2004/05 plan. The networks form the primary channel for the dissemination and reception of planning information.

Action	Responsibility	Dates
Consultation Document to sector	NDSA/Local Networks	September 2003
Sector Review of 2003/04 plan	Sector	September 2003
Analysis	Local and Regional Networks, Maori and Pacific Planners	October 2003
Identify Equitable Allocation of Additional Funding	Regional Director/ Regional MH Funding Team =>Regional Network/Coalition	November 2003
Prepare draft of 2004/05 Regional Mental Health and Addictions Plan	Coalition/ Regional Network/ Project Worker	November 2003
Consultation on draft plan	NDSA/ Local Networks	December 2003 to February 2004
Finalise plan	Coalition/ Regional Network/ Project Worker	February 2004
Present Plan to District Health Boards	Regional Director/ DHB planning and funding managers	March 2004
Submit to Ministry of Health	Each DHB	April 2004

APPENDIX - THE REGION, THE PEOPLE

The characteristics of the local areas within the northern region vary substantially in nature, ranging from sparsely populated rural areas through to the densely populated metropolitan Auckland suburbs and inner city. There is also great variability in the age and ethnicity of the populations in the various local areas.

The 2002/03 plan provided a detailed population breakdown by DHB based on the 1996 census, with projections out to 2002. Some data is now available from the 2001 census, which paradoxically provides an accurate picture of the 2001-year. However, projections on that data to 2003 are only available at the aggregate and age group level, so we cannot yet provide a projected ethnic breakdown of DHB population for the 2003 year.

Population figures used in this plan should thus be considered as additional information to those contained in the 2002/03 plan. They do not as yet provide the full picture of population mix and rate of growth for each major ethnic group in each DHB district.

Northern Region Population – Age and Ethnic Mix – 2001 Census

Table 1- Maori

	NDHB	WDHB	ADHB	CMDHB	TOTAL
0-19	19,152	18,468	11,598	29,670	78,888
20-64	19,461	20,352	16,596	30,351	86,760
65+	2,109	876	945	1,371	5,301
Total	40,722	39,696	29,139	61,392	170,949

Maori made up 13% of the region's population in 2001, with a high of 29.1% in Northland, and a low of 7.6% in Auckland.

Table 2- Pacific People

	NDHB	WDHB	ADHB	CMDHB	TOTAL
0-19	744	11,580	18,147	31,725	62,196
20-64	819	14,124	23,355	34,950	73,248
65+	45	909	2,130	2,388	5,472
Total	1,608	26,613	43,632	69,063	140,916

Pacific people comprised 10.7% of the region's population at the last census, with the range of Counties Manukau having a percentage of 18.4%, and Northland 1.1%.

Table 3- Other

	NDHB	WDHB	ADHB	CMDHB	TOTAL
0-19	24,459	97,860	67,650	67,395	257,364
20-64	56,769	221,013	192,465	148,773	619,020
65+	16,530	44,565	34,854	28,887	124,836
Total	97,758	363,438	294,969	245,055	1,001,220

Table 4- Total

	NDHB	WDHB	ADHB	CMDHB	TOTAL
0-19	44,355	127,908	97,395	128,790	398,448
20-64	77,049	255,489	232,416	214,074	779,028
65+	18,684	46,350	37,929	32,646	135,609
Total	140,088	429,747	367,740	375,510	1,313,085
Percentage	10.7%	32.7%	28.0%	28.6%	100.0%

Table 4 illustrates the variability in age distribution in the various DHBs in the northern region. Counties Manukau and Northland have young populations (approximately one third of the population under 20 years of age) and Northland also has the highest percentage of people aged 65 years or over (13.3%).

The remaining two tables provide whole population projections for each of the DHBs to 2003, together with the growth rate used to achieve those projections.

Table 5 – 2003 Projected Total Population by DHB

	NDHB	WDHB	ADHB	CMDHB	TOTAL
Total	146,300	476,900	414,800	415,000	1,453,000

Table 6 – Growth Rate 2001 - 2003

	NDHB	WDHB	ADHB	CMDHB	TOTAL
Total	2.2%	5.5%	6.4%	5.3%	5.3%

GLOSSARY

Benchmark – a measure of resource, such as available staff or beds, with an implication that it is a baseline or adequate level, a level suitable for comparison purposes.

Blueprint funding – funding allocated and committed by the government to address the resource gap between current mental health service provision, and the benchmarks established within the Mental Health Commission Blueprint.

Capacity – funding an available level of resource (inputs) such as beds or FTEs. Contrasts with fee for service, where the amount of service delivered is funded.

District Annual Plan – the planning document prepared by District Health Boards each year, which sets out their intentions for the coming year. When agreed between the DHB and government, it becomes the key accountability document, whereby government can determine whether the DHB is doing its job.

Economy of Scale – it is cheaper to serve large numbers of people through one process than small numbers of people through many distinct processes. For example, a provider has certain overhead costs such as management, information technology, office costs etc. Those costs will usually make up a larger proportion of a small provider's overall costs, than those of a large provider. Effectively, a lesser proportion of money is thus available for service delivery, where it is spread across many providers.

Equity – an equal level of resourcing, when certain factors are taken into account. The factors are a matter for discussion and agreement, and might include the incidence of mental illness, deprivation, rural/urban, or indeed none at all. The PBFF is a mechanism for arriving at an equitable distribution of health funding between DHBs.

Full Time Equivalent (FTE) – a measure of staff availability, equalling a person (working full time) or several persons (part-time) totalling 40 hours a week.

Gap – the difference between available resources and that proposed by a benchmark, such as the Blueprint.

Intra-district equity – equity of resourcing between DHB services in one region, such as the Northern region.

Intra-regional equity – equity of resourcing between regions, such as the Northern and Southern regions. While there are differences between DHBs in the Northern region, the largest gap in equity is between the Northern region and the Central and Southern regions.

Population Based Funding Formula (PBFF) - The PBFF is an aggregate formula that determines the share of funding to be allocated to different areas of the country, based on the population living in each area. The PBFF does not determine the overall level of funding. The overall level of funding is determined by the Budget process based on Government spending priorities.

The PBFF model is designed to fairly distribute available funding between DHBs according to the relative needs of their populations and the cost of providing health and disability support services to meet those needs. The PBFF will give each DHB the same opportunity, in terms of resources, to respond to the needs of its population.