Regional Approaches to Mental Health: A Sector View and Beyond

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Executive Summary

This study has evaluated the contributions and impacts of the regional approaches to mental health (MH) in order to gain an indication of the actual and potential benefits, and to consider other possible approaches to mental health organisation.

The four Regional Mental Health Networks (RMHNs) were initially mandated by the Minister in July 2001 for regional planning and as a vehicle for further development of the mental health sector, which was seen at that time as fragmented and lacking the capacity to deliver more specialised services within all District Health Boards (DHBs).

The timing of the introduction has meant the RMHNs and the DHBs have both been working out their *modus operandi* in parallel. The New Zealand Public Health and Disability Act 2000 (NZPHD Act) charged the DHBs with responsibility for their local population, whereas the formation of the RMHNs challenged the DHBs to work collaboratively with a regional focus. Although the Act makes provision for working cooperatively when this is in the interests of the local population, or for reasons of efficiency, the regional and local approaches have been seen by some as in conflict. Some of those interviewed suggested the DHBs are now more established and therefore are now more able to work cooperatively.

The literature on the formation of collaborative networks predicts such groups go through a relatively complex development process as membership, governance, leadership, decision making and accountability protocols are developed. The evolution of the individual RMHNs has no doubt been complicated to some degree by the DHBs also undergoing a learning process. It is notable that most regions have reviewed and altered their RMHNs as the participants have become clearer about their purpose and how they wish to work together. Although all four RMHNs have successfully developed regional plans, their main achievement to date could be viewed as becoming established and working out ways of functioning.

Key informants identified the main issues facing the MH sector currently as poor connections and lack of coordination within the sector, the uneven distributions of skills, the weakness of the MH sector which is in need of further development, and concerns over accountability measurement and processes.

The RMHNs allow regions to share expertise and knowledge to develop a strategic overview to formulate cooperative and collaborative solutions to skills shortages and sector-wide issues. They also provide a platform for workforce development, influencing attitudes and organising regional training.

All four RMHNs have detailed work programmes arising from their regional plans which are expected to address the problems and service gaps identified by the reviews undertaken. These are either at an early stage of implementation or planned for the next

few years. Although at this stage the actual achievements are sporadic or "in process," there is optimism and expectation that traction on some difficult issues will be gained.

The four RMHNs have evolved differently, reflecting the historical context, priorities and values, and the geographical realities for each region. The prescribed role of regional planning caused resentment in some key informants who would prefer even more freedom to choose how to work together regionally, and in fact, whether or not they retain the RMHNs.

Some question whether the costs incurred by the RMHNs are justified, given the slow emergence of major benefits. The regional arrangements were seen as accentuating MH as different from the rest of the health sector, therefore representing a risk of perpetuating stigmatisation.

This evaluation concluded the costs incurred by the RMHNs should be regarded as investment for future gain. The main benefits at this stage are the formation of collaborative ways of working and the development of detailed work plans as represented by the strategic plans. The reviews and other information gathering on which the plans are based represent the initial stages of larger processes aimed at addressing service gaps, region-wide issues and workforce development.

The four RMHNs vary on some key dimensions: nature of leadership, inclusion of stakeholders, the level of engagement between planning and operational-clinical arms of the DHB, the degree of involvement of NGOs, the extent to which work-streams draw together sector representatives from across the region, and frequency of meetings.

In the immediate future, it is our view that prescriptive formulae should be avoided because of the differing geographical and historical contexts between regions. What works for one set of circumstances does not necessarily fit for another. However with this caution in mind, this evaluation has found some features more conducive to promoting the desired outcomes, as defined by the criteria against which the RMHNs were evaluated in the research process.

- Leadership is deemed helpful, to facilitate communication processes and to give an independent focal point for advocacy and media relations. This is demonstrated most clearly by the regional director role in the Northern RMHN but is also potentially fulfilled by the RMHN managers from other regions if given a mandate to take on this role.
- Planning is best promoted by top-down input as well as bottom-up input. Top-down input is defined as analytical, clinical and DHB planning expertise. Bottom-up input refers to the stakeholder consultation and prioritisation processes.
- Consultation to supplement DHB planning input is regarded as essential to give a well-rounded and strategic overview, avoid duplication and increase buy-in to plans. The reliance on District Advisory groups as the only consultation input in the Southern region is less than optimal in our opinion.

- Bringing together people from across the sector, that is, NGO and DHB providers as well as other stakeholders, is more likely to generate dynamic and innovative solutions, while also promoting the integration and coordination of the sector.
- Including representation from cultural minorities on network discussions is one step towards ensuring services are culturally appropriate to those they serve but is not sufficient on its own. Ensuring consultation processes are conducive to hearing those minority groups; operationalising culturally sensitive practice; offering sector wide training support to increase culturally sensitive practice; and providing a parallel network as a platform for cultural liaison and leadership, as exemplified by Te Arawhata Oranga in the Central region, were identified as helpful adjuncts.
- Workstreams and project groups which draw together expertise from within and across the region are seen as helpful because they build relationships between organisations, empower by reinforcing and acknowledging the knowledge that is there (as compared to bringing in expertise from outside the region), promote innovation by bringing together diverse experience and stakeholder perspectives, and support the emergence of a regional identification as well as the local identification.

It is recommended that the RMHNs are given the time to realise the expected benefits from the investment of effort already committed, before major review. Specifically, we recommend that:

1. The Status Quo continues, to allow the RMHNs to realise the anticipated benefits arising from the strategic plans generated and to follow through the intended plans of action. This progress could be reviewed at the end of the three year planning cycle starting with the 2005-2006 regional plans. At that time the Ministry and the sector should work together to review options in the light of perceived benefits and desired outcomes.
2. The Ministry of Health works in dialogue with the CEOs and the sector to clarify expectations with regard to what is regional versus local, and to address any confusion over accountabilities.
3. This dialogue should also clarify as much as possible the intended funding path as the regions move closer to the Ministry's Blueprint funding model.
4. Although the regional MH groups have evolved differently, they face similar challenges and issues. Sharing information about the solutions developed by other regions, for example by making this report available, is one way of supporting the RMHNs' ongoing evolution.
6. Change management processes are particularly challenging to the Networks. The RMHNs may benefit from the employment of change management expertise to support change processes.

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Glossary

CEO	Chief Executive of the Organisation
CRMHAN	Central Region Mental Health and Addiction Network
DAG	District Advisory Group
DAP	District Annual plan
DHB	District Health Board
GM	General Manager
HFA	Health Funding Authority
IDF	Inter-district flows
KPIs	Key performance indicators
LAG	Local Advisory group
MH	Mental Health
MHC	Mental Health Commission
MRNOG	Midland Regional Network Operational Group
NGO	Non-government organisation
NNC	Network North Coalition
NZPHDA	New Zealand Public Health and Disability Act
PBFF	Population based funding formula
RMHN	Regional Mental Health Network
SIRMHN	South Island Regional Mental Health Network
SSA	Shared Service Agency
TAS	The Central Region Technical Advisory Service

CHAPTER ONE.
Introduction

This study is a research evaluation of the regional approaches to mental health, with a view to assessing the actual contributions to date, other possible models of regional approaches, and the potential benefits that could be expected from these.

A wide range of health sector representatives were interviewed to gain a sector view of the current issues in mental health and the functioning and contributions made by the four existing Regional Mental Health Networks. The range of stakeholder views allowed a comprehensive picture to be built up. This information is combined with a literature survey to assess what works well in the current arrangements and to consider possible adjustments.

The study was commissioned by the Ministry of Health and the Mental Health Commission but was conducted independently by the research team based at Health Services Research Centre, School of Government, Victoria University of Wellington.

Context

The District Health Boards are charged with delivering health care for their resident populations under the New Zealand Public Health and Disability Act 2000 (NZPHD Act 2000). The legislation encourages DHBs to develop co-operative and collaborative arrangements where that is expected to improve the delivery of care and promote efficiencies.

The DHBs are the purchasers of publicly funded mental health services, whether from their own DHB provider services or from NGO providers. The NGO providers make an important contribution to mental health service delivery, with approximately one third of all public mental health service purchasing funds spent on this group (Ministry of Health, 2004). The draft second mental health strategic plan *Improving Mental Health (*August, 2004*)* identified system and service coordination as one of the significant gaps in specialist service development (Executive Summary, pg iv). The strategic directions highlight the need for more specialist services, better services for Māori, greater responsiveness to consumers and the culturally diverse population, integration with the developments in primary care, and the need for systems development, both for information management and systems integration. 'Working out how the system can be better integrated is probably one of the biggest challenges the mental health system faces' (pg x). In addition, 'the last decade has seen the growth of a strong consumer voice'. The draft second Strategic Plan for mental health and addictions goes on to note consumers have mostly been involved up to now in the planning, funding and delivery of services,

but that the next phase will be to involve consumers in leadership and governance roles within the health sector (pg 17, Ministry of Health, 2004).

This is the legislative, organisational and policy environment which forms the backdrop for considering regional arrangements for mental health. Regional in this context means coordinating or collaborative arrangements super-ordinate to the DHB, or local level.

There are four existing regional mental health arrangements: the South Island Regional Mental Health Network, the Central Region Mental Health and Addictions Network, the Midland Regional Mental Health Network, and the Network North Coalition. These share some of the infrastructural arrangements of the Shared Service Agencies (SSAs), with the exception of the Midland region. In parallel with the SSAs, each network includes the DHBs of those regional groupings.

There are known to be significant differences between the four existing Regional Mental Health Networks (RMHNs) which provides a natural experiment to allow comparison between arrangements, and the contributions they make. Each of these RMHN operates in a quite different context including historical, geographic and demographic factors.

Methodology

The research combines qualitative interviews with rating scales to assess the context of the RMHN, the tasks performed, the actual impacts on different criteria or valued outcomes and reflections on the overall value of the existing arrangements. Information on resourcing and benefits gained will be combined to conduct a cost-benefit analysis. In addition, a series of interviews with key informants provide commentary on the mental health sector and the place of RMHNs within this. A literature survey supplements the research information.

Interviews

Interviews were conducted between 29 November 2004 and 14 February 2005.

The following informants were interviewed:

4 RMHN managers (or equivalent role, as different titles are used)
1 RMHN organiser
12 Portfolio Managers (in some DHBs this role is performed by General Manager)
16 NGO informants
10 Provider Managers (or Clinical Director or General manager)
2 RMHN Financial analysts (in one case this role is performed by a General Manager)
2 General Managers for Funding and Planning
3 CEO of DHBs
6 Key informants, from the Ministry of Health, Mental Health Commission and DHBNZ.

Sampling

Within each region, the RMHN manager, the financial officer supporting the network (if separate from the manager), four NGO informants and the MH Funding and Planning Portfolio Manager from three DHBs were selected. In addition the Provider Managers (or related role) from the same DHBs were approached, although in one case the role was a combined Provider-Portfolio role and in another DHB the Provider Manager was too new to the role to usefully participate in the research, which reduced the sample size to ten for this category of informant.

In three cases, a General Manager has a key role in the network and was included in the sample. For two DHBs, these were interviewed as Portfolio Manager informants whereas in a third situation the General Manager was integral to that RMHN and was an additional informant.

The DHBs were selected to give a range of the largest or lead DHB, one more distant or smaller, and a third either in between or having some feature of interest. The aim was to select a representative cross section, but removing from the sample DHBs where the Portfolio Manager was too new in the role to be a useful informant.

The NGO selection also aimed to include a representative sample, including for each region at least one mainstream provider, one Māori provider, and one consumer organisation representative. In the two areas with higher Pacific peoples population, Northern and Central, Pacific providers were included. Over the whole sample, one family representatives' organisation and one organisation working with substance abuse were included. Sampling also took into account the geographical spread of the NGOs.

The key informants from the Ministry of Health and the Mental Health Commission were selected by the organisations concerned.

Two of the DHB CEOs were selected by the role they hold in DHBNZ. Four other CEO representatives were approached, with the aim of including one CEO representative from each of the region. One of these agreed, whereas the others declined or were unavailable. By this late stage of the research further efforts to enlist a representative CEO from the fourth region were abandoned because of the time pressure.

All of the other informants approached were willing to participate, though a few pointed out they were recent appointments and on that basis were excluded from the study.

Interview Questions

Interview schedules were prepared for:

- Regional Mental Health Managers
- Portfolio Managers
- Provider Managers
- NGO informants
- Consumer representatives

The content of these interviews overlapped to a large extent, with adjustments to capture the particular stakeholder view. These interviews included information about the structure and communication channels; contextual information; clarification of the objectives and tasks of the RMHN; questions pertaining to likely impacts and rating the degree of these impacts; disadvantages and other observations about the current arrangements; and the preferences for the future.

In addition interview schedules were developed for:

- Financial officers for the RMHN
- Key informants
- DHBNZ informants, including CEOs.

The schedule for financial officers asked information about the resourcing of the RMHN and the costs incurred.

The Key Informant schedule sought an overview of the current issues facing the mental health sector and the perceived contributions of regional arrangements.

The DHBNZ asked overview questions as in the Key Informant schedule but also focused on the advantages to taking a wider approach than just a local one and also strategies used within DHBNZ to achieve this.

Content of Interview Schedules

The interview schedules are attached, in Appendix One.

Although the question regarding the aims and objectives was left an open question, the tasks of the RMHN were asked about in a structured and systematic way, including the following (see the full interview schedules for the more detailed questioning around these):

- Planning for region
- Funding and purchasing decisions
- Consultation with stakeholders
- Changing service delivery arrangements
- Workforce development
- Task groups on specific issues and problems.

The informants were then asked to rate the impacts of the regional arrangements using either a scale of one (low, negative) to ten (high, positive) or using words mild, moderate, major impact in either negative or positive direction. Informants were given the choice of using words or numerical rating scales to allow for their preference Responses of "neutral" or "don't know" were also available. For the purpose of analysis, 8.5 and above were equated with major positive, 7-8 were equated with moderate positive, 6 was equated with mild or small positive, 5 equated with neutral, 4 equated with small negative, 2-3 equated with moderate negative and 1- 1.5 equated with major negative impact.

The following criteria were rated (see the full interview schedule for prompts supplied of possible relevant information):

- What impact does the regional focus have on improving equity of access?
- What impact do the regional arrangements have on the coordination of clinical services?
- What is the impact of the regional arrangements on the integration of regional and local planning?

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- Are there any strategies for recruitment and retention that arise out of the regional arrangements? Do the regional arrangements promote a stable and supported mental health workforce?
- What impacts do the regional arrangements have on the effective use of scarce resources?
- How have the regional arrangements affected the public's confidence in the mental health services of the region?
- What impact do the regional arrangements have on safe and sustainable mental health service?
- What impact do the regional arrangements have on consultation, engagement with stakeholders and transparency (with regard to consumers, families, provider organizations, PHOs)?
- How well do the regional arrangements promote innovation?
- What impact do the regional arrangements have with regard to cultural safety of mental health services for Māori, Pacific and other cultures?
- What impact have the regional arrangements on the overall efficiency of mental health services in the region? Do benefits of the regional arrangements outweigh the costs?

Literature Search and Review

The literature search and review encompassed the following:

- Policy documents setting out the expectations and objectives of the Minister of Health and the Mental Health Commission for mental health service delivery in New Zealand.

- The research examining regionalisation as a way of organising service delivery, including some case study reports from other countries. Literature on the integration of mental health systems and collaboration

- Literature examining centralisation versus decentralisation within the New Zealand context.

In combination, the literature review provides information on central Government's policy expectations and objectives for mental health services, the expected gains to be achieved by regionalisation and collaboration, some conceptual frameworks for understanding the success or impediments to such arrangements, and the strengths and weaknesses of various models for organising MH systems.

The literature search used the following search terms:

Regionalisation
Regional services + MH
Regional planning + MH
Decentralisation + MH
Clinical collaboration + MH
Organisation + MH
Virtual integration
Participatory management
Integrated service networks

Victoria University, Ministry of Health and Wellington School of Medicine databases were searched using Medline and Proquest, then the search was supplemented by looking through specific journals.

Report Outline

This research is above all a sector view from the different stakeholder perspectives. The data is reported fully to allow the rich tapestry of stakeholder opinions to be transparent, as well as analysing data for the trend information. Where revealing the category of informant adds weight or significance, this is done so, but not if to do so would be at the expense of preserving confidentiality.

The report includes the following sections.

Chapter 2: Why regionalisation?

Chapter 3: Policy and legislative context

Chapter 4: Literature review

Chapter 5: Overview of the four Regional Mental Health Networks

Chapter 6: Comparison of the four existing RMHN and other relevant issues

Chapter 7: Discussion

Chapter 8: Conclusions

Appendix 1: Research interview schedules

Appendix 2: Southern Regional Mental Health Network

Appendix 3: Central Regional Mental Health and Addictions Network

Appendix 4: Midland Regional Mental health Network

Appendix 5: Network North Coalition

CHAPTER TWO.
The Sector Viewpoint – Why Regionalism?

A recent episode from the research data serves as a reminder of why many consider regional approaches to the organisation of MH an essential adjunct to the organisation and service delivered by individual DHBs.

A small DHB recently assessed a male patient as acutely disturbed and in desperate need of specialist inpatient care. As it was beyond the capacity and capability of the DHB to deliver that service, the provider manager phoned their neighbouring DHBs within their regional grouping. After numerous phone calls it was established the nearest DHB willing to admit him was in another region, approximately seven hours drive away. Two nurses accompanied the man but two hours into the trip he was assessed as becoming even more disturbed, and that it was too dangerous to continue, so they returned. For the next three days the man was looked after as an inpatient, "specialled" around the clock with a roster of community nurses who were not certificated to provide that level of care, until a neighbouring DHB with greater specialist capacity was able to take over his treatment.

This illustrates a number of points about the MH sector. Specialist care is not available in all DHBs but, like most tertiary services, represent scarce treatment resources which are located mainly in the larger centres. For that small number of people presenting in urgent need of psychiatric treatment, they cannot be kept waiting on a waiting list but must be attended immediately. If treatment options are limited to what is available locally then those people served by smaller DHBs will have less than optimal care. Presumably in this instance the other DHBs approached had judged they did not have any spare capacity so could not offer an open door. This DHB, like other rural and other smaller DHBs, found another way of coping with the circumstances but there are some "costs": the patient was possibly given less than optimal treatment, the nurses concerned were required to work beyond their certificated level of competence, generating undue occupational stress and the managers who were held responsible and accountable also endured an anxiety provoking situation. The family of the man may well have been reluctant for their family member to be treated out of the district but also, no doubt, wanted optimal care delivered.

Events may have unfolded differently if the sector had more capacity to allow generosity to neighbours. Within the collective capacity of the region's MH services, this man's acute needs may well have been judged as more worthy of admission than some of the present incumbents of the inpatient care if triage principles had been applied and used to determine acceptance for admission. That would be assisted if there was an attitude of shared responsibility for the provision of care to the regional population or other defined catchment, as opposed to responding to local needs first and then accepting others as a favour if there is any spare capacity left over. It assumes a culture of working

cooperatively and collaboratively with other DHB MH teams in the region in the spirit of achieving together quality services delivered equitably, regardless of district of residence.

A rapid response when an inpatient unit is already full assumes an ability to arrange packages of care based in the community for those nearing readiness to discharge. To achieve that means pre-existing good liaison with a range of provider organisations to allow that alternative treatment centre to absorb at short notice the patient who is "bumped off the list" and who is likely to still need quite extensive rehabilitation. That package of care may also allow for an established case manager to continue to deliver follow-up care from the inpatient unit in order to preserve an established constructive case manager relationship. It may have involved returning that person to their district of origin and ensuring the smooth transition to local care. The likelihood is the package of care would have drawn on services supplied by NGO providers. These NGO providers do not necessarily stay within the geographical boundaries of the DHB. Good liaison and networking makes possible fully utilising the capacity of the MH sector to provide patient oriented treatment and support services that are flexible and responsive to those clinical needs. The liaison required sometimes goes beyond the DHB locality.

Clarification of the rights of access to the more scarce specialist skills for those DHBs is one obvious desired outcome of regional discussions. Potentially it also offers the framework to facilitate that desired spirit of collaboration and the development of relationships which enable clinical coordination in seamless and optimal clinical pathways

Current Issues and Challenges Facing the MH Sector

The nine key informants (which includes the CEOs in the sample) identified a number of concerns for the sector.

All informants identified the disconnections within the sector as a problem to address. Issues this raised for informants included the Provider arms of DHBs connecting poorly to the NGO providers, with implications of the NGO sector not being fully harnessed. One informant observed a lack of understanding of the NGO sector also resulted in unequal distributions of pricing, freedoms and accountability processes. Other informants spoke of the separateness between mental health services and other parts of the health sector, with particular emphasis placed on the need for integration with primary care.

Five informants raised issues of capacity and capability, including recruiting appropriately skilled staff, up-skilling existing staff, retention issues, the lack of orientation to good information systems, the difficulty of recruiting good managers into the sector, and the lack of effective clinical leadership and advocacy.

Five of the nine informants noted the mental health sector suffered from issues of perception and credibility. One said 'it is not a glamour area' and therefore it continues to be low on the 'pecking order.' Others spoke of the sector being poorly understood but

also an area of health rife with strong opinions and misleading assumptions which can act as barriers to the instigation of good treatment. The perceptions of the community were seen as placing extra stress on the workforce in the sector.

Three raised concerns about accountability. The relatively fragmented sector was seen as reducing the scrutiny of providers and raising 'problems of standards and uniformity for the benefit of recipients.' Another stated 'the more permeable the boundary between organisations, the better the informal scrutiny to supplement more formal accountability and standards promoting procedures.' A third person considered there are no good measures of efficiency or outcomes.

Three of the seven informants saw issues with regard to Government's role in the sector. One raised concerns that the lines of authority and responsibility are muddled, with a lack of clarity whether the sector is accountable to the Ministry or to DHBs. In addition, the Governmental regulatory authorities were observed to add extra stress on the sector. Another considered the Ministry's involvement in the sector actually perpetuates the lack of integration between mental health and the rest of the health sector. A third informant regarded the lack of clear cut authority over the sector as creating only diffuse and slow mechanisms for upholding strong and consistent quality standards.

Other issues raised by single informants were the lack of collaboration between DHBs, the lack of improvement in access despite the funds going into mental health steadily increasing, and the compulsion around treatment.

Although some work force issues were considered more severe in rural rather than urban areas, in the main these issues were considered relatively consistent across the nation, with the exception of some localised improvements in coordination between services.

What's Different About Mental Health?

Informants expressed very mixed views on the vexed question of whether MH was different than other parts of the health sector to justify more elaborate and potentially more costly regional arrangements than other tertiary services delivered regionally.

For some key informants the need to collaborate to address the large and profound difficulties in the sector was almost a 'given' because of the inability to provide specialist care in all DHBs, the poor capacity and capability across the sector and the complexities caused by the lack of understanding of the mental health issues, people needing care for extended periods of time in ways that can involve all aspects of the social and occupational functioning, and the mobility of this population. One pointed out the MH Act cuts across other human rights legislation. There are legal and human rights ambiguities raised by mandated care when a symptom of illness can be lack of insight.

> 'The beneficence of the state extends its loving arms around the person who is incapable of making their own decisions, and it does that until they are capable of

taking back the control of their own life. That is one of the paradoxes, that is what makes it so difficult, what makes it so fraught, what makes it so important as you have got to take a wider view.'

Others, particularly the CEOs, did not consider MH was different. 'Like any other tribal group MH thinks it is different but in my view they are not very different at all.' One saw difficulties caused by the separateness, that it actually perpetuated stigmatisation. Another did not think it was any different from any other part of the health sector which has regional services, which are those sectors which have different levels of complexity and skill in their provision and also are required to have some equity of access. Other sectors such as renal services and oncology work out regional issues without employing additional staff to do so or by creating large networks.

However, even those who were not in favour overall of MH regional arrangements acknowledged there were benefits arising from the existing arrangements. The disagreements were more over the degree of benefits, whether the benefits justified the costs, whether they could be attained another simpler way, and over the imposition of this way of collaborating within the local model of health delivery system.

Perceived Benefits of the RMHNs

Informants pointed out the following benefits:

- The regional arrangements allow the means for DHBs to collaborate to pool expertise. More complex disorders are likely to require sophisticated and rare skills that are not able to be supplied by all DHBs. Regionalisation of these services promotes equity of access and economies of scale, but requires health needs assessments, planning, agreements on service guide lines, joint ownership of issues, and coordination as the foundations. Regional approaches also offer the potential to manage demand by DHBs backing one another, with larger DHBs ensuring smaller DHBs 'are afloat.'

- Regional arrangements can provide the infrastructure to address sector wide issues more efficiently and effectively, including regional approaches to workforce development, training, developing information systems, telepsychiatry and clinical issues that are in common with other DHBs. It also potentially can avoid duplications.

- Regional arrangements offer the means to help integrate the sector, to facilitate working relationships and collaborations, to ensure communication channels are open, and to encourage inclusiveness and consultation.

- In a sector that is relatively fragile and undeveloped there is a need for extra protection such as the ring fenced funding. New money allocated regionally needs sector wide consultation with all stakeholders to set priorities for purchasing.

- Regional forums can facilitate the discussion of bigger strategic issues. One indicated the RMHNs should offer guidance on how to link MH with primary care.

- There are particular features of the MH sector which require a broader focus. People are sometimes cared for over a long period through times of relative wellness as well as more acute episodes. Illness can affect many aspects of functioning requiring intervention on a number of levels by inter-sectoral providers. MH consumers are, on average, more mobile than the rest of the population. This requires an extra degree of flexibility and integration in the sector.

- The MH sector has difficulties measuring performance. Regional arrangements are perceived by some as offering a forum to drive more consistent quality and standardisation of care. Regional arrangements can be a means to share innovation and promote best practice.

Difficulties Caused by Regional MH Arrangements

Informants also identified a number of difficulties caused by the separate regional arrangements.

- CEOs in particular felt it confused the accountability for MH. By law DHBs are responsible to provide for their population's health, for which they are held accountable through the District Annual Plan. One informant complained the requirement to produce a regional plan has no basis in the legislation and how it fits in the accountability frameworks is ambiguous. This informant considered the RMHN to be in a guardian role because of the Ministry's lack of trust in the DHBs to adequately safeguard MH. Two others commented RMHN potentially usurped the authority of the Board. One informant observed a degree of resentment and antagonism amongst CEOs at the imposed "solution." While not doubting the MH sector has some particular problems, 'I believe the way to solve that is to win hearts and minds rather than prescriptive solutions of another layer of protection.' The ring fenced funding and the Mental Health Commission were seen as sufficient safeguards.

- Some expressed concern at the bureaucracy built up which has created an extra layer of cost. One referred to some research in process which shows access has not improved since 1992, nor have tertiary services increased, despite all the extra money going into the sector, which 'indicates a huge failure of infrastructure.' One observed 'regional arrangements are covering too much time in talkfest but then people are too thin on the ground to get the work done.' Time is wasted if people are involved in meetings not directly relevant to them.

- There are problems caused by MH having separate arrangements and regional approaches. Some approaches are not consistent or useable in other arts of the sector, causing wastage of resources and investment. For example MH workforce development uses different approaches to those adopted by the Workforce Development Group under the DHBNZ. One informant observed problems for the perception of MH by the rest of the sector caused by the fact that MH has money to spend on employing extra people and the additional layer of bureaucracy.

- There are also lost opportunities caused by regional issues worked through in separate discussion forums as it reduces the profile of MH within DHBs.

  'When issues or plans are coming through the Executive team, or the Board and committees, and are being debated, it means everybody is aware of it. When the Network is outside of us, we don't have that same awareness, so it perpetuates the separateness.'

- Communications sent directly out from the RMHN were perceived by one CEO as undermining the position of the DHB.

- The complexity of funding and planning arising from having both regional and local processes, and the more complex consultation structures was seen to offset the advantages obtained by local approaches, according to one informant. Although there was a general acceptance of the need for some level of regional organisation, 'regional approaches should be used only sparingly.' The focus of regional arrangements should only be on those services not provided in all DHBs, where ownership and input is required from other DHBs. It should not extend beyond this into 'local business' nor monitoring. It was not seen as necessary either when DHBs have trouble supplying services, as that is a DHB to DHB arrangement.

- Some informants commented on the fact that DHBs have evolved and matured over their existence and so are now more capable of working out collaborative relationships without necessarily having an additional structure. The role of the Ministry was seen as developing strategies, policies, to monitor performance and to intervene if necessary but to allow the DHBs to evolve whatever arrangements worked for them, recognising that different arrangements were likely to work better for different regions.

- Informants also pointed out some of the desired outcomes could be achieved in other ways. For example regional service access protocols and coordination could be worked out on an issue-by-issue basis, in the same way other regional services do. The Auckland region has a Regional Service Configuration group which is concerned with how services inter-relate and avoiding duplication across the health sector. There are other ways relationships within the sector can be promoted, for example meetings around issues of common interest, or DHBs

creating opportunities such as education sessions. Consultations should be suited to the purpose required.

Regardless of the structure and processes used, there was general agreement that the purpose and accountabilities needed to be very clear and transparent. One observed care needed to be taken to not over represent the groups' authority to avoid unrealistic expectations.

CHAPTER THREE.
Policy and Legislative Context of the RMHN

Legislative Context

The District Health Boards (DHBs) are charged with delivering health care for their resident populations under the NZPHD Act 2000, Part 3 s 22. However the Act also allows the DHBs to enter cooperative arrangements to assist the DHB in meeting its objectives and promote efficiencies. Under Part 3 s 23(b) the Act enables the DHBs to

> "actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities."

Although this is widely interpreted to mean the primary responsibility of the DHBs is to their resident populations, it can also be read as encouraging collaborative arrangements where that is beneficial to the people and advantageous to achieving desired outcomes and efficiencies.

Strategic Direction

The overall direction for the mental health sector that the DHBs are required to deliver is determined by the New Zealand Health Strategy and the sector focused strategies which sit underneath that, including strategies for mental health and primary care. The first *National Mental Health strategy: Looking Forward* (Ministry of Health, 1994), and its associated plan, *Moving Forward* (Ministry of Health, 1997) was supplemented by the *Blueprint for Mental Health Services in New Zealand: How things need to be* (Mental Health Commission, 1998) which provides a normative guide to resource levels for specialist mental health services. A second strategic mental health is currently in draft form and is undergoing consultation *Improving Mental Health: the Second National Mental Health and Addiction Plan 2005-2015* (Ministry of Health, 2004).

The Primary Health Care Strategy provides the framework for DHBs to provide for primary care services, delivered by PHOs. This promotes a significant change of direction towards comprehensive health promotion and prevention approaches, based on community involvement and the integration of services between multi-disciplinary providers.

The 1994 National Mental Health Strategy expressed concern at the low resource allocation to community mental health services, poor coordination between hospital and

community providers, workforce issues, a lack of systematic information systems, and unclear accountability to the various agencies involved. At that time Māori and children and families were seen as lacking appropriate services and there was a perceived lack of provider responsiveness to consumers and whānau. The issues highlighted in this Strategy were translated into action by the *Moving Forward* implementation plan, which also spelt out the underlying values and principles the sector was expected to adhere to. Prominent in these are principles of empowering consumers and their whānau, improved service specification to meet the diverse needs of consumers, improving access to quality services which meet consistent safety standards, ensuring the involvement of Māori in planning appropriate services for Māori, and the integration of services at all levels to strive for the best possible outcomes for consumers and their families.

The MH strategy also introduced the concept of benchmarks as the target level of mental health services to be provided, suggesting that mental health services should be directed at the 3% of the population who are likely to be in need. The Mental Health Commission (MHC) published the *Blueprint* funding model as its description of the mental health service developments required in order to achieve this desired level of access. The Blueprint funding model has been widely used since as a guide for different aspects of the service delivery while incorporating the recovery approach and the empowerment of consumers, as embraced in the Strategy.

The Executive summary of the Blueprint document acknowledges the challenges for the mental health infrastructure of:

- delivering mental health services using a recovery approach which empowers service users to increase their control over their mental health and their lives, fully acknowledges their rights and promotes participation in society.
- accommodating all types of providers as optimal for the provision of flexible and responsive services.
- promoting innovative, flexible and well coordinated services that match the diverse emotional and cultural needs of the service users.
- fostering an environment which encourages those working in the MH sector to continually seek new and better ways of delivering services.
- allowing consumers to move easily between services and health sectors without discrimination and supporting full participation in society.
- providing culturally appropriate services for Māori and Pacific peoples.
- incorporating support for families and utilising the family as part of the care programme.

The History of Regional Arrangements

The notion of regional mental health networks was signalled as a policy intention in a policy paper "Labour on Mental health" in October 1999 (cited by Platform report, undated). This was applauded by some sector stakeholder groups, with some position papers presented in support, for example that of Platform, representing the NGO sector.

The MHC (2000), whose task is to ensure the implementation of the national mental health strategy and to maximise the progress towards improving MH outcomes for consumers and their families, perceived the regional arrangements as an essential development over and above the District Health Boards to be introduced by the NZPHD Act 2000. They issued guidelines to the sector recommending that DHBs establish regional mental health networks to provide:

- Mental health planning and funding for the region
- Collaborative approaches to quality improvement, audit and review
- Joint workforce development, recruitment and retention initiatives
- Increased integration and collaboration across the whole range of services.

At that time RMHNs were seen as the vehicle for progressing the implementation of the Blueprint funding levels to achieve service delivery deemed adequate to fully address the needs of the severely disturbed. The RMHNs were anticipated to provide the means to overcome problems of fragmentation in the sector, the lack of capacity and capability in DHBs to deliver the full range of more specialised services, and inequitable access to services. The RMHNs offered advantages of greater cooperation and collaboration; sharing of resources, including planning expertise; a means of involving stakeholder groups, including Māori and consumers; and a platform for quality improvement processes.

The MHC envisaged that the regional plans developed by the RMHNs would spell out how the region intended to make progress towards achieving improved service delivery, would guide strategic direction and purchasing priorities for individual DHBs. It was recommended that each RMHN establish regional advisory committees with representation from all stakeholder groups to inform the planning process and to increase the understanding and integration between agencies.

The MHC suggested the existing HFA groupings as the starting point for the geographical boundaries between regions. The DHBs in each group would be responsible for establishing a RMHN, which in turn was to be governed by and was accountable to the DHBs of the region. The DHBs were jointly charged with resourcing the RMHN to enable the regional plan to be implemented through local MH service development, and performance monitoring processes that coordinate with the regional processes.

In July 2001 the Minister of Health (referred to in a Ministry of Health communication to DHBs, October 2001) informed the DHBs of her expectations that they would actively work together in RMHNs to contribute to regional MH planning, to progress the implementation of the Blueprint funding model. Additional funds were to be allocated to resource this. The regions were required to reach agreement on the vision and priorities for the development of specialist services, quality improvement approaches, agreement on purchasing of regional services to address the identified gaps in locally purchased services, access agreements and other collaborative approaches to infrastructural improvements.

The Ministry of Health required the DHBs to provide an annual regional MH plan. The guidelines for 2002/03 issued by the Ministry of Health (October 2001) made explicit how the regions were to report against these expectations, including both an analysis of service gaps and the plans to collaborate to ensure regional service accessibility. Specifically, the plans for these aspects were required:

- Forensic service provision
- NGO services development
- Services for Māori
- Services for Pacific
- Consumer advocacy and peer support
- Family advocacy and peer support
- Implications for ongoing services
- Quality improvement initiatives
- Regional collaboration to address capacity and capability issues in local services.

From the 2005/06 planning cycle forward, the requirement will be for three yearly Regional Strategic Plans. However the essential themes continue to be the reporting of significant mental health issues and service gaps for the region, the intended steps to address the identified needs and to move the region more towards meeting adequate service delivery levels, and the ways the DHBs will collaborate regionally to achieve the desired outcomes. The DHB's District Annual Plan for mental health is expected to translate the regional plan into the action necessary to progress this overarching regional strategic direction, including the key steps and milestones to measure progress.

Other Contributions to the Policy Context

Some prominent reviews and commissions of enquiry also offer insight in to the expectations placed on regional collaborations.

1. The Health and Disability Commission's enquiry (2001) following the Mark Burton tragedy perceived formal regional alliances with other DHBs as a key to improving service quality and as a means to ensure consumer access to specialist services, with specific reference to services addressing the combined presenting difficulties of mental illness and substance abuse. The enquiry identified critical capacity and capability shortages in the DHB as a stand-alone service, and questioned whether the DHB was able to deliver services of an adequate standard without collaborative support from the regional DHBs.

2. The Mental Health Commission (December 2002) reviewed the mental health services funded by the DHBs in the Auckland region. Although paying tribute to the commitment of the workforce striving to deliver quality services, significant regional problems were identified: poor coordination of services; gaps in provision of services; poor information about services creating access barriers; uneven resourcing; a lack of

agreement between DHBs; a demoralised workforce; and a lack of leadership and shared vision. At DHB level there was found to be disconnections between those making resource allocation and planning decisions, and the DHB and NGO providers. A package of recommendations aimed to promote continuity of care directed to recovery outcomes, with key elements of a General Manager, Regional Mental Health Services with a Service Coalition to manage the contracting and to coordinate mental health services for the three Auckland DHBs, with a push towards integration between MH services and inter-sectoral services.

3. The Cull enquiry (2003) attributed the failure of the triage assessment of Paul Ellis in South Auckland mental heath services to a serious lack of capacity to cope with the high demand on the services, particularly given the severity of the presenting illness in that case. It was recommended that there should be good liaison and coordination of care between agencies, information systems in common, quality improvement initiatives, and equalizing the resourcing of the MH teams in the region to allow safe and adequate services with sustainable services workloads.

4. A Ministry of Health (July 2003) report on the future options for Waitemata DHB MH Services considered the various options to centralise MH services in Auckland to achieve greater cooperation and coordination. At that time the Regional Director had only just been appointed and the success of this was noted to depend on the three Auckland DHBs giving him decision-making authority.

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CHAPTER FOUR.
Literature Survey

Other Health Policy Systems

There are no policy systems that are directly comparable. However Canada is noted for having adopted regionalisation (reported by Church and Barker, 1998; Lewis and Kouri, 2004; Smith, Kokorudz and Pohl, 1995) with the desired objectives of better coordinating and integrating health care delivery, controlling expenditure, more effective service delivery and an avenue for citizen participation in health care decision making. It was seen to be a remedy for fragmentation and incoherence.

Athough 'somewhat ill-defined' regionalisation generally means:

> 'an organisational arrangement involving the creation of an intermediary administrative and governance structure to carry out functions or exercise authority previously assigned to either central or local structures. Accordingly, regionalisation may entail the shifting of responsibility for public health from a series of local boards to a regional agency, or a general devolution of power from a central governing agency to regional bodies.' (Church and Barker,1998, pg 468)

In Canada regionalisation efforts include both upward and downward movements of authority and responsibility. The Canadian model includes characteristics of regional governance and management boards made up of either appointed or a mixture of elected and appointed boards, budget holding, a shift in emphasis from institutional settings to community settings for delivery of services, an emphasis on monitoring and evaluation, and the downsizing and restructuring of provincial departments. The governance structure and budget holding plus the use of service plans are more akin to the New Zealand DHB model.

Frankish and colleagues (2002), writing about British Colombia in Canada, described decentralisation as the dispersal of power from higher to lower levels of government with regard to public planning, management and decision-making. They defined four main types of decentralisation, depending on the types of authority transferred: deconcentration (administrative authority); devolution (political authority); delegation (managerial authority); and privatisation (service delivery). Regionalisation is related to decentralisation but commonly refers to the adaptation of central Government 's policies, plans, and programmes to consider the special characteristics of a region. Regionalisation in Canada involves competing elements of centralisation and decentralisation, as there is a reduction of local organisation which reduces local input but there is also some devolution down from central Government control.

Church and Barker identified significant obstacles to achieving the desired integration and coordination of services for economies of scale, including adequate information management systems and possibly increased costs. Lewis and Kouri found change to be 'incremental and constrained.'

Fleury, Denis and Sicotte (2003) and Fleury Mercier and Denis (2002) examined the role of regional planning and management strategies, used by regional management boards seeking to rationalise and integrate health care systems and to enhance efficiencies to transform the Quebec healthcare system. As in New Zealand, these regional plans identified problems, priorities and goals, then mapped out the way to achieve these goals. Although their tripartite committees are not quite comparable to the RMHNs here, having more inter-sectoral focus, the limiting factors are comparable. The role of planning alone was constrained by the context in which it was implemented, particularly where there are autonomous organisations and different cultures, and at most was able to lead to incremental change. Planning was found useful for the functions of drawing together information and was a means of communication, direction setting and monitoring against but on its own was not sufficient to achieve substantial changes. However while the regional pan was of limited effectiveness in achieving the desired integration, it was the catalyst for much wider changes.

Wyss and Lorenz (2000) examined the functioning of the health care delivery system in Switzerland, which is an example of a highly decentralised system. These authors define decentralisation as a transfer of resources, functions and authority from the centre to the periphery. It can also be defined as devolution within the public sector. Cantons are responsible for organising the provision of health care within a defined geographical area. Within this political and legal system, there is little power or influence centrally and no national Ministry of Health, though some bi- or multi-lateral arrangements between cantons. Although these work well in some cases, in others they are blocked by strong local interests. The Swiss health system faces increasing costs and other problems where it would be more advantageous to act in a coordinated way but with twenty-six independent systems, reform is difficult to achieve, despite the current system being both inequitable when considering data across the nation and is likely to promote inefficiencies. It is concluded that in order to achieve inter-district coordination, it is essential to have a sufficiently strong and competent central structure.

Perceived Benefits in Regionalisation

Regionalisation implies some centralising of power in regional structures which may facilitate the better coordination of services and the realisation of economies of scale. It may promote greater equity in delivery of services, allow for more coherent budgetary process, and prudent containment of health care expenditure. On the other hand, devolution or decentralisation increases the chances health programmes will be more sensitive to local needs and provides an avenue for citizen participation in healthcare decision-making (Church and Barker,1998).

Brady (2002) identified the factors to be taken into account when considering whether Governmental decision-making should be centralised or decentralised in the New Zealand context. Factors implying the need for centralisation include the economies of scale and scope, the need for coherence and coordination, the need for uniform and consistent standards, and an overall view of the needs of a system. Decentralisation was likely to be preferable where localised knowledge and information are relevant, where there is a need to respond flexibly to local conditions, where community involvement and participation are important, and where there is a need to avoid an unnecessary concentration of power or risk of abuse of power.

Shulman (1991), considering the needs of the elderly mentally ill, recommended a regional approach to overcome problems of fragmentation, competition and dissociation between different sections of the health care system that serve the same clients. However 'to work effectively and efficiently, this system depends ultimately on a true spirit of collaboration.'

How to Achieve Collaboration and Integration

Gray (1985) collated a large body of research to distil out the essential conditions for inter-organisational collaboration, which is needed when there are problems which are larger than any one organisation can solve on their own. She suggests this also gives a framework for analysing and understanding where there are failures to achieve collaboration.

According to Gray (and endorsed by many authors since) successful collaboration follows a process: a problem-setting phase when stakeholders in a domain recognise common problems and their interdependence to solve them; secondly, a direction setting phase as stakeholders articulate values and shared objectives; and thirdly, structuring to create ongoing forms of interaction to support and promote the shared problem solving. Collaboration is enhanced, according to Gray, when there is a shared view of the problem dynamics and mutually acceptable frameworks are developed to organise the domain's activities.

The problem-setting phase includes the crucial question of who should participate? It is suggested the stakeholder set needs to reflect the full complexity of the problem, with the corollary that the more who participate, the more information shared. The inclusion of stakeholders should be viewed as a process of continual adaptation. Conversely the exclusion of significant or legitimate stakeholders will limit the implementation of any solutions generated. Problem setting efforts are enhanced when stakeholders expect the benefits of collaborating will outweigh the costs, the inter-dependence among stakeholders is recognised and there is mutual acceptance of legitimacy to be involved between stakeholders. Problem setting is further enhanced when the convenor is perceived to have legitimate authority and personal attributes of leadership and communication which mobilise other stakeholders.

The direction-setting phase is enhanced by the development of a shared view of problems and the values that apply. Considerable time and information gathering may be needed to reach this. Secondly, to enhance collaboration, power needs to be sufficiently dispersed to allow all participant stakeholders to influence direction setting, though not necessarily an equal distribution as that can result in stalemate and inaction.

The structuring phase is enhanced when stakeholders recognise they are inter-dependent and need to continue to act together to achieve desired directions. Mandated structuring is unlikely to be effective in bringing about collaboration unless the enhancing conditions in the problem setting and direction setting phases are addressed. Effective structuring will require the negotiation between stakeholders of ways of regulating their processes, systems for implementation and allocations of power.

Geographical proximity facilitates structuring whereas conversely, geographic dispersion is likely to increase costs and reduce the frequency of meeting.

Successful implementation of collaborative agreements will depend on the ability of individual stakeholders to manage the change process in their local context, including relationship management with those outside the domain.

It is suggested this is the process that RMHNs need to progress through to successfully form collaborative alliances which gives the platform for constructive regional problem solving and development.

Integration of Health Systems

Other authors also contribute useful pointers within the relatively large body of literature on integration of health system services.

Hoge and Howenstine (1997) examined service integration in a multi-provider system from the point of view of what is needed to soften individual organisational boundaries to allow the emergence of a shared identity to promote the functioning of the greater organisation. Agencies normally control the flow of staff, patients and resources across boundaries to maintain the equilibrium which is necessary to function effectively and efficiently. But tight boundaries can limit inter-agency collaboration and also means that staff may rigidly identify with that agency.

Integrating MH services can be done by structural change in which a central authority is created and vested with single point clinical, administrative, and fiscal responsibility for care in defined geographical area. However this is at best a starting point rather than the whole solution as research on delivery of services has demonstrated that appropriate organisational structures must be accompanied by "facilitative conditions" if collaboration is to occur.

Eight strategies are suggested to promote service integration:

- Create a new consortium or umbrella organization, which shifts the focus to 'who's included.'
- Creating integrative Task Groups which bring staff from multiple agencies together frequently to manage the larger system to foster shared perceptions of the larger service environment and greater consensus regarding potential responses to problems or needs.
- Participatory Management. Convening task groups from diverse provider agencies raises question as to who is in charge. Participatory management involves power-sharing, to promote a sense of control, ownership, identification, and minimising resistance to its development. Participation by a broad range of staff and stakeholders increases the likelihood that problems will be accurately defined and will increase buy-in to solutions generated.
- Strategic planning to promote service integration ideally involves all stakeholders, and will integrate the diverse input to develop a shared vision of the system's future. The plan is an important output but the process of planning is also designed to enhance the stakeholders' ownership and identification with the larger system.
- Boundary spanners. The creation of boundary spanning positions break up the rigid patterns in which staff work for only one agency, fosters consensus and compromise among participatory organisations.
- Team building. If agencies are highly boundaried, they can tend to more highly value their own agency and de-value other agencies. They can lack an awareness and understanding of other's work. Unless overcome, this can be a strong impediment to collaboration and service integration. This is best overcome by dialogue to increase understanding, to foster a sense of interdependence and a congruence of values and goals among provider groups. It is the development of staff relationships across agency boundaries that appear to be instrumental in maintaining cooperation and communication, and promoting cross-agency referrals.
- Resource sharing. If systems are highly boundaried, scarce resources are used inefficiently due to duplication of effort, e.g, in-service training.
- Multi-agency programming. Combining resources from two or more agencies to create new services.

Cocozza and colleagues (2000) monitored systems integration strategies used in an Access programme for homeless persons, who were also mentally ill, for a five-year period over eighteen sites. These researchers found a 'core' set of strategies which were central to efforts to achieve integration of its service delivery systems: having a senior or leadership person specifically assigned responsibility for system integration; an interagency coordinating body involving the major providers and stakeholders to be convened; and a plan with objectives, tasks and timetables based on the discussions and resources of the convening body and the project staff. Interagency agreements and consolidation of programmes (combining multiple programmes under one administrative system) were also used frequently. Some other strategies were more difficult to implement such as developing inter-agency information management systems; client tracking systems; and the establishment of uniform eligibility criteria or intake assessments.

Fleury and Mercier (2002) described integrated service networks as a model for organising mental health services in Quebec The main objective was to enhance the health system to deliver better outcomes and well-being to the overall population but particularly those with chronic health problems, who are seen as needing more extensive services that are well coordinated, relevant and coherent. This is also seen as a way of increasing efficiency, improving quality, avoiding service duplication, enhancing accountability and allowing clients to move freely between agencies without having to repeat their histories.

They distinguished between vertical integration and virtual integration. Vertical integration refers to a hierarchical organisation in which a single provider offers a majority of diversified services to a given clientele and coordinates the basic aspects of the other services offered to that clientele within that system.

Virtual integration is structured around a set of service distributors that coordinate their action so as to offer diversified continuous services to a system's clientele. Virtual integration depends on reciprocal exchange; complementary activities and functions among organisations and actors; the expertise, reputation and trust developed between partners; and information sharing aimed at meeting needs efficiently.

These authors highlighted the complexity and difficulties of achieving any transformation of a healthcare system.

- There is the initial premise that the local organisation should redefine their mission to suit the service needs identified in regional planning, coordinate their services and redistribute their resources to fit with that regional direction. This may be in conflict with their local and organisational interests.
- A second area of challenge is developing workable governance and accountability structures. Fleury and Mercier suggest that as integration strategies increase amongst the organisations, accountability and governance tend to become more diffuse, so that it is less clear who is responsible for what.
- Thirdly, for rural territories the problems are more in the nature of difficulties in coordinating resources remote from one another to ensure accessibility of services for the local population.
- Finally, but not least, these authors point out it is still debatable whether the advantages gained in terms of benefits for the clients are greater than the costs of coordination procedures among healthcare organisations and professionals. Studies that have tried to address this question have been inconclusive or contradictory, mainly due to the difficulties of implementation and the difficulties of comparing interventions.

Leutz (1999) examined the integration of health care systems in both the United States and the United Kingdom. Integration is defined by this author as the search to connect the health care system with other systems to improve outcomes e.g. clinical, satisfaction, efficiency. Integration is perceived as conveying benefits of addressing cross-system

problems, including poor coordination of services and benefits, cost shifting and frustration for users in accessing services. Leutz asks what degree of financial and organisational integration is needed to achieve clinical integration, defining three levels of integration: linkage, coordination and full integration. Although in the longer term these ways of working may be more cost effective, in the shorter term they are likely to cost. The greater the degree of integration, the greater the effort required to pave the way. Means of integration include joint planning, training, decision-making, instrumentation, information systems, purchasing, screening and referral, care planning, benefit coverage, service delivery, monitoring and feedback.

Gray (2002) in reviewing the literature pertaining to regional coordination and integrated service delivery, found the evidence of benefits or improved outcomes for individuals and/or their families/whanau from such service developments as lacking. The benefits that do arise tend to accrue for the participating agencies in improved processes, better relationships and a clearer sense of direction. Although some evaluations have found positive gains in processes and relationships, there is little research evidence this flows onto improved outcomes for the target population.

There are many risks and barriers to successful service integration identified by this author, including the following which may be pertinent to the RMHNs:

- Lack of shared agenda
- Mandated collaboration
- Exclusion of any significant stakeholders from the collaboration
- Overload from too many new initiatives
- Differing cultures, systems and values for the participating agencies
- Tight timeframes, or timeframes that do not recognise collaboration is much more difficult and time consuming
- Lack of change management
- Disillusionment if expectations are raised for communities and then not met
- Differences in power and perceived status among agencies
- Confusion over accountabilities
- Lack of research, monitoring and evaluation.

Local Versus Regional Versus National

Cumming and Cangialose (2000) identified a number of criteria for assessing whether tasks should be done regionally or nationally, in preference to the local level:

- Treaty of Waitangi: where services are more appropriately organised at other than local level in order to ensure partnership with Māori.
- Shortages in skill mix and availability or where there is critical mass required to purchase, procure or provide services.
- Economies of scale and scope in the planning, procurement, and production of health and disability support services. They suggested it may not always be desirable for

individual DHBs to decide alone to invest in new services or expensive technologies. Secondly if there are few providers, cross-boundary flows will be significant. High cost services are likely to incur high development costs which need to factored into the price paid by other DHBs for the services, or the funding formula adjusted to compensate a DHB with a high share of specialised services.

- Need for close coordination of services and inter-sectoral linkages at regional or national level or across services where substantial health gains or financial savings are to be achieved by close coordination between DHBs or services.
- Compelling benefit from standardised service or where strict quality control is desirable.

These authors suggested there are a number of ways DHBs can collaborate to make joint arrangements to overcome the issues identified above:

a) joint advisory/ administration agencies
b) joint purchasing through a lead DHB or a jointly run DHB agency
c) separate DHB providers
d) an elected DHB.

Alternatively the Ministry of Health could hold the budget and take responsibility for the purchasing of particular services.

These authors assessed the skills shortages in mental health, disability support services, Māori Health, Pacific Health and public health as best being addressed by joint regional DHB servicing centres (combined with training and a national agency), because of the flexibility to DHBs and skill development.

Evaluation of RMHNs

Saville-Smith, de Raad and Yeabsley (September 2002) analysed the conditions to optimise the performance of the RMHNs. At that time the RMHNs were found to focus primarily on planning and funding allocation activities, and secondly, allowed another platform for consultation with consumers. These authors considered this generated three risks. There is a risk of duplication of planning and consultation within DHBs with increased costs to both the organisations and to stakeholders. Secondly, the emphasis on funding and planning may reduce focus on some of the systemic collective problems, including workforce issues, inter-service protocols between multiple providers, the need for clinical leadership to ensure a focus on recovery outcomes for consumers, service reconfiguration, establishing systems to promote DHBs sharing resources where there are capacity issues, promoting consistent quality and access, and service evaluation with regard to the recovery outcomes approaches. Thirdly, it was suggested this was likely to set up the equivalent of the previous HFA system, with disconnection between funding/management and the providers, therefore losing the potential advantage of the DHB model. However the authors did see the RMHNs as offering some opportunities for

improving outcomes by bringing together representative groups of stakeholders, including planners, clinical directors and consumers.

CHAPTER FIVE.
Overview of the four Regional Mental Health Networks

The Southern Regional Mental Health Network

The six South Island DHBs make up the Southern Regional Mental Health Network. This geographical region covers a large area, with a high proportion of rural areas with relatively low density population. This region is relatively well funded against the Ministry's Blueprint funding model, with some variation between individual districts.

The DHBs making up the Southern region were characterised by informants as reflecting a spirit of independence, self-sufficiency and local pride, which was also labelled as parochialism, conservatism and resistance to influence or new ideas.

Several referred to the traditional rivalry and antagonism between Otago and Canterbury, and the general suspicion of Canterbury as being overly dominating. One informant shed light on the origins of this fear of Canterbury taking over, linking it to the 1995-1996

> 'huge push for a South Island (S.I.) wide MH service, driven by Healthlink South, the CHE that ran Canterbury MH service, and the CEO of the day who had a passion for this view of the world … The rest of the SI saw this as a takeover bid from Canterbury, they envisaged the Healthlink South flag sitting in the church square in Greymouth.'

Nelson-Marlborough had been included in the Wellington based HFA stable and was perceived as still looking towards Wellington as it's preferred source of regional assistance. Southland and Canterbury have traditionally collaborated, as have South Canterbury and Canterbury, and the West Coast was observed by one informant as swinging between reliance on Canterbury and being fiercely independent. Initially two regional networks and two Shared Service Agencies (SSAs) were favoured to fit the realities of this north of the South Island- south of the South Island divide. One informant summed up 'Historically it is quite complex. Time will tell whether they will get better at working regionally.' The geographical barriers, sparse population spread over vast areas, the distances and times involved to travel further add to the context of the Network.

The Southern Regional Mental Health Network is shaped by a strong culture that the autonomy and authority of the DHBs prevails. The CEOs of the region place firm limits on the regional network, keeping it to a relatively constrained support and advisory role. Operational matters are explicitly excluded from the business of the Network. The predominance of the local DHB approach over the regional approach has been the strongly held view of the CEOs since the inception of the Network.

The Southern RMHN consists of a representative from each of the six member DHBs, chaired by the manager of the MH team from the Southern SSA and supported by the MH team of the SSA. The RMHN reports to the regional General Managers and the regional CEOs who retain the decision-making authority.

The regional network has a planning and funding role to focus on those services which cannot be supplied in all DHBs and those tasks which all the DHBs have in common which are deemed advanced by a regional focus. Consultation is regarded as the task of DHBs and is not part of the regional process. Some network participant informants indicated they felt constrained by these role restrictions and did not agree with all aspects of them.

NGOs have no involvement in MH regional processes organised through the DHBs, nor are the regional meetings transparent to those not involved. This is a source of frustration and disenchantment to informants from this sector who point out the lack of integration of services, missed opportunities to incorporate wider stakeholder viewpoints, and the duplication of efforts that can arise from planners not being informed about developments in other organisations. It was also seen as a missed opportunity to challenge what is perceived as an overly medical culture. The researchers observed the divide between the NGO and DHB parts of the sector generated suspicion of a lack of contestability in contracting processes and undermined partnership. NGO informants also identified potential benefits for their organisations from regional approaches. The exclusion of NGOs from the RMHN is considered to reflect the prevalent culture of the region rather than the exclusion directly causing the division.

Māori stakeholders have also been excluded from the RMHN, despite a reference group being called upon to draw up a strategic plan for Maori MH. The lack of direct engagement is a source of irritation and concern for those stakeholders, particularly given the uncertainty that the plan will be implemented and the inability to oversee that process.

The RMHN is a relatively low cost organisation, with only one representative from each DHB but relying heavily on the SISSAL analytical resources. The main benefits generated by the RMHN have been the formalising of the regional access protocols and the provision of a MH "think-tank." The successful resolution of the regional access project, with its associated monitoring and evaluation for feedback, provided a turning-point for the region as it offers tangible evidence of the benefits of collaborating. Traditionally a higher value has been placed on self-reliance rather than cooperation.

Despite the Southland enquiry following the Burton tragedy urging more regional sharing of resources to ensure viability of services within small DHBs, this has not been the focus of attention within the RMHN. However the parallel Provider Managers' networking was considered to provide more of a platform to share information about day to day operational issues. It is not clear from this evaluation whether these latter informal communication channels can be relied on to generate solutions if there was an equivalent strain on capacity. Although those involved in the RMHN generally considered there to have been a positive impact on safety and sustainability, this was associated with the

small volume regional services, rather than the mainstream services. The NGOs and provider managers gave less glowing assessments, with specific concerns about the funding levels threatening the viability of their services.

Informants interviewed in this region included the manager of the Southern RMHN, two Portfolio Managers, one General Manager (all involved in the RMHN), one CEO, three Provider Managers/Clinical Directors (two from the same DHB) and four NGO informants, including a mainstream provider, a Māori provider, a consumer organisation, and a families of MH consumers organisation. One of the NGO informants also happened to be a Pacific person. Further comment was gained from a Provider Manager who recently left the district and was interviewed in his new North Island role. Informants gave insight into the perspectives of four DHBs, though from differing vantage points and not always fully encompassing views.

For detailed findings on the SIRMHN, please see Appendix Two.

Central Region Mental Health Network

This network incorporates the DHBs of Capital and Coast, Hutt Valley, Wairarapa, Hawkes Bay, MidCentral and Whanganui. Four of the DHBs are assessed as funded close to the Ministry's Blueprint funding model, while MidCentral and Hawkes Bay trail behind. Historically Capital and Coast has taken a lead role, both for delivering regional services and for stepping in when other regional DHBs get in trouble. This history has left a legacy of some other DHBs feeling taken over or fearing domination. CCDHB continues to deliver the majority of regional services. Historical collaborations continue to determine neighbourly cooperation rather than systems worked out through the Network.

The RMHN consists of an executive team (consisting of the six DHB Portfolio Managers, a General manager representative and the SSA MH team); CRMHAN, the regional network which includes cross-sector stakeholder representation; and Te Arawhata Oranga, a Māori network.

The regional network was relatively quick to become established, being the first to produce a regional work plan. According to one informant this was very ambitious with unrealistic time frames. The DHBs were themselves still working out their *modus operandi* in parallel with the newly formed Central Region Mental Health and Addictions Network (CRMHAN) so that it has taken 'two or three years to get them bedded in.' The slippage on the overly ambitious regional plan was perceived as creating frustration and disjointedness. There is now an impressive set of workstreams at various stages of progression which are anticipated to deliver much benefit to the region, but there is a gap between what is intended and what has actually happened so far. Therefore informants often made a distinction between what is current and what it would be like if the plan was implemented as intended.

Workstreams in process include an alcohol and drug services review, a workforce development strategy "Valuing People," Forensics and Child and Youth services reviews, and the regional risk management plan. There have also been innovative service developments around consumers: the pilot consumer-lead case management scheme and the training of teams of consumer auditors as part of the quality monitoring.

Although some informants saw the region as poised to really benefit from the work done up to now as they move into a phase much more oriented to implementation, barriers to overcome include a low level of understanding or commitment from the regional CEOs, at least one Portfolio Manager not valuing the Network greatly and a lack of credibility in some of the DHBs due to disharmony and fall out from previous Network projects, where outcomes have not been delivered on or there has been unhappiness with the process used. The region also has a high turnover of both Portfolio Managers and Provider Managers.

On the positive side, CRMHAN is widely acknowledged as highly committed, experienced, and knowledgeable and is broadly representative of the mental health and addiction sectors. CRMHAN is attributed with the useful development of shared vision, sharing of best practice ideas, joint projects and is perceived as a source of innovations. There are well functioning cross-representations with the regional consumer network, Central Potential. The communication channels from CRMHAN to the Local Advisory groups is generally perceived as working well.

The Māori network, Te Arawhata Oranga, was formed to steer the capacity and capability building for Māori and is a more recent development. This is widely perceived as a strongly positive development which holds much promise for the future. This development model is now being used to focus on Pacific capacity and capability but that work is at an earlier stage.

Innovation was a quality many associated with the Network, both arising from the CRMHAN forum and directly promoted through Speakers Day. The latter forum is dedicated to providers showcasing their new ways of doing things, parading success stories, celebrating innovations and to share these ideas around. This forum is open to all in the region, plus invited guests from other regions. Te Arawhata Oranga is also heralded as spearheading real changes for Māori.

The Network has undergone a review recently, which has now been accepted. This evaluation draws on what has been the existing structure, though where relevant the adjusted structure will be noted. The adoption of the review is expected to correct a perceived gulf between the Executive and CRMHAN and also to overcome a disconnection between the RMHN and operational staff.

This section of the research included three Portfolio Managers, two TAS staff directly involved with the Network, one General Manager, two Provider Managers and four NGOs which included informants from a consumer support group, an alcohol and addictions service provider, a Māori provider and a Pacific provider. Most informants

were directly involved with the Network. Three informants were not directly involved: one of the provider managers, the Māori provider and the Pacific provider. The latter two both struggle with small capacity and do not find the time to attend. However the Pacific informant was well connected with parallel networks, including the LAG, therefore was able to keep loosely abreast with happenings at CRMHAN level and was often approached for consultation. The Māori informant had been invited to LAG but had not acted upon it and was much more peripherally connected.

For detailed findings on the Central RMHN, please see Appendix Three

Midland Regional Mental Health Network

This region includes the five DHBs of Waikato, Lakes, Bay of Plenty, Tairawhiti and Taranaki DHBs. The RMHN and parallel Provider Manager's Forum is pervaded by a strong spirit of collaboration and cooperation, with many examples offered of DHBs helping each other out through informal and other ways. 'There is a culture of collaboration' and 'we are hugely advantaged in the Midland region that there is a strong desire to work regionally' are representative views. However, difficulties with the structure, over-emphasis on consultation, and initially insufficient resources to implement changes has meant the RMHN has been slow to achieve its objectives and it is only now that the DHB decision-makers are looking forward to implementation.

The current Midland RMHN structure consists of the regional General Managers and CEOs as the decision makers, supported by the Midland Regional Network Operational Group (MRNOG) which consists of the Portfolio Managers, two General Managers, a representative from each of the five Local Advisory Groups (LAGs) and a representative from the Provider Manager-Clinical Director forum. The MRNOG implements the decisions of the RMHN. Both these groups are informed by a large regional planning forum held once a year for stakeholders to identify service gaps and priorities, followed by a second meeting to hear reports back on progress. This forum draws together representatives from the parallel stakeholder regional forums: Māori, Pacific, consumer, family, alcohol and drug services, as well as Portfolio Managers, Provider Managers and General Managers.

Throughout it's history, the Midland RMHN has been characterised by an extensive consultation framework. This was found to be unwieldy and cumbersome by DHB decision makers, who called for a review late 2003, heralding in changes early 2004 which sought a tighter structure with clarity of purpose for meetings called. Although this review improved focus for some and made the Network more easily operational, other previously included stakeholders were disenfranchised, resulting in a degree of anger and criticism which is evident in the information gathered from some informants.

Thus, on the one hand there is the point of view that there was extensive networking built up over two years, with regional Māori, Pacific, Alcohol and Drug Services, Consumer

and Family networks, which together formed a Regional Advisory Group (RAG) which met bimonthly. 'The buy-in in those stages was tremendous. We had several meetings with 50 or 60 people attending.' From the point of view of participants, this had allowed stakeholders to come together to talk about far more than the Strategic Plan.

The other point of view is that these groups often had unrealistic expectations of their role. From this perspective, the consultations were seen as very costly and resulted in an increasingly cumbersome structure where consumers and other stakeholders wanted to be involved at all stages of decision making. The RAG generated a number of projects but because there was no allocation of funding and a low level of commitment from the DHB decision makers, the proposals and plans did not go anywhere.

Both viewpoints agree the lack of action led to a loss of faith in the sector, disillusionment as people felt their advice was not valued, and the RMHN lost credibility.

The review, implemented early 2004, resulted in some reduction of consultation meetings, the formation of the operational group (widely referred to as MRNOG), moving the RMHN out of the SSA into Lakes DHB (now the lead DHB for MH) and greater clarity of planning processes. This was matched with more commitment from the General Managers and CEO decision makers. Participants of MRNOG now look forward to some of the anticipated benefits after this long and somewhat difficult gestation period.

For those who have been relatively disengaged by the changes, disappointment lingers on. One informant observed a lack of strategic direction and a lack of will to develop a shared vision between providers of what services should be moving towards.

> 'There has been none of that discussion. There are passionately enthusiastic people in the sector, and funding and planning people need to engage with the sector rather than just feeling under siege, to see where all of this needs to go.'

Although this region in many ways achieves the intention of the regional structures through the strong culture of collaboration, there are weaknesses that undermine its ability to achieve. The consultation structure continues to be costly yet still with significant gaps, particularly in the low level of engagement with the NGO sector. The NGO sector are only involved at LAG level. The only path onto MRNOG is if they happen to be the chair of the LAG.

Some informants questioned whether the nature of the consultation adds as much value as would be desirable. The planning day which is the main forum to allow the different groups of stakeholders to come together was described as 'telling us what we already know.'

Secondly, by placing such an emphasis on consultation with stakeholder groups, and the commitment to be highly responsive to these priorities, some informants considered there is insufficient attention to clinical expertise, clinical leadership and analytical work to support the planning process. Although the Clinical Directors and General Managers do

now meet and a representative joins the MRNOG, there seemed to be a disconnection there. The lack of SSA was regretted by some informants who perceived significant negative consequences flowing on from this lack of analytical capacity. The recent appointment of a strategic planner may make up some of this shortfall.

Other barriers and difficulties for this region are the geographical spread, highest Māori population in the country, rurality, and relatively high levels of poverty. Midland is poorly resourced against the Ministry's Blueprint funding model.

The only regional service currently is the Forensic one, delivered by Waikato DHB in conjunction with Waikato Hauora. Therefore the region is starting from a low baseline for delivering or organising services regionally. The regional discussions have identified gaps but the service development to respond to these is inevitably slower and is happening locally, for example the project to respond to those with high and complex needs is being developed at Waikato for piloting or as a regional service.

Others attributed the slowness of the implementation phase to the initial lack of resources, projects being delegated to already over-loaded Portfolio Managers and the difficulty in keeping a focus when the sector viewpoints are so varied. There was also criticism from an NGO informant that the solutions sought are DHB based ones, rather than harnessing the innovations from the NGO sector.

Despite these barriers to overcome, there are a long list of projects in process which are expected to deliver major benefits in the medium to long term and were the cause of optimism for those involved. The next phase is intended to bring together "movers and shakers" into focus groups to more actively generate productive solutions. However at the present time some informants were unsure the cost benefit balance was favourable, given the relatively heavy cost of consultation and the long lead time before benefits are realised.

This section of the research process was based on interviews with the Regional Mental Health Manager, two Portfolio Managers, two General Managers, three Provider Managers, one CEO and four NGO informants, including informants from one Māori provider organisation, one consumer organisation and two mainstream provider organisations. Informants were drawn from four DHBs or their districts.

For detailed findings on the Midland RMHN, please see Appendix Four.

The Northern RMHN, Network North Coalition

The Network North Coalition (NNC) includes the three DHBs of the greater Auckland region plus Northland DHB. The NNC operates under the auspices of the Northern DHB Support Agency, the SSA which is jointly owned by Auckland, Counties Manukau and Waitemata DHBs, and which Northland DHB accesses as a customer.

The region covers the greater Auckland area and extends north to include all of the Northland peninsula. Although the metro-Auckland area appears compact and accessible, in practice the transport infrastructure means it can be time consuming to cross the city, which has implications for service delivery. The communities served by Counties Manukau are very different from those in, for example, Rodney within the Waitemata DHB. Northland as a smaller DHB is not only distant from the rest of the region but also has a spread out, largely rural population with relatively poor populations, but with intra-district variation.

Currently the Northern region has been assessed as being relatively poorly funded, according to the Ministry's Blueprint funding model, although this varied between DHBs. Although large amounts of additional funds are now being awarded to the region, any service development is from a low starting point. However this is also seen as making it easier to generate the impetus for change.

NNC has been in existence since September 2003. The formation of NNC was precipitated by a Mental Health Commission Review, and incorporated a previous regional network and a "Service Coalition" recommended by the Review. This Network has a regional director and an inclusive consultative structure that incorporates 'the who's who of the mental health sector.'

The Network North Coalition includes a wide range of sector stakeholders in its monthly meetings, with each of the stakeholder representatives supported by a second tier of stakeholder reference groups, to allow each representative to fulfil the role of both representing and then conveying back the information generated by the meeting. This makes for a very transparent, comprehensive and easily accessible structure.

The NNC has generated a high level of activity since its inception, with wide ranging activity on planning, reviews and project groups, drawing on expertise from across the region to work together in task groups. This has enhanced the sharing and cross fertilisation of ideas which occurs in the larger forums. Planning has incorporated both "top down" and "bottom up" approaches.

Although NNC only has an advisory role, its power has been enhanced by being very inclusive and transparent. 'We are aware the power of NNC is not in the meeting as such but with the people who attend who have decision making authority within their own DHBs or NGOs.' In addition, three of the four the Funders and Planners are employed out of the NDSA office rather than by the DHB, which means they identify with the regional view as much as the local view.

Informants expressed a great deal of positivity about the NNC which is attributed with the development of a shared vision, clarity about the way forward and optimism for the future. There has been strategic development of the NGO sector and innovations focussed on these organisations. The Regional Director is widely seen as providing a very helpful focal point and source of leadership. His independence from any one DHB is particularly useful for advocacy, whether with DHBs or with the media.

The speed with which the many issues have been energetically tackled was seen as a weakness by some, who observe some stress caused for staff by too much change too quickly, that organisations 'are required to be married before we have had a chance to date' and that a slower consultative process and more considered way forward would lead to more thorough and well grounded approaches. Some find the large meetings intimidating and therefore not conducive to contributing and would prefer more wide ranging ways of consulting. The cost of attending meetings is high and particularly onerous for small provider organisations or the unpaid.

Nearly all informants saw the regional approach adopted by the NNC as offering many benefits and there was a high level of commitment to its continuation. However this should not be assumed to be the answer to all MH service planning and service development: DHB informants were in no doubt of the value of local approaches, bearing out the appropriateness of the NNC vision statement of "Local delivery but regional consistency."

For detailed findings on the Network North Coalition, please see Appendix Five.

CHAPTER SIX.
Comparison of the Four Regional Mental Health Networks and other relevant issues

Functions

Planning activities to identify gaps against the Ministry's Blueprint funding model and the allocation of Blueprint funds have been a predominant activity for all four RMHNs. DHB planners and funders have integral roles in the structure. Only the Northern RMHN defines its scope of activities as also flowing into general MH service development planning.

Consultation is central to the functioning of the three North Island RMHNs but is explicitly excluded from the role of the South Island RMHN. Although in theory there is consultation via the Local Advisory Groups (also called District Advisory Groups in some DHBs), in practice this evaluation found the "consultation" around the Southern RMHN was at best a one way reporting back and allowed no meaningful participation. The Southern NGO informants reported a high degree of dissatisfaction with this state of affairs. Examples were given where the lack of consultation has resulted in duplication or other inefficiencies. The NGO sector informants in our sample spoke of feeling devalued, disadvantaged and marginalised. Some perceiving this as a prevailing culture which extended to poor contracting terms compared to those for providers within DHBs or North Island equivalent services.

The form of consultation in the North Island RMHNs varied. The Central RMHN has successfully brought together a representative group of sector stakeholders which is attributed with qualities of being dynamic and innovative due to the high calibre of participants and the cross-fertilisation of ideas flowing from that forum. Representatives from a well functioning consumer forum and the DHB Local Advisory Groups are included in that forum to link in those spheres of consultation. Although there was a high degree of satisfaction from most participants and communications were regarded as transparent, one funder and planner reported dissatisfaction because the agenda was not sufficiently targeted on those issues of strategic concern to planners.

The Midland RMHN has a high commitment to consultation but initially focused more on single stream regional consultation forums, with representatives then meeting with other stakeholders in an annual planning forum to identify service priorities. A second meeting of all stakeholders checks what has been done with the advice offered, and allows consultation on the draft regional plan. This planning process was found to be unwieldy and cumbersome, and not adding a lot of value to DHB Funders and Planners. A review resulted in the introduction of an operational group to more easily move the regional planning into action. Although this forum includes representation from LAGs

and a Clinical Director representative, there is no systematic representation of stakeholders nor is there inclusion of the NGO sector. Informants expressed various views about the adequacy of the current consultation processes, depending on their vantage point, ranging from outrage at being excluded to satisfaction that there was finally a workable model that was not so hamstrung by consultation they could move into action. How to achieve adequate representation without compromising action continues to be the subject of debate in this region.

The Northern RMHN has adopted a very inclusive and transparent consultation process, with all stakeholder groups represented on the regional forum, with each representative backed up by reference groups to both inform and in turn to be informed. LAG and consumer representation are prominent. There was a high degree of satisfaction at the inclusiveness and communications emanating out were reported to be reliable and full to allow occasional participants to track developments and to attend selectively to reduce the costs of participation. Dissatisfactions noted were more of the nature of some finding it difficult to speak up in a large forum and secondly, the speed of progress reducing the thoroughness with which all aspects of issues being considered. This was seen by one informant as creating implementation issues down the track and increasing stress for some in the workforce, because there is not sufficient groundwork to achieve widespread buy-in before implementation: the "the marriage before a decent period of dating" problem.

The regional planning is attached to action planning which has implications for service delivery. However most of the informants reported few changes resulting from the deliberations of the RMHNs. The South Island RMHN has a firm constraint imposed by the regional CEOs that its activities are not to extend into operational development. However the most significant achievement of that group has been clarifying the access protocols under the Regional Services Access project. According to some this marked a turning point: because it did move into more operational matters; was successfully resolved because of the liaison with the DHB Provider Managers and Clinical Directors; and it has become a watershed in the evolution of the RMHN due to the demonstration of some real advantages of regional collaboration.

The Central RMHN has had a two or three year development phase. Despite having 'an ambitious programme' from early in its existence, informants regard the implementation phase only just beginning. This may reflect the time necessary to move through the planning and consultation phases but could also reflect the relative disconnect with the operational side of the DHBs' functioning. Two provider managers have been included in CRMHAN along with a selection of NGO providers but the independent Review identified a general disconnect between the planning and operational activities. This is now being corrected by regional Clinical Director and Provider Manager meetings and cross representation.

The Central region's sharing of capacity and access to regional services continues to be problematic on occasions. The two barriers identified are the high turnover from key personnel and the lack of involvement and buy-in from the operational staff. Unless

clinical and operational staff are involved in working out solutions, any plans developed are likely to fail at critical times so that instead of triage principles applying, historical collaborative patterns based on existing relationships predominate. The recently initiated meetings of Provider Managers and Clinical Directors may enable more traction, not only for these issues but also to progress the multi-stranded work programme flowing from the regional planning.

Midland also has been slow to move into implementation, although those participants in the operational group considered they are finally achieving the groundwork and structures which will allow them to move into action. This region also has belatedly sought more connection with the operational expertise. Over the last six months there has been a regional meeting of Clinical Directors and Provider Managers who send a representative onto the operational meeting and then to the large regional planning forum. A provider manager informant considered the clinical and technical expertise of the region has not been fully utilised because of the strong commitment to be responsive to consumer, family, Māori and Pacific. A strength of this region is the collaborative culture which has meant in practice a willingness to share resources between DHBs as needed.

The Northern Network stands out as having had a fast moving and dynamic work programme. Over its relatively short duration (NNC has been in existence approximately eighteen months now) it has been noticeably more active and productive than the other RMHNs. The inclusive structure includes key sector representatives including planners and provider managers, both DHB and NGOs. This Network was able to pick up the collaborative operational policies already present, such as treating acute inpatient beds as a regional resource, and then to use it's widely inclusive membership to firm up and make more cohesive the frameworks for sharing resources. The greater activity of the NNC could be attributed to a larger pool to draw project resources from and more frequent meetings. However there does also appear to be evidence that planning alone will not lead to change and that having appropriate representation or linkage with those directly affected is an essential component to any MH service development. The NNC has strongly endorsed this principle.

All four regional Networks anticipated the regional workforce coordinators would give a boost to efforts to develop workforce and give a strategic direction.

Table 1: Summary of functions of the RMHNs

	Southern	Central	Midland	Northern
Planning: a)Blueprint funds b)General MH funds	BluePrint Plan. Yes Gen.MH.Plan. No	BluePrint Plan Yes Gen.MH Plan. minimal	BluePrint Plan Yes Gen.MH Plan. No	BluePrint Plan Yes Gen. MH Plan. Yes
Advising on purchasing	No	Minimal	Flowing from regional plan	Advisory, yes

decisions				
Consultation	No	Yes	Yes	Yes
Changes to Service delivery	General, no Reg.Pl. yes	Some implications from projects	Not as yet	Yes, from Reg.Strategic Plan
Workforce development	Emerging	Yes	Yes	Yes
Taskgroups	Yes	Yes	Yes	Yes
Quality improvements	No	Some initiatives	Some initiatives	Yes

The Impacts of the RMHNs

The ratings given by informants are indicators rather than measures but do offer some information about the impacts on the desired outcomes, particularly when considered alongside the explanatory comments.

Table 2: The impacts of the four RMHNs, rated against the desired criteria

See below for key to ratings

	Southern	Central	Midland	Northern
Equity of access	7.1 average, Three maj. pos. Three d.kn.	6.1 average Range 4 to 7.5	5.7 average Three d.kn. Ranged 3 to 7	6.7 average, Eight '7' responses
Coordination of clinical services	5.7 aver. Six neutral,5	6.1 average Range neutral,5 to moderate positive,7	5.5 average Ranged 4 to 7, One 'hopefully positive'	6.7 average Range 5 to 8
Integration of regional and local planning	6 average NGOs neg. or d.know, Planners varied	6.9 average Range neutral,5, to major positive,7.	7.5 average Two d.kn. One 'negative' One 'promising'	7.6 average, Range 5 to 9, One 'mod. hopeful'
Promoting stable and supported workforce	5.2 average Six neutral	5.9 average, Four neutral to three mod. positive	5.2 average Seven 'neutral' One 'too early'	5.7 average, Range 3 to 7
Effective use of scarce resources	6.4 average Planners rated mod.pos. or better, 7+	5.9 average Range Mod.neg.,3 to mod-high positive,8.	6 average Range 5 to 8.5 Two d.kn.	6.5 average, Range neutral,5 to strongly pos, 9.

Public's confidence in MH servcies	5.2 average Eight neutral,5	6.2 average, Six neutral, 5, the rest a range of positives	5.5 average Four 'neutral' Four d.kn.	6.8 average, Range 5 to 9
Safe and sustainable MH services	5.1 average Planners 7, NGOs mod-to major negative	6.3 average, Ranged small negative,4 to med-high pos.8	6.1 average Range 3 to 9 One 'mildly optimistic'	7.1 average, Range neutral,5 to strongly pos., 9
Consultation, engagement, transparency	3.6 average NGOs major-mod. negative	8 average, 5 strongly positive	6.6 average Range mod.neg.3 to strongly pos., 9	8.6 average, Range small pos.6, to strongly pos.,10
Promoting innovation	5.6 average	7.7 average Mostly strong or mod. positive	6.1 average Range mod.neg.,3 to strongly pos.,9. Three neutral	7.3 average, Range 5 to 9
Culturally safe MH services	5.6 average Seven neutral or d.kn.	6.5 average, Range mod. neg.,3 to strong positive,9	6.9 average	5.8 average, Range mod.neg.,3 to mod-high pos.8
Overall efficiency, Benefits vs costs	5.2 average three negatives three neutrals three positives	6 average, Ranged from mod-major negative,2 to mod.high positive,8	7.average Five not rated or d.kn.	6.9 average, Range 4 to 9, One 'small positive gains for big negative costs.'

Key:
Major positive equates to 8.5 and above
Moderate positive equates to 7-8
Mild or small positive equates to 6
Neutral equates to 5
Small negative equates to 4
Moderate negative equates to 2-3
Major negative impact equates with 1-1.5

Consideration of the Networks against the criteria

Equity of access

All the RMHNs are prompted to identify gaps in services by the reviews and discussions undertaken. The Ministry's Blueprint funding model guidelines have also offered useful normative standards, with the allocation of funds also moving DHBs towards more

consistency. However some RMHNs features are more conducive to solutions than others.

To achieve regional consistency, the planning participants must adopt a notion of moral responsibility for the regional population, rather than the commitment to local people prevailing. It is suggested only the Northern region has achieved some regional identification so far. It is noteworthy that the principles identified by Hoge and Howenstine (1997, previously cited) to achieve identification with a larger integrated structure have all been applied by this region. In promoting solutions to increase equity of access, this region was starting from a position of having already established collaborations between DHBs, as initiated by the regional Provider Managers. Most informants rated the impact of regional processes on equity of access as now moderately positive. Their focus is now shifting to consistency of delivery models for minimum baseline quality of service.

An alternative way forward is demonstrated by the Southern region who have achieved some regional equity of access to specialist services by arguing the merits on cost benefit grounds, backed up by monitoring and feedback reviews. However the gains were only achieved, according to some informants, once they moved beyond the straitjacket of tightly defined constraints on role and ventured into liaising with operational personnel. The exclusion of the RMHN from dealing with operational matters is likely to limit severely the impacts of this Network as inevitably the translation of planning into action must integrate with those delivering the services. With regard to general, non-specialist services, the culture of the RMHN has not supported collaborating or concern for the relative strains on individual DHB services, and the disconnect with the Provider arms of the DHBs and the NGOs also acts as a barrier. The Provider Managers networking currently offers more flexible and responsive options for addressing any such concerns arising.

Midland region is hampered by having few regional services directly at their disposal, but facilitated by the strongly collaborative culture which promotes informal solutions to problems arising. The regional meetings enhance this by providing the opportunities to discuss matters arising. The structure of discussions happening in silos, e.g. consumers talking to other consumers in the regional forums, identifies issues but is not conducive to generating solutions which are more likely to arise out of cross-sector discussions. Although the planning day does bring the whole sector together, this forum is possibly too large to focus on high level planning. The planned focus groups bringing together "movers and shakers" from across the sector may make up this shortfall. It is suggested the operational group redefining their role to one of leadership rather than their current role of being 'the servant' of the Network would also facilitate solutions arising, working in conjunction with the operational experts in the Provider Managers and Clinical Directors forum.

The Central region has attempted to resolve issues around equity of access to regional and general services but the occasional failures in these systems have highlighted the need for more connection with those involved with service provision. Although the

reviews undertaken by the RMHN have identified the gaps in services, it was considered the implementation of solutions has not proceeded sufficiently for there to be much difference for Māori, Pacific or rural people as yet. The lack of capacity for Pacific peoples is identified as of particular concern although the RMHN is starting to address the issue of building capacity and networking by building a Pacific Network, based on the Te Arawhata Oranga model.

Coordination of clinical services

The bringing together sector representatives, particularly those from the clinical services was seen as the key to increasing coordination between clinical services, with many informants highlighting the importance of establishing relationships. In this respect Southern RMHN is regarded as missing the opportunity for this desired outcome, though their regional access protocols enhance the coordination around specialist services. CRMHAN participants valued the opportunity for networking with other providers and cited tangible coordination benefits arising. Midland also saw strengthening relationships within the sector as the key to coordination, with connection to the DHB clinical leaders now established but the relationship with NGOs still under developed. Northern region emphasised the involvement of clinicians as crucial to allow the achievement of agreements around access, best practise and referral protocols.

Cocozza (2000, previously cited) highlighted leadership of system integration, an interagency coordinating body and interagency agreements as promoting integration, whereas inter-agency information systems and establishing uniform eligibility criteria were found to be more difficult.

Integration of local and regional planning

There were no major issues re the integration of planning processes though the RMHNs reflected different values.

- The Southern RMHN adhered to the ruling of the CEOs of the region that the district planning takes pre-eminence and the regional planning picks up only those services and issues in common. The regional planning processes lack transparency for those not involved.
- Central region has developed a Planning Framework to ease the process of integrating regional and local planning, although this is untested as yet. There are no major issues with integration nor transparency for this region.
- The Midland region has placed a strong value on “bottom-up” planning, to an extent that has hampered achieving focus, according to some informants. Timing created some difficulties in the recent round, because of the pressures of achieving local and regional plans in parallel for the planners, and stakeholders complained they were planning for the next year before they had feedback on what had been achieved from the previous plan.

- Northern region uses both "bottom-up" and "top-down" approaches to planning with wide consultation. The only issue raised in this region was the lack of direct power in the Network to have the regional plans adopted.

Promoting a stable and supported workforce

Those RMHNs which bring sector representatives together generate benefits by fostering understanding of others perspectives. In addition the regional focus to training offers some efficiencies, with the RMHNs being well placed to influence culture and address attitudes, for example, as incorporated in Central region's Valuing People programme. However cautionary notes are the training needs may differ between districts and some training was deemed most effective when adapted to local circumstances.

Most of the Networks rated the impact currently as 'too soon,' therefore neutral but looked forward to the impact of the recently appointed workforce coordinator. Northern respondents were more positive in their ratings, due to the optimism engendered by having a shared vision and the wide spread engagement of the sector, and the moves to equalise pay and conditions.

Effective use of scarce resources

All four RMHNs associated the fine-tuning of the use of regional services as promoting the effective use of scarce resources and opportunities for economies of scale. The Networks varied on how widely regions collaborated on other initiatives to achieve economies of scale or to share learning from pilot projects. The Northern RMHN discussion was defined as focussing explicitly on the best use of scarce resources, using the widely inclusive forums to take a strategic overview and work collaboratively on service development initiatives.

The overall lack of capacity was identified as a constraint as it reduced choice to direct resources.

Promoting peoples' confidence in the MH sector

Generally this dimension was seen to be a function of individual incidents and the RMHNs were not in a strong position to impact. However some activities of Networks were seen as helpful:

- Consulting regional experts was confidence boosting for service users (Central and Southern informants).

- Openness to incorporate consumers' points of view and genuine attempts to consult (Central, Midland and Northern informants).

- Dealing proactively with the media, particularly having the Regional Director to speak on the behalf of the region without being aligned to any one DHB or NGO (Northern informants).

Promoting safe and sustainable MH services

The common commitment of the RMHNs to improve services and address gaps in a planned and strategic manner was seen as promoting safety and sustainability. This is enhanced by wide consultation with all relevant stakeholders to increase buy-in, as used by the three North Island Networks.

From the consumer perspective, the adherence to the "recovery as a right" approach is an important dimension for safety. The three North Island Networks have strongly embraced this approach and have made efforts to both change attitudes and to operationalise this approach. At least one informant is of the opinion that choice and autonomy wanted by consumers is sometimes in conflict with the community wanting safety. The Southern RMHN ability to achieve the "recovery as a right" attitude change is weakened by the lack of direct consultation with consumer stakeholders.

Risk management plans were seen as promoting safety and sustainability but clearly the existence of such plans is not a guarantee. Insufficient commitment to collaboration, lack of buy-in from Provider Managers, lack of knowledge of others' services, and a lack of capacity to share were all cited as barriers to the RMHNs gaining traction on this criterion. Some regarded this issue the business of the Provider Managers and Clinical Directors, who would use informal networking to seek help if necessary, whereas the RMHNs was less in touch with the day to day complexities and the meetings too infrequent to rely on that channel. The Southern RMHN did not regard this as its business, even after the Burton enquiry. Central region has a plan but implementation is not fail-proof. Midland successfully relies on the collaborative culture. Northern has firmed up existing collaborations.

Stronger clinical links and coordination enhances safety and sustainability by more fully utilising the sector's resources in optimal ways. The Southern RMHN narrow engagement misses this opportunity. The NGO sector has strong concerns about their lack of financial sustainability. NGO informants would like the Midland to strengthen the engagement with their sector.

Despite the opportunities for RMHNs to promote safety and sustainability, informants were also realistic that there are inherent risks in the MH sector. The optimal approach is one of doing whatever possible to manage these risks but to also support each other if incidents occur in a spirit of mutual learning rather than adopting a blame culture.

Impact on consultation, engagement and transparency

The three North Island RMHNs are all strongly consultative. Central and Northern stakeholders indicated a high level of satisfaction with the transparency and opportunity for involvement. Midland informants gave mixed accounts: despite Network participants holding a strong accountability to stakeholders, those excluded reflected disquiet and suspicion because there is no Māori, Pacific, consumer or family representatives included in the Network's operational group.

The Southern RMHN does not consult or engage with stakeholders. Some informants regarded this as a serious weakness, whereas one DHB informant pointed out that district had strengthened their local consultation to make up the shortfall.

Other research, as reported in the literature survey, suggests planning and change processes are more likely to be successful if all relevant parties are involved.

Promoting innovation

All four RMHNs promote innovation as an implicit outcome by striving for best practice, sharing ideas and disseminating information about innovations introduced by individual DHBs or provider organisations.

Some informants attributed the mix of DHB and NGO providers as being fertile ground for generating innovation, as allowed by the Central and Northern structures and in a more limited way by the Midland structure.

The Central region explicitly promotes innovation with the Speakers Day which is an opportunity to showcase new ways of working.

The Northern region's use of task groups which bring together people from different backgrounds and experiences was seen as promoting innovation. These also lead to wider sector stakeholder engagement than would otherwise occur, so that the sphere of influence is extended.

DHB planners' willingness to recommend the allocation of money to pilot schemes was appreciated. Constraints included the difficulty of translating "bottom-up" innovations to other settings, those responsible for implementation being too over-loaded to act quickly, and the DHB environment was seen as sometimes constraining compared to the more flexible NGO sector. Being innovative can require taking risks which may be in conflict with being "safe and sustainable." One DHB planner observed it is easier to be innovative at the abstracted regional level whereas the translation at the local level is more likely to run into constraints as change is negotiated through the Board and is challenged by local realities.

Promoting culturally safe MH services

All four RMHNs have placed a priority on promoting culturally safe services for Maori but with varying degrees of success.

The Southern RMHN has drawn up a strategic plan for Māori, but risks tokenism by not engaging with the reference group nor having a firm commitment to implementation.

Central region's Te Arawhata Oranga is widely acknowledged as offering strong leadership and is expected to have significant impact.

Midland region has a high commitment to kaupapa services for Māori but has found more leadership and training is required to raise standards in general services.

Northern region also has drawn up a strategic plan for improving cultural sensitivity for Maori but has been hampered by factions between the Māori representatives.

Midland, Central and Northern also have plans in place for the increasing capacity and the development of culturally sensitive services for Pacific peoples. The Northern region has used partnering and mentorship between provider organisations to allow the sharing of skills for mutual benefit, for example trading cultural awareness and practice for skills towards certification. A Pacific informant emphasised the cultural competency values need to be translated into grass roots practice, as current clinical practice may clash with approaches more appropriate to culturally sensitive practice.

The inclusion of Māori and Pacific representation in discussion forums is helpful but not sufficient on its own to achieve change. Pacific informants highlighted the difficulties of challenging the mainstream view as a minority voice, particularly as the style of debate was not always easy for representatives from those cultural groups and as small capacity organisations, the time taken to participate was relatively onerous.

Overall efficiency, with benefits outweighing the costs

The Southern region informants expressed concerns about the high cost of regional access to specialist services. Those who focussed on the positives saw the structure as cost- effective and that the RMHN has been effective in sorting out some 'long standing fights.'

Central informants were mostly positive that the benefits of improving regional access, sharing ideas and avoiding working in silos justified the costs involved. A few informants were not convinced and regarded the Network as expensive for the small benefits generated so far.

Midland informants were mixed in their views due to the fact that the benefits are mostly still anticipated while the costs are current and ongoing. One informant stated 'it is a very heavy Network.'

Northern informants were more consistently and strongly positive due to perceived cost savings from the pooling of knowledge, sharing of skills, avoiding duplication of effort, and the more integrated stakeholder groups developing shared understanding around issues. Informants predicted major positives on efficiency and effectiveness as plans are followed through. The cost of participation was a negative for some whereas the advantages were seen as mostly lying in the future.

Cost benefit analysis

The research plan included a cost-benefit analysis. In practice, this was difficult because the achievements of the RMHNs are not easily quantified and most projects are still in process. Task group reviews have been done by all the RMHNs, as detailed in the four case study reports, but are still to be implemented. Therefore the groundwork has been done but this will only translate into benefits once the action plans are implemented, so that the relatively costly development phase has been in process but without the regions having reached the benefits.

Secondly it is not possible to quantify the counter-factual. Although planners were able to give the costs of the reviews and development projects, such as one regional review costing collectively $25,000 whereas it would have cost an estimated $15,000 for each DHB to have done the work separately, it was not possible, for example, to calculate the cost savings, both economically and in qualitative terms, from having smooth access to regional treatments, therefore promoting more optimal and cost-effective treatment.

An assessment of the costs and benefits is detailed below, as far as the details are available, for each of the RMHNs.

Southern

Costs
Running costs are estimated at $140,000 per year. This includes the cost of the SSA team who carry out much of the project work and the infrastructural support to support the RMHN.

Six members attend meetings, representing the member DHBs, each of whom bears costs of preparation time, the time involved in the meetings and the costs of travel. In 2004 there were ten five-hour meetings, which are expected to reduce to six meetings with two-hour teleconferences in the intervening months in 2005.

Benefits

1. Regional access project has facilitated smoother client pathways through specialist services. The more optimal treatment is hypothesised to lead to shorter inpatient treatments, more efficient use of scarce skills and better matching of patients and services. This has strengthened the right of access for small DHBs. Alternately the regional services are delivered by supervising and training mainstream staff, with the advantages of increasing the skills and experience of those staff, plus avoiding the costs to family/ whānau from their family member being treated out of the district.
2. Anticipated benefits on service provision frameworks, drawing on the model from the Regional Access Project but extending to the general services, to promote optimal clinical pathways.
3. Reviews in process on task groups: Alcohol and Drug services; Child, Youth and Family services; and Forensic services.
4. Collaboration on Information Management systems.
5. Anticipated benefits in retention from workforce development initiatives.
6. Regional access project has demonstrated benefits from collaborating in a region which has not easily adopted this approach, therefore opening the way for further collaboration.
7. Having a structure to share ideas, strive for best practice and raise concerns about service gaps or capacity.
8. Pooling planning and analytical resources and expertise.

Disbenefits

1 .The structure of the RMHN has promoted a disconnect between the DHBs and the NGO providers.
2. The process of the development over the MH Strategic Plan for Māori has alienated Māori stakeholders, which may make it more difficult to work in partnership in future.
3. The lack of involvement with stakeholders increases risk of duplication of efforts through not being aware of what other organisations are doing.
4. Lack of NGO involvement was seen by some as perpetuating medicalisation and missing the opportunity to promote community based treatment.
5. The requirement to have a RMHN was seen as generating antagonism amongst the CEOs of the region.

Central

Costs

The annual budget for the RMHN was estimated at $560,000 per year. This includes $20,000 to administer meetings, publish the Regional Plan and to cover travel required to liaise with the region. The remaining $540,000 funds project managers and 3.4 FTE staff on the SSA MH team. There is provision for unemployed stakeholders to be paid $175 per day.

For the first two years the $560,000 was top sliced from Blueprint funds, whereas the third year was paid out of Blueprint under-spend.

Time and travel is contributed by the participant's employing organisation.

Meetings include:

1. Executive, consisting of the six DHB Portfolio Managers, one General Manager representative, plus the MH team from the SSA. This group meets for a full day once a month in Wellington.
2. CRMHAN meetings are held in Palmerston North, with the frequency having dropped back from an earlier commitment of two days per quarter to the current one each six months. This group includes representatives of the six Local Advisory Group, three consumers, one family member, five NGOs, two Provider Managers, five Māori, one Pacific and six Portfolio Managers.

Benefits

1. Generating innovative approaches by bringing sector representatives together, and supporting selected projects. For example, the consumer lead case manager development work, and the initial pilot, has been funded by the RMHN.
2. Reviews are expected to fine tune regional and specialist services, with particular reference to Alcohol and Drug, Child and Youth, and Forensic services. This is expected to improve equity of access.
3. Bringing together people from across the sector enables a strategic overview.
4. The "Valuing People" project is at the point of being rolled out to all staff. This programme is expected to achieve attitude change and strengthen the adoption of the "whānau ora" and "recovery as a right" approaches.
5. A pilot programme is designed to improve the selection of MH workers.
6. There are implicit benefits of raising awareness of policy issues and national strategies.
7. The regional risk management programme has provided a guide to those coping with demand outstripping capacity, although this set of protocols still needs to be consolidated.
8. Plans are underway to develop more support and training for Portfolio Managers.
9. The sector-wide representation creates opportunities for cross-agency supervision and sharing information.

Disbenefits

1. The interface between local and regional approaches has not always been smooth.

Midland

Costs

The budget for the current year is $350,000. This includes $60,000 allocated to support the meetings and travel throughout the district for liaison purposes. There are three FTEs supporting the RMHN. An additional $100,000 has been supplied by the Ministry of Health for workforce development.

The costs of time and travel are borne by the DHBs concerned. Those participants from other organisations are paid for travel, accommodation and incidental costs but not their time.

The RMHN consists of the five CEOs and five Funding and Planning General Managers who meet monthly to consider regional issues, of which mental health is just one of many. It was estimated that time allowed for mental health discussion, plus preparation time, would amount to approximately forty minutes per month.

The RMHN operational group, commonly known as MRNOG, has a membership of 14-16 and meets bimonthly for 5.5 hours per meeting.

In addition there are regional forums for Māori, Pacific, Alcohol and Drug, Consumers, Family, Portfolio Managers and Clinical Directors/Provider managers.

Each of these forums sends five representatives to the annual planning forums which meet twice a year for a full day meeting.

Benefits

1.The regional plan offers overall strategic direction, therefore more certainty to planning.
2. The cooperation and collaboration is already present but the bringing people together stimulates further sharing of resources.
3. The RMHN has offered training support to NGO providers to assist with the process of certification.
4. The RMHN generates some equity gains due to:

- Collaboration and sharing of resources
- regional consistency is a major goal of discussions and reviews
- sharing knowledge of each others' services
- making explicit the variation in components of services creates a pressure towards uniformity
- creating a stimulus for at least minimum quality standards for rural people.

5. The RMHN facilitates an integration of the national strategic direction, regional vision and local planning.
6. There are anticipated benefits from the workforce stock-take and workforce coordinator but these have not been realised as yet.

7.The consumer movement draws strength and confidence from the regional forums and relationships.

Disbenefit

1. NGO informants considered the lack of involvement of NGOs meant that solutions to issues tended to focus on DHBs, rather than utilising the innovative potential and capacity of the NGO sector.

Northern

Costs

The total budget for the Regional Director and the activities of the NNC were set at $490,000 for the 2004/05 year. This includes $58,000 to run the RMHN and covers the payment to unwaged consumer representatives, set at $150 per day.

Thirty to forty people attend the main meetings of the NNC, which are now of two hours duration (reduced from the earlier half day) at monthly intervals. Participants meet for a shared lunch then reconvene for the various work-stream groups. The scheduling is intended to maximise the efficient use of time for those who travel from a distance.

In addition there are stakeholder reference groups of varying composition and size, which also mostly meet monthly in parallel with the main meeting. These include groups for Māori, Pacific, consumers, family, Clinical Directors, General Mangers, Health for Older People services, Alcohol and Drug services, Child and Youth services, and the Local Advisory groups.

The Regional Funders and Planners meet for half a day a fortnight.

Benefits

1. The bringing people together develops relationships. This is seen as the key to generating collaborative approaches.
2. The working together on projects and work-streams, mixing people from diverse backgrounds, integrates and coordinates stakeholders, by getting agreement on planning, access and best practice. The pooling of knowledge, skills and experience was seen as highly positive for generating solutions and sharing resources.
3. The widely inclusive membership allows a strategic overview.
4. It is expected the implementation will have a direct effect on service delivery as the regional work-streams move into the implementation phase.
5. The awareness of gaps arising from the reviews and regional discussions generates a pressure towards improving equity of access and service consistency.
6. The NNC gives a platform to generate and support innovation, and then to share the learning from the pilot projects, e.g., the Counties-Manukau DHB provider arm- NGO partnership providing a different type of community living programme; and mentoring and skill sharing between NGOs.

7. The NNC has strengthened the pre-existing collaboration over the regional inpatient beds.
8. Regional workforce developments including creating uniform pay and conditions for equivalent roles to reduce competition; sharing of capacity when there have been pressure points; and strategic up-skilling of staff to reduce pressure on more specialised services and for accreditation. Regional training has included alcohol and drug competencies, governance skills for NGOs, leadership training, and basic competencies.
9. Morale and optimism in the workforce was perceived to have improved due to the certainty of long term planning, improvement in industrial relations, increased training opportunities, and better mutual understanding of each others' positions and constraints.
10. The regional information system is still being developed but is another area of collaboration which is expected to deliver considerable improvements in coordination between services.
11. The combining of DHB and NGO provision in creative ways was seen as using scarce resources more effectively.
12. There are perceived benefits of working positively and proactively with the media.

Disbenefits

1. The speed of change has caused a decrease in morale amongst affected staff in some parts of the sector according to one informant.

Comparisons of Achievements, Strengths and Weaknesses

The summary table shows key achievements or progress steps which were highlighted by informants. This is not intended as a complete or representative list. The strengths and weaknesses are those identified by the researchers, though obviously drawing on the opinions of the informants.

Table 3: Strengths, weaknesses, critical success factors

	Southern	Central	Midland	Northern
* Significant Achievements (not intended as the full lists of projects underway)	1.Regional Access project 2.Other reviews completed, implementation underway	1.Speakers Day 2.Risk managemt. protocols, but still needs consolidation 3.Te Arawhata Oranga estab. 4.Consumer run case mgt. pilot	1.High and Complex needs project underway 2.Pacific networking infrastructure 3.Workforce	1.Innovative developments between NGO and DHB Providers 2.Upskilling for certification 3.Many projects underway

			initiatives	
Strengths	1.Clear purpose 2.Efficient structure 3.SSA analytical support	1.CRMHAN Supports innovation 2.Māori capacity building 3.”Valuing people” wkforce devt, involving staff all levels and parts of sector. 4. Consumer devts.	.1.Collaborative culture 2.High stakeholder interest 3.Now good structure to facilitate implementation.	1.Inclusive and transparent 2.Draw on expertise of region to resource projects 3.Wide reaching projects 4.Proactive approach to public relations.
Weaknesses	1.No consultation 2. Constrained	1.Patchy support 2. Slow to build connection with operational 3.Instability of planners	1.Clumsy consultation structure 2.Lacks SSA support 3. Has not adopted strong leadership role.	1.Many meetings, therefore costly in time. 2.Fast moving, some ”speed bumps”
Factors promoting success	1. Tightly defined role, cost-effective within limited role.	1.CRMHAN Very successful mix of stakeholders 2.Strong and innovative consumer involvement. 3. Te Arawhata Oranga widely acclaimed as providing leadership on Māori tikanga.	1.Democratic and consultative 2. Collaborative culture.	1.Regional Director 2.Widely inclusive membership 3.Workstreams mixing parts of the sector. 4.Strategic development of NGOs.

*Achievements of the RMHNs are difficult to list or quantify as most projects are still “in process”. The list here shows the activities which informants highlighted as being particularly positive.

Other Issues Raised

Participation by Small Provider Organisations

The difficulties of participation were raised by several small NGOs for whom meeting time was a relatively greater drain on capacity. In addition to the trade-off between desirable economies of scale, therefore favouring organisations of a certain size, versus the flexibility and responsiveness of the sector making a greater diversity of providers desirable, there are some other points that are pertinent.

NGOs contributing to culturally sensitive services are a part of the sector where there is an overall drive to increase capacity, but typically they are small providers with key personnel holding multiple roles. The costs of participation are higher for these people while it is also more critically important that they do participate because of the degree of difference between mainstream services and the models of service they promote.

There was a striking parallel between the two NGO Pacific informants interviewed. Both valued participation as the way to make progress for their people, identified as high needs but with low levels of representation, yet struggled with the many conflicting priorities to free the time to attend meetings. There were also problems with that form of consultation process: large meetings of articulate and forceful people are intimidating and alien to the Pacific cultural style, making it difficult to 'be heard' or to deputise to others in the organisation. Smaller focus groups or receiving reports to make written submission with time to consider and consult with reference groups were preferred. Consultation processes with consumers in situ were reported to be much appreciated and well attended.

Secondly, sporadic attendance accentuates already existing difficulties of challenging the majority view. One informant explained to achieve culturally sensitive practice requires some drastic changes in thinking on some aspects of treatment but that is hard to argue for as a minority voice, and particularly if some parts of the policy development process have been missed through only attending sometimes.

Thirdly, the lack of critical mass of Pacific capacity makes it difficult to achieve ongoing impact on issues.

The Role of Portfolio Manager

A number of informants identified this role as a key pressure point in the RMHNs. With the creation of the 21 DHBs, the existing funding and planning expertise was spread thinly. Central region in particular has been marked by instability in this part of the workforce. Although the RMHN is an opportunity to mentor newcomers and support their learning process, inexperienced people in this role can also hinder the RMHN from making progress, either from the time taken to train up newcomers or the loss of intellectual capital as the knowledge of systems departs with the previous incumbent. At

least one NGO informant saw the Portfolio managers as a pressure towards conservatism because they were answerable to GMs and CEOs rather than the RMHN.

A related issue is that this is a highly pressured position with a number of competing demands in a very complex sector. Project work for the RMHN can drop off the priority list under the weight of other tasks. For some of these personnel the regional role is not specified in their job description, or is a 'one liner' and is not included in their Key Performance Indicators, which increases the likelihood that under pressure the role of attending to local DHB work will take priority.

Solutions raised by informants include training and support for this part of the workforce, and matching Portfolio managers as leaders of projects with project management resources to ensure task groups do not founder from this risk.

Funding Issues

Informants raised a number of issues around the Ministry's Blueprint funding model, the relationship between PBFF funds and Blueprint funding, and the inter-district flows.

- Although the Blueprint model was acknowledged as having been a helpful guide for planning, some also questioned what the funding path is to be once Blueprint guidelines are approached.
- As a normative guide the Ministry's Blueprint funding model sets out desired funding guidelines for national planning purposes. Each district and region needs to apply these guidelines in the context of the particular health needs of the district or region. This is a challenge that is not always understood.
- Some informants reported scenarios in individual DHBs where Blueprint funds ring fenced for MH reduced the funding through PBFF, pitting the MH sector against the rest of the DHB who had relatively reduced funds available. For DHBs who are below Blueprint funding model guidelines, and are on a funding path to receive more and more Blueprint funds, this can be expected to further distort the balance between MH and other parts of the sector within the DHBs funding allocations. In another DHB the Blueprint funds were not allocated separately but mixed in with PBFF funds which also made it difficult to protect the MH funds from encroachment.
- IDFs were seen by some as discouraging regional approaches to collaboration: for those referring because of the payments discouraging the use of services, and for the host DHB by increasing risks of carrying non-viable services. However others saw it preferable for treatment quality if there is less reliance on inpatient regional services, and another saw it as increasing the incentives on the regional services to provide high quality and cost effective treatments. Although some regions do pay on a per capita basis, buying capacity, at least one region has moved to a system based on utilisation.
- Consumers in long term rehabilitation services or under the umbrella of follow-up care over an extended period create further ambiguities for the IDF system as it becomes increasingly unclear whether the person is local or a transfer, particularly as

those with mental health histories are known to be relatively mobile in living location, compared to those without mental health histories.

- For those DHBs with a number of regional services 'there is a lot of risk to manage' and the focus becomes risk management rather than creative approaches to services. The reasons for the location of regional services are often historical. 'DHBs may be left with historically devolved services that other DHBs have opted out of, that may not best meet the needs of their local population or may not be financially viable.'

Consumer Representatives

One Māori informant made a strong plea that consumers should not be regarded as separate from their whānau or significant others, nor should they be considered as different from the rest of the population, as this is what perpetuates stigmatisation. From a different angle, another informant expressed concern about consumers making a career out of their mental illness history which was seen as working against recovery, 'another form of institutionalisation,' and also perpetuates a notion of these people being different and therefore increases stigmatisation. In this region there was perceived to be no succession of more recent consumers coming through into the representation structure. 'We have strong consumers who are kind of professionals at being consumer advocates, who have pulled the rope ladder up behind them'.

There are also differences of opinion within this region of what "consumer capacity building" means with the DHBs wanting to increase capacity for input into decision-making, whereas the consumers interpreted this as capacity building in a recovery sense. Although these concepts are not mutually exclusive, they are quite different perspectives, which become relevant when decisions are to be made about the use of funds set aside for this purpose.

The Central region has developed a team of consumer auditors of services, who can go to other DHBs to avoid conflicts of interests, and also has supported an innovative pilot scheme of using consumer case managers.

Overall, there was strong endorsement by informants of the value of input from consumers to encourage the whole sector to embrace the recovery model.

CHAPTER SEVEN.
Discussion

Do the RMHNs Deliver the Desired Benefits?

The report card is very mixed with regard to the expected benefits. All four undoubtedly bring together planning and funding expertise to take an overview of the region to draw together plans for improvements and addressing service gaps. The RMHNs have also successfully worked through decision-making processes to prioritise desired service developments and to allocate additional Blueprint funding. All look forward to the additional workforce coordinator role to promote workforce development to add momentum to plans previously drawn up. Working through these tasks has implicitly and explicitly challenged them to find ways of working together in collaborative alliances. Some have unifying strategic vision and the plans spell out overall direction. Though there were some tensions in the interface between local and regional planning, mostly these are regarded as part of a dynamic tension between the regional and the local focus of attention. That is, this is a healthy tension rather than a sign of major problems.

However these tasks and cooperative processes are merely means to an end. Once the actual outcomes are measured, or the impacts rated on the valued dimensions or criteria, the results are quite patchy and in some case barely greater than neutral. However there were many comments of optimism that once planned changes are implemented, then much larger impacts would flow. It is not clear whether this optimism is justified or whether it remains hope.

The preliminary work towards assessing costs and benefits indicates many "soft" benefits but at this stage most of the more substantial changes in service development are still "intended" or "in process."

The few examples of actual changes to service delivery are striking and positive. In the South the regional access project has had significant beneficial effect, according to most informants, which has increased equity and effective use of scarce resources. In the Central region the innovations between NGO providers, the secondments between DHB and NGO, and the consumer case manager system all stand out. In Midland addressing the "High and Complex Needs" group will make a big difference to the overall adequacy of services. In the Northern region clarifying pre-existing regional collaborations for specialist services, mentoring between NGOs and alliances of DHBs and NGOs to spearhead improvement in community based services are just a few of many changes going on.

Most informants spoke of much greater changes "just around the corner." In that sense the formation of the RMHNs and the process of sorting out functional ways of operating, and the plans resulting, are investments or sunk costs. The literature review suggests it is

in the nature of such system integration change that it is likely to be incremental and constrained, (Lewis and Kouri, 2004; Church and Baker, 1998; both previously cited). The literature also indicates that planning is useful to forge a common direction and therefore is a catalyst, rather than instrumental in bringing about change alone (Fleury, Denis and Sicotte, 2003, Fleury, Mercier and Denis, 2002, both previously cited). The risks arising from a preoccupation with planning raised by Saville-Smith and colleagues in the 2002 review continue to be pertinent.

The mandatory Regional Plans may unintentionally overly direct the DHBs towards the planning function of the RMHNs. The structure of the Network and the linkage back to the more executive levels of the Networks is through the planning and funding functions of the DHBs. It is noticeable the reviews and task groups adopted by the RMHNs are broadly aligned to the aspects of service delivery asked for in the Regional Plan outline requested by the Ministry, suggesting the need to meet reporting requirements is a significant influence on the planning agenda. However this is not the only influence as, for example, all the regions have independently moved into alcohol and addiction services reviews, perhaps reflecting the wide spread concern about the increased incidence of dual diagnosis substance abuse with mental illness. Alcohol and addiction services are not asked about specifically in the regional plan template.

At the heart of the achievement wish list for the Networks is the sharing of rare specialist skills to allow services to have desirable economies of scale and for DHBs to have equitable access, plus the related issue of sharing capacity so that DHBs back each other in time of demand exceeding resources. This research suggests the involvement of all relevant personnel is a key to achieving satisfactory solutions to these issues, endorsing the importance attached to this aspect by Gray (1985, previously cited). Establishing a culture of collaboration, favourable cost-benefit analyses and effective management of the interface between regional processes and the local implementation are also relevant. Scanning across the RMHNs suggests implementation is subject to potential barriers: lack of buy-in from key stakeholders; staff turnover; historical arrangements prevailing; consumer resistance to moving away from local support networks; and the general pressure on resources were all noted in this research. This underlines the complexity of the change processes required, the need for ongoing working at new systems and monitoring to provide feedback loops to allow review and improvement. Gray (2002, previously cited) makes some useful leads on potential risks.

It seems an obvious truth that change in operational practice will only happen when there is engagement and participation from those personnel and that planning alone will not achieve that. There is ample evidence from informants that in a vacuum, historical or relationship based cooperation will predominate. Although the worth of this should not be underestimated, it may not be the most efficient way forward and it leaves vulnerable those smaller DHBs or situations where there has been high turnover of staff.

So who to include in the RMHN does matter. As Gray (1985, previously cited) pointed out, the exclusion of significant stakeholders will limit both the information available and the implementation of any solutions generated.

The South Island limited membership has serious risks attached: a disaffected NGO and consumer sector, a more narrow focus, duplication of the efforts of others, and missed opportunities for the creativity and dynamism arising from cross-sector debates.

The strength of the Central Network is in the cross-sector representative group which is able to bring a depth of experience, wisdom and sector knowledge together into a crucible of discussion.

Midland has struggled to achieve the right balance of consultation and action. An inclusive model adopted in the early phase of its existence was found unworkable and costly. A more streamlined structure has attempted to keep the focus more on implementation of the plans formed, but there continues to be some tension around that Network membership which potentially diverts energy away from the more important business at hand. The appropriate balance of stakeholders continues to be the subject of review. In particular the NGO providers are poorly represented. The annual planning forum that brings representatives together may be too large to get to grips with the problems to be addressed and to stimulate the problem solving debate that is desirable. There are plans to use focus group discussions which may correct this.

Northern has a very inclusive and transparent structure with various channels for those who wish to know about the Networks activities and to participate.

The South Island regional CEO group has been of the firm opinion that consultation should occur locally, and there is no place for consultation at regional level. The three other Networks have various consultation or sector representation arrangements, as previously described. The potential gains from inclusion of others are achieving a more balanced view of problems and priorities, overcoming fragmentation towards greater coordination in the sector, the application of many viewpoints to progress complex problems, generating new and innovative approaches, and providing a platform for strategic education or attitude change, for example, the recovery approach or how to implement whānau ora. Without clarity of purpose there is a risk of consultation being unwieldy, slowing down progress, raising unrealistic expectations of what can be achieved and increasing costs without compensating benefits.

Regions do not have a natural community to consult with, therefore the LAG is the natural conduit between the local community and the region. Selected sector representatives from all stakeholder groups, including LAG representatives, seems an important, if not essential element in the success of the RMHNs. The Northern RMHN incorporates reference groups for these representatives which broadens the consultation base. Central RMHN relies on the natural networks that representatives communicate through as well as the LAGs. The Midland region has had a strong emphasis on stakeholder reference groups but perhaps that has been at the expense of the cross-sector regional forum developing an identity and purpose which has allowed it to move forward constructively.

In weighing up the actual gains achieved so far it should be kept in mind that the problems tackled are in the main, "big" problems which are insurmountable by one DHB on their own. It is in the nature of such problems and the process of collaborative alliances that change takes time and is incremental. The ratings give some indicators of impact achieved which are explained and expanded on by the explanatory comments. Some change is being achieved but informants predict much greater pay-off to be reaped, given the time for processes to come to fruition. Most informants involved in the RMHNs have considerable optimism and direction to the future.

The RMHN meetings provide a forum for sharing innovative ideas, for striving for improvement, for sharing learning from new ideas tried, as well as distilling out best practice ideas. Grass roots innovation developed for a local situation may not be transferable directly but shared ideas may stimulate others in new directions. Some RMHN seek innovation more explicitly than others However having a forum to pool resources to problem solve and generate creative solutions is invaluable.

It is concluded the RMHNs should be given that time to follow through strategic planning to fruition, but where possible, to provide the enabling and facilitative conditions to support their functioning.

What is Helpful to the Functioning of the RMHNs?

The context of historical groupings, geography and culture are all influential and each region has gone through a process of determining what works. What works in one region is not necessarily transferable to another.

Within those cautions in mind, there are some aspects which are perceived to enhance the functioning of the RMHNs.

1. Leadership. The Regional Director role in the Northern RMHN was attributed by many as giving a cohesion, focus, and an independent advocate voice, which has facilitated a strong sense of strategic direction.
2. Appropriate consultation, including representatives of all relevant stakeholders and fields of expertise. Including the "who's who."
3. Obvious shared benefits. For individual participants to continue, there must be expectations of benefits and belief their participation is relevant and worthwhile.
4. There needs to be at least some shared identification with the regional focus. Hoge and Howenstine's work (1997, previously cited) is a useful framework for thinking about this process. It is noteworthy that the Northern RMHN has used all of these strategies to achieve a greater identification with the regional approach.
5. A key rationale of working regionally is to share expertise. Cross-matching of experts from different organisations to form working groups helps with relationship building and extends the dynamic sharing that generates creative solutions. This is used extensively by the Northern RMHN.
6. The development of a shared vision and strategic direction.

7. “Success breeds success” helps generate commitment and continued application.
8. A culture of innovation. The Speakers Day in the Central region is a good example of making that explicit.
9. Having a mix of stakeholders at the table was seen to be a key element by many.
10. Avoid project progress being dependent on already busy people. Northern uses a solution of matching credible project leaders with project management resource to manage that risk.
11. Having SSA analytical capacity is useful for supportive research and monitoring purposes.
12. A redundancy of communication helps ensure the information does disseminate.
13. Support from influential others is helpful, including CEOs, GMs, and external stakeholders such as the Ministry of Health and Mental Health Commission.
14. Clarity of purpose, including not only what is the focus of the group but also the limits to that purpose, to avoid duplicating the local functions, or creating unnecessary tension by having too inclusive a focus.
15. Having a clear governance structure and accountability structure.

There are also some factors which act as barriers to the functioning of RMHNs.

1. The resistance to being mandated can distract from the fact that the RMHNs offer opportunities to achieve more efficient solutions to complex problems which affect all the DHBs in the region.
2. The time it takes to form and structure the RMHN to gain traction can lead to loss of credibility and the withdrawal of support.
3. If expectations are poorly managed then participants can become disillusioned and cynical about the value of participating.
4. There is the potential to get bogged down with excess consultation. However, there is no easy answer regarding what is the right amount of consultation as that will depend on the context and purpose.
5. A lack of overall direction can be the outcome if there is excess consultation without that being balanced by leadership.
6. A lack of support at critical levels, such as CEOs or key personnel, will constrain what the RMHN will achieve.
7. If the cost structure appears high without early benefits, then the commitment of those needing to allocate resources is tested.
8. Geographical distance between DHBs increases costs of meeting and also may reduce the attractiveness of the potential benefits of participating, for example there may be resistance to the use of distant regional services.
9. There may be a lack of power to persuade decision-makers and frustration that those making the decisions may not understand all the complexities.
10. Perceived incompatibility of local priorities with the regional ones will work against regional collaboration while those participants still identify primarily with the local focus.
11. Portfolio Managers have been in a key role in the RMHN but are in a role that is often pressured and overloaded. Particularly if their incentives are strongly oriented to their local role, this a point of vulnerability for the RMHNs.

12. If information is not open and transparent there are lost opportunities for engagement and integration.
13. Any change process is stressful and may well meet with resistance. Unless it is treated as a change management process and the time is taken to engage those affected, the implementation may be ineffective.

What delivers the desired benefits

Within the existing regional arrangements, there were some features that emerged as promoting the desired outcomes and others evaluated as inhibitors.

Equity of access
Equity of access is promoted by a collaborative culture that takes a regional view to develop clear protocols to guide those frontline staff in their decision-making and liaison with other services. The allocation of costs needs to be perceived as fair to both referring DHBs and to the host DHB. Ongoing monitoring and evaluation offers a means to identify issues arising, providing a feedback loop for continual improvement, and also promotes willingness to trial systems for those with concerns. Collaboration is promoted by relationships between participants, multiple projects where participants can give and take, and cost-benefit analysis supporting the case for collaboration. Regional identification is promoted by project involvement across the region and by including the regional role in employment conditions, e.g. inclusion in performance indicators and employed under the regional structure as well as the DHB, as used by the Northern RMHN.

Any protocols developed must achieve buy-in at the local level. To be successful in achieving the desired outcomes, the Network must engage with those operational staff or have open and transparent communication systems to disseminate to all who need to be influenced. Engagement and consultation promotes both knowledge of agreed systems and allows feedback loops for any issues arising.

Coordination of clinical services
The RMHN offers an opportunity for provider organisations, both DHB and NGO, to build relationship and share information, which facilitates smoother and more flexible client pathways, as well as the emergence of more innovative partnerships for service delivery. Formal protocols for referral between services can also be helpful in more circumscribed ways.

There may be other more cost-effective ways of bringing people together with common interests, such as education sessions or support networks around topics. The RMHN can assist by promoting a culture of regional approaches to training and striving for best practice.

Integration of regional and local planning

The integration of planning assumes a compatibility of values and priorities between local and regional. The opportunity for discussion to allow a common strategic overview to emerge promotes integration, though there was widespread agreement on the importance of local variation and the need for flexibility to accommodate that. Balancing "top down" and "bottom-up" approaches is necessary. Commitment to consultation should not be at the expense of leadership and analytical support. A lack of consultation can lead to a less balanced view and a lack of buy-in from those parts of the sector which have been excluded.

Workforce development
Bringing together sector representatives promotes mutual understanding of others' roles. The RMHN is well positioned to deliver training more efficiently by offering economies of scale and to strategically influence culture, therefore facilitating the development of a shared vision. The workforce development coordinator role offers opportunities for efficient recruitment drives; to ensure training and skills development; and to equalise employment conditions to reduce poaching of staff.

Effective use of scarce resources
The RMHN promotes effective use of resources by the reviews which share information about resources, health needs and gaps in services. Joint projects also promote economies of scale.

Impact on the public's confidence in MH services
Although not strongly linked to the role of the RMHN, this was seen as positively promoted by consultative approaches, having well developed specialist support links between local and regional services, demonstrating a willingness to incorporate consumers views and providing a spokesperson focus for the media which is independent from provider organisations.

Promoting safe and sustainable MH services
Wide stakeholder involvement and strong clinical coordination in a collaborative culture is helpful in creating an environment which promotes sharing of stresses and cooperative efforts to ameliorate any strains. Encouraging the adoption of the "recovery as a right" approach is also deemed helpful to making services safer for consumers.

Lack of financial viability for NGOs and lack of capacity are barriers to achieving this outcome.

Consultation, engagement and transparency
Wide involvement of stakeholders and open communication channels promote transparency and engagement. Ideally a range of methods of consultation within well defined communication and representation channels allows participation and input, while avoiding costly "talkfest" meetings which are not relevant to all participants.

Promoting innovation

Bringing together stakeholders from different backgrounds and experiences to share best practice ideas and strategic solutions promotes innovation. The mix of DHB and NGO providers was seen as particularly helpful.

Promoting culturally safe MH services
Representation on discussion groups is insufficient to achieve changes in sensitivity, though this helps integrate cultural competence in to other developments. Leadership and training support to assist staff understand and develop skills to operationalise cultural safety is also required.

Overall efficiency with benefits being greater than costs
Clarity of purpose and ensuring there is a "goodness of fit" between the purpose of meetings and those participating help ensure efficiency. The function of the RMHN should be to address those issues which are unable to be addressed locally, or where there are efficiency gains from regional approaches.

Can These Desired Benefits Be Achieved in Other Ways?

The combined sector viewpoint had some common themes about the preferred models for solving regional problems in MH.

There was little support for separating MH off from other parts of the health sector. Although one or two favoured a stand-alone MH organisation, the majority who commented on this option perceived the disadvantages outweighing the benefits. Advantages included the extended and different nature of MH services, and the fragile state of the sector benefiting from more transparent protection of the funding streams. However the disadvantages were perceived as perpetuating stigmatisation and increasing risks of MH consumers receiving less adequate general health care. A holistic approach is preferable, particularly as long term MH difficulties are associated with greater incidence of health problems. Furthermore, there was a reluctance to let DHBs "off the hook" for dealing with MH issues adequately.

Some sector informants objected to the mandatory aspect of regional arrangement. At the time of the introduction of the RMHNs, DHBs were still working out their *modus operandi* but have evolved numerous ways of collaborating since then. There was a plea from these informants that the DHBs should be trusted to work out what is best for their region. However other sector participants held anxiety about individual DHBs not respecting the degree of sector development needed in the MH sector and perceived a risk to MH funds not protected by ring fencing. Some saw MH as providing a useful model for regional development which other parts of the health sector could learn from.

There was strong support for the local delivery of MH services, hence the Northern vision "Local delivery but regional consistency." The importance of adapting clinical services to the unique features of a district was far more compelling than any perceived

regional direction. Therefore a single MH Regional DHB-equivalent is predicted to hold little attraction.

However there was a frequent request for greater clarity of what should be delivered locally, what should be delivered regionally and what should be delivered nationally. There was also confusion for some over whether the primary accountability of the RMHN rested with the DHBs or with the Ministry of Health.

The RMHNs' existence has been integrally bound up with the Blueprint funding as that has largely resourced developments to date. This raises the question "what happens after the Ministry's Blueprint funding model guidelines are reached?"

An unresolved question for the MH sector is how it should best link in with primary care developments. Some suggested the RMHN forum could help provide a coordinating forum between primary, secondary and tertiary services.

Possible Approaches to Address the Need For Regional Services

The minimum contribution of regional approaches is the means to allow more equitable access to specialist services that cannot be provided by all DHBs.

Option A: Trust DHBs to act as they see fit

DHBs could be left to sort out access protocols on an issue by issue basis without prescribing the form this should take. CEOs highlighted this occurs routinely for other tertiary services, therefore could be assumed to be feasible for MH as well.

The advantages of this option are potential efficiency gains as only the relevant operational staff are called on to address the issues; avoiding the energy loss from working against the DHBs wishes; and clear accountability as each DHB is responsible for finding a solution for their population.

The disadvantages are that small DHBs are pushed back into reliance on "grace and favour" arrangements through the IDF system. With capacity frequently under pressure, there is the risk of the case study scenario detailed at the beginning of this report often occurring. Unless the host DHB for the regional service has an incentive to provide equitably for the DHBs in the region, there is the risk of services delivered inequitably, with geographic proximity being a determining factor.

Addressing the regional services issue alone would preclude the other opportunities the RMHN currently offer: the integration of the sector; working on "big" issues that are in common to all is more efficient; forming a strategic direction which gives a vision and consistent quality standard to aspire to and work towards; shared expertise and teamwork; a platform to share innovations and to generate pilot projects as new ways of working are trialled; and to provide a regional focus for workforce development.

The DHBs may generate other ways of collaborating to address these gaps, may decide to continue the RMHNs as the most cost-effective way of meeting multiple needs, or MH may suffer from stagnation and not grow as much as is feasible because the enabling conditions are not present.

Option B: Status quo, joint advisory agency, with or without compulsion

The Status quo can be regarded as a joint advisory agency, established by the DHBs collectively, and accountable to the DHBs. The advantages this model offers is that it allows the DHBs to retain flexibility to respond to local needs while offering efficiency gains of avoiding duplication, sharing expertise and allowing the DHBs to work collectively on "big" issues which are common to all. The RMHNs hold neither purchasing nor provision capacity, but can advise on both.

This option may continue to be mandated by the Ministry of Health or left open to the DHBs to form as they choose (which may mean reverting to Option A). If the mandated regional planning requirement is lifted there may be other ways of creating incentives towards regional cooperation, such as requiring regional reporting on MH outcomes; education and sharing innovations nationally promoting collaborative ways of developing services; requiring regional solutions to access of scarce resources problems; and contingency plans between neighbours for capacity issues. Holding DHBs jointly accountable for MH outcomes of the region may also be helpful. However this starts to resemble the same reporting requirements as mandated by the regional plan it is attempting to replace.

Option C: A regional MH Service formed by the DHBs, or a DHB has lead to purchase regional services

These options could be elected by the DHBs of the region, to give either a separate agency to deliver regional services, or a lead DHB which has been given that role. The regional agency would hold a budget and have both planning and purchasing functions on behalf of the region.

The advantages would be economies of scale and scope, potentially bringing a critical mass of planning expertise together, and would be more efficient in situations where there are only one or two providers. For the providers there would be fewer DHBs to contract with. This may give greater clarity of strategic direction without the conflicting pulls of local priorities. There would be greater power within the regional agency without needing to go through layers of decision making.

The disadvantages are the funding issues would still need to be resolved in determining the budget, so would not necessarily avoid the transaction costs of the IDF system, while the interface between local and regional processes would need careful clarification. There are risks of the regional service agency making choices which increase the interface difficulties without the more direct governance control the DHBs exercise.

Overall this option would offer few gains and would accentuate the separation of MH from other health services.

Option D: Stand-alone purchasing RMHN agency, funded by and accountable directly to Ministry

This would be similar to Option C, being a budget holding purchasing agency for regional services.

Under the current legislation there is no provision for this occurring unless DHBs agree.

As with Option C there are disadvantages posed by heightened risks of disconnections between regional services and locally provided MH services, when the optimal is smoothly coordinated clinical pathways. This risk is likely to be increased if funding is from a separate funding stream and accountability structures as compared to continuing to have a governance and accountability relationship with the owner DHBs of Option C.

There may be advantages for Central Government holding a clearer policy direction for the regional MH service, but in the process this is likely to create further separation and further antagonism.

Option E: Separate MH Services for the region, funded by the DHBs or funded by the Ministry directly, delivering all MH Services

This would give planning, purchasing and provision power to a regional MH services which would then organise access and strategic development of services as a whole. If funded by the DHBs there would continue to be accountability to the DHBs of the region. This would have advantages of pooling scarce resources, increase the chances of access being equitable, greater clarity to clinical leadership and strategic direction, increase service integration within the region, and some efficiency gains by reducing duplication of efforts.

The disadvantages are the loss of focus on the local health needs and the responsiveness to these communities, and the loss of integration with the wider health sector. Furthermore, the separation of MH services from general health services was seen to have major disadvantages: perpetuating stigmatisation around MH and secondly, placing MH consumers at risk of receiving less adequate general health care, even though their propensity to mental illness increases other health risk factors.

The single regional purchaser-provider may increase the perception of NGOs of being relatively powerless. The dominance of one purchaser- provider viewpoint may be a force against change and innovation. There would be reduced opportunities for peer review quality monitoring.

If funded by the Ministry this type of regional service could be governed by an elected Board. It could be regarded as a MH DHB. However in general, informants considered

there were already too many DHBs and therefore there is likely to be little political approval for creating further DHB structures.

CHAPTER ELEVEN.
Conclusions

This study has used a research evaluation approach to assess the contributions and impacts of the regional approaches to mental health in order to gauge the actual and potential benefits and to consider other possible approaches.

It is clear that the RMHNs need further time to implement the action plans that have been drawn up and are intended over the next few years before the benefits are realised. Although at this stage the actual achievements are sporadic or "in process," there is optimism and expectation that traction on some difficult issues will be gained. All RMHNs have detailed work programmes depending on sign-off.

Continued support from significant others, including the Ministry of Health and Mental Health Commission, is a critical element in the enabling conditions for the RMHNs to realise the benefits from the investment of effort, costs and time. It is suggested that on balance it is best to leave the status quo in place but consider a further review of achievements of the various RMHNs at the end of the three-year planning cycle which is to start with the 2005-2006 plans.

The sector needs clarity over the intended funding path beyond the Blueprint funding model which is the main source of funding to resource RMHNs currently.

Clarification of what is appropriately regional and what should be left to local DHBs would be helpful. This could be done by engaging the sector, including MHC and CEOs, in discussions or possibly by the MHC acting in a supportive role to the sector.

Clarification of accountability would be useful: are the RMHNs accountable to the DHBs or to the Ministry, as the latter requires the Regional Plan and sets the larger strategic direction? What legal accountability do CEOs hold in relation to performing against the regional plan?

There needs to be recognition that those involved in implementation of the regional strategic plans are often attempting complex change management processes. Support for these processes may include using short-term change management expertise; encouragement to draw in key personnel to be involved; and having realistic time frames.

Encouraging clarity around the purpose of forums and meetings would assist in keeping meetings efficient, avoiding "talkfest" and large meetings where not all issues are relevant to all participants.

Clarifying expectations around consultation would be helpful. It is suggested broad consultation with the community is a district level activity but at regional level there

should be stakeholder group representatives, with particular emphasis on combining LAG representative, consumer, Māori, expertise from the range of MH providers and DHB planning personnel.

No one model of RMHN is going to suit all regions because of the very different context each operates in. Therefore it is not surprising that the models in the four regions have evolved in quite different ways. The strengths of these should be supported and where the RMHNs request it, assistance offered to make the structure more effective. Each has struggled to find ways of resolving the complexities of governance, membership, functions and decision making and the resultant structures reflects this shared application over an extended period. However opportunities to learn what works well in other regions may stimulate new ways of working.

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Appendix One.
Interview schedules

1. Regional Mental Health Network Manager

Regional Approaches to Mental Health Project

Questions for Regional Mental Health Network Managers

Description of regional arrangements

1. What is the structure and organisation of your regional arrangements?
   - What are the reporting lines?
   - What the relationship with the funding and planners and the CEOs?
2. What meetings occur, attended by whom?
3. What Māori representation is there on the regional networks and forums, and at what levels? What difference does this make to decision-making?

Features of your region

4. Are there any historical, geographical or cultural factors that impact, impede or promote taking a regional approach?
5. What are the Blueprint access levels for your region? Do you have any reports or data on this?
6. What resources constraints affect your region?
7. Where are the following specialist services delivered:
   - Acute assessment and crisis intervention?
   - Specialist inpatient care?
   - Child, youth and family services?
   - Alcohol and drug services?
   - Psychogeriatric specialist assessment and treatment?
   - Forensic services?
   - Eating disorders?

Functions of the Network

8. What are the main aims and objectives of your Network? Do you have any prepared reports that we could have a copy of?

9. What tasks are carried out by the Network:

a) Planning for region, with regard to Blueprint funds?
With regard to general mental health budgets?

What is the interface between regional planning and local planning at the DHB level?

b)What contribution does the Network make to funding and purchasing decisions?
For Blueprint funds?
For general Mental health budgets?

c)Consultation with stakeholders?
How are the local advisory groups, or their viewpoints, represented in the Network's discussions?
What other consultation processes occur in addition to that incorporated into the LAGs?

d)Service delivery arrangements- what changes arise in service delivery because of the Network's activity?
Specialist services?
Response in time of crisis? E.g Times when demands on service , workforce shortages, natural disasters
Collaborative efforts between two or more DHBs with regard to specific services?

e) Workforce issues- what initiatives arise from the Network's activities
Training for staff across region or sub-regions?
Supervision and peer review?
Trouble shooting of acute capacity and capability problems?
Industrial relations and personnel management issues

f)Task groups on specific issues and problems within the Region? Please specify nature of project groups.

g) Education and raising policy awareness

10. What are the communications channels into your regional discussions and the channels emanating out from your regional arrangements?

What difference do the regional arrangements make?

11. In considering the following dimensions which regional arrangements could potentially impact, please indicate whether your arrangements have:

-strongly negative
- moderately negative
- no impact or neutral
-moderately positive impact
-strongly positive impact

Please comment briefly also on the reasons you have chosen that rating.

a).How does the regional focus improve equity of access?

Blueprint access levels, access to specialist services, quality of services, access for rural and smaller centres may be relevant.

b)What impact do the regional arrangements have on the coordination of clinical services?
Potential impact on optimal clinical pathways, case worker relationships, information management systems, coordination between service components may be relevant.

c) What is the impact of the regional arrangements on the integration of regional and local planning?
The interface between local and regional planning, and the degree to which
the DHB Funders and Planners identify with the regional focus may be relevant.

d) How do the regional arrangements promote a stable and supported mental health workforce?
Access to supervision/ mentoring/ peer review/ training; staff morale; impacts on staff retention may be relevant.

e) What impacts do the regional arrangements have on the effective use of scarce resources?
Potentially promoting economies of scale and scope; shifting around resources when under or over capacity.

f). How have the regional arrangements affected the public's confidence in the mental health services of the region?
Potential impacts on media reports, complaints

g)What impact do the regional arrangements have on safe and sustainable mental health service?

h). What impact do the regional arrangements have on consultation, engagement with stakeholders and transparency? (With regard to consumers, families, provider organisations, PHOs)

i)How do the regional arrangements promote innovation?
Sharing best practice ideas, problem solving in project groups may be relevant.

j)What impact do the regional arrangements have with regard to cultural safety of mental health services for Māori, Pacific and other cultures?

k) What impact have the regional arrangements on the overall efficiency of mental health services in the region?
Benefits of the regional arrangements outweigh the costs

Disadvantages of the regional arrangements

12.What disadvantages arise from taking a regional focus when the responsibility and decision-making rests with the DHBs?

- Have there been "disconnects" that have arisen?
- Have the Network had difficulty effecting a change which is perceived by many as being in the regions best interests because the Network lacks the power?
- Have there been conflicts arising at the DHB level because of mistrust, suspicion, lack of clarity about the Network's role?
- Who has final sign-off on decisions? How does that process work, and have members of the Network had difficulty achieving sign-off in their individual DHB on actions approved and wanted by the Network?
- What difficulties have there been in getting members to take responsibility for solving regional problems when they identify with their local area and their primary responsibility stops there?

Strategies and other potential solutions

13 What strategies have you employed to overcome the problems identified in No 11? What strategies would you like to employ?

14. How widely through the region's DHBs do key personnel adopt a regional approach or identify with regional concerns? What are the incentives that encourage DHB personnel to take a regional approach?

15. How are regional roles specified in employment contracts?

16. What support and encouragement for taking a regional approach do you receive from influential others? (e.g. the Minister, Ministry of Health, Mental health Commission, DHBNZ, SSAs)

17. What other arrangements can you envisage? What are the potential advantages and disadvantages of these arrangements? How feasible would it be to introduce these arrangements?

Collaborations between DHBs

18. What collaboration has occurred between DHBs prior to the regional arrangements or independent of the regional arrangements?

The Future

19. Would you like to see further development of the regional approach? If not, why not?

- What form could or should that take?
- How feasible would it be for these changes to occur?

- Are there any strategies you see as helpful to move the Network more in that direction?
- Are there reviews scheduled?

20. If the regional arrangements were expanded what else would be needed? What costs would be involved?

21. Would you like to see leadership on this issue? From whom?

22.Do you have any other comments on the regional arrangements?

2. Funding and Planning Managers

Regional Approaches to Mental Health Project

Questions for DHB Mental Health Portfolio Managers

Description of regional arrangements

8. What is the structure and organisation of your regional arrangements?
9. What meetings occur, attended by whom?
10. What Māori representation is there on the regional networks and forums, and at what levels? What difference does this make to decision-making?

Features of your DHB

11. Are there any historical, geographical or cultural factors that impact, impede or promote taking a regional approach?
12. What are the Blueprint access levels for your DHB? Do you have any reports or data on this?
13. What other resources constraints affect your district?
14. Are the following mental health services delivered locally? If not, where are they provided?
15.

- Acute assessment and crisis intervention?
- Specialist inpatient care?
- Child, youth and family services?
- Alcohol and drug services?
- Psychogeriatric specialist assessment and treatment?
- Forensic services?
-Eating disorders?
-Community based treatment and rehabilitation

Functions of the Network

8. What are the main aims and objectives of your Network? Do you have any prepared reports that we could have a copy of?

9. What tasks are carried out by the Network:

b) Planning for region, with regard to Blueprint funds?
With regard to your district's mental health services?
What is the interface between the regional planning and local planning at your DHB?

b)What contribution does the Network make to funding and purchasing decisions?
For Blueprint funds?

For your general DHB Mental health budget?

c)Consultation with stakeholders?
How is your local advisory group, or their viewpoints, represented in the Network's discussions?
What other consultation processes occur in addition to that incorporated into the LAGs, that is then included in the regional discussions?

d)Service delivery arrangements- what changes arise in your DHB's service delivery because of the Network's activity, eg. Services not able to be delivered locally?
*Response in time of crisis? E.g Times when demands on service , workforce shortages, natural disasters
Collaborative efforts between two or more DHBs with regard to specific services?

f) Workforce issues- what initiatives arise from the Network's activities
Training for staff?
*Supervision and peer review?
Trouble shooting of acute capacity and capability problems?
Industrial relations and personnel management issues

f)Task groups on specific issues and problems within the Region? Please specify nature of project groups.

10. What are the communications channels into your regional discussions and the channels emanating out from the regional arrangements?

What difference do the regional arrangements make?

11. In considering the following dimensions which regional arrangements could potentially impact, please indicate whether the arrangements have:

-major positive impact
-medium positive impact
-no impact or neutral
- medium negative impact
-major negative impact
-don't know

Alternatively, you may refer a scale of one to ten where one is highly negative and ten is highly positive.
Please comment briefly also on the reasons you have chosen that rating.

a).How does the regional focus improve equity of access?
Blueprint access levels, access to specialist services, quality of services, access for rural and smaller centres may be relevant.

b)*What impact do the regional arrangements have on the coordination of clinical services?
Potential impact on optimal clinical pathways, case worker relationships, information management systems, coordination between service components may be relevant.

c) What is the impact of the regional arrangements on the integration of regional and local planning?
The interface between local and regional planning, and the degree to which
the DHB Funders and Planners identify with the regional focus may be relevant.

d) Are there any strategies for recruitment and retention that arise out of the regional arrangements? Do the regional arrangements promote a stable and supported mental health workforce?
Access to supervision/ mentoring/ peer review/ training; staff morale; impacts on staff retention may be relevant.

e) *What impacts do the regional arrangements have on the effective use of scarce resources?
Potentially promoting economies of scale and scope; shifting around resources when under or over capacity.

f). How have the regional arrangements affected the public's confidence in the mental health services of the region?
Potential impacts on media reports, complaints

g)*What impact do the regional arrangements have on safe and sustainable mental health service?

h). What impact do the regional arrangements have on consultation, engagement with stakeholders and transparency? (With regard to consumers, families, provider organisations, PHOs)

i)How do the regional arrangements promote innovation?
Sharing best practice ideas, problem solving in project groups may be relevant.

j)*What impact do the regional arrangements have with regard to cultural safety of mental health services for Māori, Pacific and other cultures?

k) What impact have the regional arrangements on the overall efficiency of mental health services in the region?
Benefits of the regional arrangements outweigh the costs

Disadvantages of the regional arrangements

12.What disadvantages arise from taking a regional focus when the responsibility and decision-making rests with the DHBs?

- Have there been "disconnects" that have arisen?
- Have the Network had difficulty effecting a change which is perceived by many as being in the regions best interests because the Network lacks the power?
- Have there been conflicts arising at the DHB level because of mistrust, suspicion, lack of clarity about the Network's role?
- Have you had difficulty achieving sign-off in your individual DHB on actions approved and wanted by the Network?
- What you had difficulties taking responsibility for solving regional problems when you identify with your local area which is where your primary responsibility rests?

Strategies and other potential solutions

13 What strategies have you employed to overcome the problems identified in No 11?

14. How widely through the district and DHB do key personnel adopt a regional approach or identify with regional concerns? What are the potential gains or incentives that encourage DHB personnel to take a regional approach? Are there disincentives?

15. For the funder arm, how are the regional roles specified?

16. What support and encouragement for taking a regional approach do you receive from influential others? (e.g. the Minister, Ministry of Health, Mental health Commission, DHBNZ, SSAs)

Collaborations between DHBs

17. What collaboration has occurred between your DHB and other DHBs prior to the regional arrangements or independent of the regional arrangements?

The Future

18. What other models of regional arrangements can you envisage or changes you would like to see? What are the potential advantages and disadvantages of these changes? How feasible would it be to introduce these changes?

19. If the regional arrangements were expanded, what else would be needed? What costs would be involved?

20. Would you like to see leadership on this issue? From whom?

21.Do you have any other comments on the regional arrangements?

* These questions are more relevant to the Manager of the Provider Arm but are included for completeness.

3. NGO providers

Regional Approaches to Mental Health Project

Questions for NGO provider organisations

Involvement in the local RMHN

1.What is your relationship to the Regional Network (s)?
Are you involved in meetings? How frequently do these occur, and who else attends?
If you are not involved, what is your understanding of the Network's role, and how relevant is it to your organisation?

2. What costs are involved for your organisation by the Network's activities or meetings?

- Time at meetings and preparations for these
- Involvement in projects or consultations arising from the Network,
- Communications arising from the Network

3. Are you able to influence what is put on the agenda of meetings?
How effective is your input and what impact do you and other NGO representatives have on decision-making?

Functions of the RMHN

4.. What are the main aims and objectives of your Network from your point of view?

- How well does the Network deliver on these from your viewpoint?
- Are there aspects that cause you concern, and what would you like to see happen differently?

5.If you are involved with more than one Network, what differences do you notice between Networks?

- What are the strengths and weaknesses of each of these arrangements?
- What changes have arisen from each of these arrangements?

6.What tasks are carried out by the Network:

- Planning- regional
  -use of Blueprint funds
  -use of general Mental health budgets
  -What is the interface between regional planning and planning at the local level?
- What contribution does the Network make to funding and purchasing decisions for the DHBs in your region?

-for Blueprint funds?
-for general Mental health budgets?

- Consultation with stakeholders?
  -How are the local advisory groups, or their viewpoints, represented in the Network's discussions?
  -What other consultation processes occur in addition to that incorporated into the LAGs, stimulated by the Network's activities?
- Service delivery arrangements- what changes have arisen in service delivery because of the Network's activity?
- Workforce issues- what initiatives arise from the Network's activities
- Trouble shooting problems within the Region
- Education and raising policy awareness.

7. Are the communication channels satisfactory (for each of the Networks you are involved in) from your point of view? Please explain any difficulties.

What difference do the regional arrangements make?

8. In considering the following dimensions which regional arrangements could potentially impact, please indicate whether each of the arrangements you have involvement with:

-strongly negative impact
- moderately negative impact
- no impact or neutral
-moderately positive impact
-strongly positive impact
-don't know

Please comment briefly also on the reasons you have chosen that rating.

a).How does the regional focus improve equity of access?
Blueprint access levels, access to specialist services, quality of services, access for rural and smaller centres may be relevant.

b)What impact do the regional arrangements have on the coordination of clinical services?
Potential impact on optimal clinical pathways, case worker relationships, information management systems, coordination between service components may be relevant.

c) What is the impact of the regional arrangements on the integration of regional and local planning?
The interface between local and regional planning, and the degree to which
the DHB Funders and Planners identify with the regional focus may be relevant.

d) How do the regional arrangements promote a stable and supported mental health workforce?
Access to supervision/ mentoring/ peer review/ training; staff morale; impacts on staff retention may be relevant.

e) What impacts do the regional arrangements have on the effective use of scarce resources?
Potentially promoting economies of scale and scope; shifting around resources when under or over capacity.

f). How have the regional arrangements affected the public's confidence in the mental health services of the region?
Potential impacts on media reports, complaints

g)What impact do the regional arrangements have on safe and sustainable mental health service?

h). What impact do the regional arrangements have on consultation, engagement with stakeholders and transparency? (With regard to consumers, families, provider organisations, PHOs)

i)How do the regional arrangements promote innovation?
Sharing best practice ideas, problem solving in project groups may be relevant.

j)What impact do the regional arrangements have with regard to cultural safety of mental health services for Māori, Pacific and other cultures?

k) What impact have the regional arrangements on the overall efficiency of mental health services in the region?
Benefits of the regional arrangements outweigh the costs

8. What collaborations occur between DHBs in your region (s)? Has this arisen from the Network(s) or were those collaborations occurring historically?

9.What are the main benefits for your organisation from the Networks you are involved in?

Disadvantages of the regional arrangements

10.What disadvantages arise from the regional focus when the responsibility and decision-making rests with the DHBs?

- Do you observe "disconnects" between DHBs and the Network?

11. Are there any disadvantages for your organisation arising from the regional arrangements?

History and culture of the region

12. Are there any historical, geographical or cultural factors that impact, impede or promote taking a regional approach? Please specify for each region you are involved in.

The Future

13. Would you like to see further development of the regional approach? If not, why not?
    - What form could or should that take?
    - How feasible would it be for these changes to occur?
    - Are there any strategies you see as helpful to move the Network more in that direction?
    - Are there reviews scheduled?

14. Would you like to see leadership on this issue? From whom?

15.Do you have any other comments about taking a regional approach to Mental health services?

4. Consumer representatives

Regional Approaches to Mental Health Project

Questions for consumer representatives or organisations

Involvement in the local RMHN

1.What is your relationship to the Regional Network (s)? Are you involved in meetings? How frequently do these occur, and who else attends?
If you are not involved, what is your understanding of the Network's role, and how relevant is it to your organisation?
Are you involved in a Local Advisory Group (s)?
How does your consumer network relate to the Regional Network?

2. What costs are involved for your organisation by the Network's activities or meetings?

    - Time at meetings and preparations for these
    - Involvement in projects or consultations arising from the Network,
    - Communications arising from the Network

3. Are you able to influence what is put on the agenda of meetings?

4. At what levels do you or your organisation have opportunity to make input?
- How effective is this input from your point of view?
- What impact does your input have on decision-making?

Functions of the RMHN

4.. What are the main aims and objectives of your Network from your point of view?
- How well does the Network deliver on these from your viewpoint?
- Are there aspects that cause you concern, and what would you like to see happen differently?

5.If you are involved with more than one Network, what differences do you notice between Networks?

- What are the strengths and weaknesses of each of these arrangements?
- What changes have arisen from each of these arrangements?

6.What tasks are carried out by the Network:

- Planning- regional

-use of Blueprint funds
-use of general Mental health budgets
-What is the interface between regional planning and planning at the local level?

- What contribution does the Network make to funding and purchasing decisions for the DHBs in your region?
  -for Blueprint funds?
  -for general Mental health budgets?
- Consultation with stakeholders?
  -How are the local advisory groups, or their viewpoints, represented in the Network's discussions?
  -What other consultation processes occur in addition to that incorporated into the LAGs, stimulated by the Network's activities?
- Service delivery arrangements- what changes have arisen in service delivery because of the Network's activity?
- Workforce issues- what initiatives arise from the Network's activities
- Trouble shooting problems within the Region
- Education and raising policy awareness.

7. Are the communication channels satisfactory (for each of the Networks you are involved in) from your point of view? Please explain any difficulties.

What difference do the regional arrangements make?

8. In considering the following dimensions which regional arrangements could potentially impact, please indicate whether each of the arrangements you have involvement with:

-strongly negative impact
- moderately negative impact
- no impact or neutral
-moderately positive impact
-strongly positive impact
-don't know

Please comment briefly also on the reasons you have chosen that rating.

a).How does the regional focus improve equity of access?
Blueprint access levels, access to specialist services, quality of services, access for rural and smaller centres may be relevant.

b)What impact do the regional arrangements have on the coordination of clinical services?
Potential impact on optimal clinical pathways, case worker relationships, information management systems, coordination between service components may be relevant.

c) What is the impact of the regional arrangements on the integration of regional and local planning?
The interface between local and regional planning, and the degree to which
the DHB Funders and Planners identify with the regional focus may be relevant.

d) How do the regional arrangements promote a stable and supported mental health workforce?
Access to supervision/ mentoring/ peer review/ training; staff morale; impacts on staff retention may be relevant.

e) What impacts do the regional arrangements have on the effective use of scarce resources?
Potentially promoting economies of scale and scope; shifting around resources when under or over capacity.

f). How have the regional arrangements affected the public's confidence in the mental health services of the region?
Potential impacts on media reports, complaints

g)What impact do the regional arrangements have on safe and sustainable mental health service?

h). What impact do the regional arrangements have on consultation, engagement with stakeholders and transparency? (With regard to consumers, families, provider organisations, PHOs)

i)How do the regional arrangements promote innovation?
Sharing best practice ideas, problem solving in project groups may be relevant.

j)What impact do the regional arrangements have with regard to cultural safety of mental health services for Māori, Pacific and other cultures?

k) What impact have the regional arrangements on the overall efficiency of mental health services in the region?
Benefits of the regional arrangements outweigh the costs

9.If you are involved with more than one Network, what differences do you notice between Networks?

- What are the strengths and weaknesses of each of these arrangements?

10. What collaborations occur between DHBs in your region (s)? Has this arisen from the Network(s) or were those collaborations occurring historically?

11.What are the main benefits for your organisation from the Networks you are involved in?

12. Does it increase your members' confidence in the service delivery in the region?

Disadvantages of the regional arrangements

11.What disadvantages arise from the regional focus when the responsibility and decision-making rests with the DHBs?

- Do you observe "disconnects" between DHBs and the Network?

12. Are there any disadvantages for your organisation arising from the regional arrangements?

History and culture of the region

13. Are there any historical, geographical or cultural factors that impact, impede or promote taking a regional approach? Please specify for each region you are involved in.

The Future

14. Would you like to see further development of the regional approach? If not, why not?

- What form could or should that take?
- How feasible would it be for these changes to occur?
- Are there any strategies you see as helpful to move the Network more in that direction?
- Are there reviews scheduled?

15. Would you like to see leadership on this issue? From whom?

16.Do you have any other comments about taking a regional approach to Mental health services?

5. Provider managers

Regional Approaches to Mental Health Project:

Questions for DHB Mental Health Provider Managers

Involvement with the Regional Mental Health Network

1. Do you have any direct involvement with the local Network's activities or meetings?
2. Do you hear regularly about the Network's activities? Anecdotally?

Features of your DHB

3.Are the following mental health services delivered locally? If not, where are they provided?

- Acute assessment and crisis intervention?
- Specialist inpatient care?
- Child, youth and family services?
- Alcohol and drug services?
- Psychogeriatric specialist assessment and treatment?
- Forensic services?
- Eating disorders?
- Community based treatment and rehabilitation

4.Are there any historical, geographical or cultural factors that impact, impede or promote taking a regional approach?

5.What other resources constraints affect your district?

Functions of the Network

6. What functions or tasks are organised collaboratively or regionally?

a)Service delivery arrangements- what changes arise in your DHB's service delivery because of the Network's activity or regional arrangements, eg. Services not able to be delivered locally?
Response in time of crisis? E.g Times when demands on service , workforce shortages, natural disasters
Collaborative efforts between two or more DHBs with regard to specific services?

b)Workforce issues- what initiatives arise from the Network's activities
Training for staff?
Supervision and peer review?
Trouble shooting of acute capacity and capability problems?

Industrial relations and personnel management issues

c)Task groups on specific issues and problems within the Region? Please specify nature of project groups.

What difference do the regional arrangements make?

6. In considering the following dimensions which collaborative efforts and regional arrangements could potentially impact, please indicate whether the arrangements have:

   -no impact or neutral
   -small positive impact
   -medium positive impact
   -major positive impact
   -any negative impact

Please comment briefly also on the reasons you have chosen that rating.

a).How does the regional focus improve equity of access?
Blueprint access levels, access to more specialised services, quality of services, access for rural and smaller centres may be relevant.

b)What impact do the regional arrangements have on the coordination of clinical services?
Potential impact on optimal clinical pathways, case worker relationships, information management systems, coordination between service components may be relevant.

c) Are there any strategies for recruitment and retention that arise out of the regional arrangements? Do the regional arrangements promote a stable and supported mental health workforce?
Access to supervision/ mentoring/ peer review/ training; staff morale; impacts on staff retention may be relevant.

d) What impacts do the regional arrangements have on the effective use of scarce resources?
Potentially promoting economies of scale and scope; shifting around resources when under or over capacity.

f). How have the regional arrangements affected the public's confidence in the mental health services of the region?
Potential impacts on media reports, complaints

g)What impact do the regional arrangements have on safe and sustainable mental health service?

i)How do the regional arrangements promote innovation?
Sharing best practice ideas, problem solving in project groups may be relevant.

j)What impact do the regional arrangements have with regard to cultural safety of mental health services for Māori, Pacific and other cultures?

k) What impact have the regional arrangements on the overall efficiency of mental health services in the region?
Benefits of the regional arrangements outweigh the costs

Disadvantages of the regional arrangements

8.Are there any disadvantages that arise from taking a regional focus when the responsibility and decision-making rests with the DHBs?

- Have there been "disconnects" that have arisen?
- Have you had difficulties taking responsibility for solving regional problems when you identify with your local area which is where your primary responsibility rests?

Collaborations between DHBs

9. What collaboration has occurred between your DHB and other DHBs prior to the regional arrangements or independent of the regional arrangements?

The Future

10. What other models of regional arrangements can you envisage or changes you would like to see? What are the potential advantages and disadvantages of these changes? How feasible would it be to introduce these changes?

11. If the regional arrangements were expanded, what else would be needed? What costs would be involved?

12. Would you like to see leadership on this issue? From whom?

13.Do you have any other comments on the regional arrangements?

7. Key Informants

Regional Approaches to Mental Health Project

Questions for Mental Health Commission and Ministry of Health officials

1. What do you see as the main problems, issues or resource constraints challenging the mental health sector?

2. For each of the problems identified, please give an indication of whether this is consistent across the country or whether there are regional or district variations (broadly speaking)?

3. What do you understand to be the current arrangements for each of the regions?

4. What are the strengths and weaknesses of each of these current regional arrangements from your perspective?

5. What contributions do you perceive the current Regional Mental Health Networks making towards resolving the issues and challenges facing the mental health sector? Please specify which Network you are referring to when speaking of specific benefits. What evidence informs your opinion?

6. What issues and challenges to the mental health sector are not being met by the current regional arrangements? What changes would you like to see to improve the current arrangements?

7. Do you anticipate different models may suit different regions, and what are the factors that would influence you?

8. What are the potential benefits that you consider could flow from more regional approaches? With regard to:

    - Workforce issues
    - Equity of access to services, including specialist services
    - Staff morale and occupational stress
    - Fast and responsive assessment
    - Safe service delivery and appropriate risk management
    - Consistent quality of service
    - Coordination between services
    - Consultation with stakeholders, including consumers and families
    - Culturally safe practices

- Staff training, supervision and peer review
- Public confidence in the mental health services
- Innovative services and use of "best practices"

Could the current arrangements deliver these benefits? If not, what would need to change?

10. What steps may be required to achieve these changes? What would be the resource and other implications?

11.Are there critical success factors that enhance regional arrangements' effectiveness? What factors are likely to impede taking a regional approach?

12.How may primary care mental health initiatives delivered through PHOs fit in with the current Regional Mental Health Networks? How may they fit in with strengthened regional arrangements?

13.Do you see any difficulty for DHB s taking a regional approach when the NZPHD Act charges them with being responsible for their local populations? How may any disconnection arising from this be addressed? What is different about the mental health sector than other parts of the health sector, that might justify regional approaches?

14.Overall, what is the potential value in having regional arrangements for mental health? What are the disadvantages of regional approaches?

8. DHBNZ informants

Regional Approaches to Mental Health Project

Questions for CEO and DHBNZ informants

9. What do you see as the main problems, issues or resource constraints challenging the mental health sector?

10. For each of the problems identified, please give an indication of whether this is consistent across the country or whether there are regional or district variations (broadly speaking)?

11. As you will be aware, the current regional arrangements vary. What works well in your opinion? Are there aspects that you would prefer changed?

12. Are there other regional arrangements you would like to see introduced? What may be the potential advantages and disadvantages of these arrangements? How feasible would these models be?

13. What is different about the mental health sector than other parts of the health sector, that justifies regional approaches in a model that charges local DHBs with the responsibility for service delivery?

14. What contributions do the current Regional Mental Health Networks make to resolving the issues and challenges facing the mental health sector? Please specify which Network you are referring to when speaking of specific benefits.

15. What should be the functions and role of the regional arrangement? How should they differ from arrangements at a local level?

16. Overall, what is the potential value in having regional arrangements for mental health? Would you prefer to see more emphasis on regional arrangements or less?

17. Looking at the work of DHBNZ in general, what is the value in taking regional and national approaches to health sector problems? What are the potential disadvantages?

18. What strategies have been used in DHBNZ to encourage members to take a wider focus than their local DHB level? What factors have impeded members from taking that approach?

9. Financial officers

Regional Approaches to Mental Health Project

Questions on Financial aspects and costs of Regional arrangements

1.What is the Network's budget for the current financial year?

What are the main items of expenditure?

How many FTEs are employed to directly support the Network?

If you share some aspects of the budget and costs with, for example the SSA, what is the Network's estimated portion, and what are the additional costs?

2. What are the funding arrangements with the DHBs of the region? Are contributions equitable between DHBs and if not, how is this determined?

3. Are there any other sources of income?

4. What other costs are incurred by the Network's activities? This may include time and resources used for meetings, Network projects or other activities directly arising from the Network, by DHBs, PHOs, NGOs, consumer and family representatives or other stakeholders.

5. Is there a dedicated funding pool to cover travel and other incidental costs or are some of the costs absorbed by the DHBs? Who covers the cost of catering for meetings?

6. What payments are made to Network participants not employed by DHBs?

7. What collaborative arrangements occur in your region? Who pays for these and any other costs arising?

8. What project work is occurring in your region and how are these projects funded? What savings may arise from these projects in positive outcomes? Are there opportunity costs from working on these projects?

9. Are there savings achieved by the Network creating a more efficient model?

10. Are there opportunity costs incurred by the Network?

11. How would you describe the current level of funding for Network activities?

Scale: -Far too much

- Too much
- Enough
- Too little
- Way too little

12. If you had additional funds, what would you spend the additional resources on?

13. If there were no regional arrangements, what impact would that have on resources and costs?

Appendix 2.
The Southern Regional Mental Health Network

Regional Services

The following services are delivered regionally, mainly from Canterbury DHB:

Eating disorders
Maternal MH
Child, Youth and Family Specialty services
Some aspects of Alcohol and Drug services
Forensic services

A dual diagnosis service for those people with substance abuse difficulties and also MH difficulties was recommended out of the Southland enquiry but the region lacks the capacity or expertise to deliver those services.

Structure and Meetings

The SIRMHN consists of a representative from each of the six member DHBs and the Mental Health Manager from SISSAL. The DHB representatives are mainly Funding and Planning Portfolio Managers but also include two General Managers who have combined Funder and Provider Manager roles. The members have met approximately monthly for a whole day (in practice ten meetings a year), though in 2005 they are adopting a bimonthly meeting with a teleconference for the in-between month system.

The SIRMHN directly reports to the regional General Managers network, which is in turn answerable to the SISSAL Board of CEOs. The manager of the SIRMHN chairs the RMHN meetings. He has an active role in facilitating, advice giving and guiding the discussion but has no voting rights. The infrastructure of the SIRMHN is intrinsically bound up with SISSAL, which is owned by the DHBs and which then employs the MH manager (the chair of the Network) and the MH team who provide analytical and project manager support as required. The SISSAL MH team also attend the SIRMHN meetings without voting rights.

Resourcing the SIRMHN

There is no budget allocated to the network as it is subsumed under the SSA. However the budget can be estimated from the following deductions.

The total budget for the SSA is $1.3-$1.4 million. Of the 20 staff in the SSA, there are five FTEs on the MH team, so 25% of the operating costs could be attributed to MH. The

work of the MH team is split approximately 50-50 between regional and district work. As a "crude estimate" it was estimated the running costs of the SIRMHN amount to $140,000 a year. This figure includes the estimated 0.2 FTE spent on running the SIRMHN due to preparations and administration support, and the costs emanating from the projects arising from the regional plan.

The costs of participation, including travel and time spent for members or district staff contributing to regional projects, is borne by the participant DHB.

The funding to resource the SSA was determined initially by the size of population but more recently has been renegotiated on the basis of actual or perceived utilisation of the SSA by the DHB. For example Canterbury has 47% of the SI population but has a large funding and planning team and therefore is less reliant on the SSA. They now pay 32% and others topped up the difference.

The only other source of funding is the workforce coordinator role which is paid by the Ministry of Health.

Aims and Objectives

The Terms of Reference define the assigned roles of the SIRMHN: developing the regional plan for the provision of regional mental health services, facilitating regional tasks and projects, fostering collaboration between DHBs to improve quality of service provisions, coordinating regional workforce development initiatives, promoting increased integration and collaboration across the whole range of mental health services, and providing advice to the DHBs through the regional General Managers network.

One summed up the purpose as "looking across DHBs at regional issues, seeing the key things we need to iron out, change and plan, so we can get a better and more consistent level of service across the whole region." Allocation of Blueprint funds, workforce development as a key part of quality improvement, a planning forum to improve access to regional services and to support DHBs in that process, monitoring regional projects, to improve services for the service users and to help keep in touch with the larger world of mental health policy were mentioned by informants.

One ventured the opinion that although the role was guided by directives from the Ministry and MHC, it missed the spirit of the intention. That informant would have liked more stakeholder involvement.

Functions

There was a consistency of response between informants with the exception of the NGO informants who simply did not know or had patchy and sporadic information about the functions performed. Regional planning, workforce development and regional projects were defined as the business of the Network.

Planning

The regional planning was viewed as addressing sustainability and viability issues, while ensuring consistent quality and comprehensive services, with access evenly spread throughout the SI. In some cases, such as the Opiate Substitution review, the aim will be to improve quality locally rather than setting up a regional service. In other cases, for example, forensic services, established service were reframed as regional.

Planning with regard to non-Blueprint DHB MH funds, funding and purchasing decisions are deemed the task solely of the DHBs.

Consultation

Consultation is also regarded the task of each DHB and as an extension of that, any communications emanating out from the Network and consultations passed back into the network forum are entirely at the discretion of each participant DHB.

Workforce

The Network did a Stocktake to identify training priorities which was the catalyst for some regional training around adopting the recovery based services approach. The newly appointed workforce development coordinator, a position funded by the Ministry of Health, is expected to lead on to more training organised regionally.

Funding and Purchasing Decisions

This is not regarded as a function of the SIRMHN.

Changes to Service Delivery

The regional access project resulted in the establishment of service provision frameworks which have brought some changes in service delivery but in other respects, operational matters are regarded outside the scope of the Network.

> 'There is a very clear directive from the CEOs and GMs it is to be a funding and planning mechanism, not a de-facto MH service development committee. They police that to the point of irritation.'

Encouraging regional collaboration is another objective. One said it was 'like pushing magnets together to get it to gel,' referring to the earlier days of the Network. Another informant perceived the CEOs and DHBs as not placing a high value on collaboration, unless there were strong cost-benefit pay-offs for cooperating.

With regard to risk management, while some discussion occurs 'particularly if it affects more than one DHB,' mostly these issues of capacity and capability are discussed over

lunch, rather than as part of the formal agenda. It was thought 'not really the function of the Network to organise help in times of crisis or capacity issues.' One observed

> 'The Southland enquiry I thought had the potential to be used as a tool to generate thinking around those issues to stimulate discussion about how we could solve those issues between districts, but that never happened. The issues could have applied to any DHB and could have stimulated discussion comparing notes and best practice.'

Another said that sort of discussion was more likely to occur between the Provider Managers when they met.

The Provider Managers' network preceded the SIRMHN and has no direct link. This national forum was called initially by the Ministry and has met quarterly now for ten years, with emails frequently used in between meetings to canvass opinions on issues from colleagues.

> 'Whereas the SIRMHN is prescribed by both the Ministry and the DHB CEOs, the Provider Managers networking is flexible and responds to need…[it] grapples more with the whole day by day complexity that occurs in running a MH service, peer support and problem solving.'

One informant suggested the Burton tragedy actually acted as a barrier to collaboration for a time as the reputation of the Southland DHB was sullied, and therefore it was more difficult to arrange cross-DHB professional development activities, as had happened previously.

Task Groups of the SIRMHN

There are a number of task groups undertaken by the SIRMHN:

- Alcohol and drug services review
- Child and Youth project
- Forensic services framework
- Regional access project
- Opiate substitution project is about to start.
- Primary Care MH project will start once the Ministry of Health clarifies their approach regarding MH and primary care.

Impacts of the SIRMHN

Equity of Access for Consumers

Of the ten informants who rated this impact, three NGO informants simply did not know.

Of the others, three rated a major positive impact with reference to the regional access project. Another three gave a mild or moderate positive ratings. One who had given a major positive rating based on the existence of the access protocols noted the impact still needed to be confirmed by the monitoring evidence. One NGO manager who networks widely thoughout the SI, has had recent conversations with others from Southland, Otago, Nelson-Marlborough and the West Coast, confirming there was a wide spread impression of access to regional specialist services based in Christchurch as having improved. This informant gave a reserved positive rating, wanting to see this positive gain maintained over a longer period, given the history of major issues of access. She was critical that it has taken this long for improvement to occur when the Network has been there for three years.

Provider manager informants from a more distant DHB were not aware of the access protocols but had noticed improvements in access to some, but not all regional services.

Despite these cautionary notes it is concluded that the regional access project is widely seen as a success. Under this project the scope of regional services was defined and service provision frameworks developed, setting out the obligations and limitations of the host DHB (in most cases Canterbury) and the referring DHBs' rights of access. Now the rules of engagement have been established, the use of these regional services is being monitored and evaluated. The regional services focus on the skills and expertise not available in all DHBs and includes consultation and training as well as admission to the specialist care centres. Access for these services is now on clinical need rather than on serving the local population first.

The Coordination of Clinical Services

All six informants involved in service delivery, either as NGOs or Provider managers, rated the impact of the SIRMHN on the coordination of clinical services as neutral or 'don't know' which is read in this context as "I have not noticed any impact." One of the NGO informants is involved in a project arising at District Advisory Group level specifically to look at the coordination of statutory and the NGO sector. 'We quickly became aware of the immense amount of work needed on that. I have not seen any changes with regard to that.'

However, most of the planner-Network participants were more optimistic about the impact of the Network, giving it a moderately positive rating with reference to the regional specialist services. The fourth gave it a small positive rating with regard to the regional services while observing neutral impact for other services.

One informant justified her moderately positive rating by reference to the intention to extend the Service provision frameworks developed with the Regional Access project to each DHB to 'provide a simple, clear, concise and sensible guide to how people move through services and what support needs to be there.' In addition the Network is facilitating collaboration between DHBs on information management systems. The Network is also looking at the possibilities of using the outcome reporting as promoted in

the MH SMART national initiative. She predicted these collectively will have major impact, but may not touch all aspects of the MH sector.

The Integration of Local and Regional Planning

The four NGO informants rated the integration as "don't know" or moderately negative. The latter rating was from a disgruntled Māori provider organisation informant who had been in the reference group to draw up the Māori MH regional plan. This group was disbanded after the plan had been completed with no information given about how that plan was to be implemented.

The four Network participants gave varied responses: one neutral, one moderately positive and one major positive. The fourth did not give a rating but spelt out . 'It is absolutely and abundantly clear that the DAPs drive the regional plan, not the other way round.' The regional plans pick up the regional issues and those issues in common which could be usefully advanced regionally.

It is concluded there is integration between local panning and regional planning but the interface may be smoother at some DHBs than others. It is also apparent the planning process is not transparent for those not directly involved.

Impacts on Workforce Issues

Of the ten informants rating this dimension, eight gave a response of neutral (with two "don't know" responses). One NGO informant rated the impact as moderately negative because 'without regional coherence and [proper financial] support for support workers the development of workers is a lot slower than it otherwise could be.' A Network participant rated the impact for her DHB as "major positive" because of the anticipated gains on retention arising from the workforce development initiatives introduced by the workforce coordinator.

The Effective Use of Scarce Resources

The NGO informants all rated this as "don't know" or neutral, with one noting the huge disconnect between the NGO sector and the DHB providers.

All four Network participants rated this as a moderately or major positive impact. The regional access project has allowed the economies of scale to purchase access to those services and specialty skills which each district needs only in small volumes. Other examples were given of DHBs acting collaboratively for the good of all.

> 'South Canterbury funded those consultation –liaison positions for a year with the expectation then they will be funded by IDFs and shared contributions. More recently Southland, South Canterbury and Nelson-Marlborough have agreed to put some of their 03-04 under-spend into funding a FTE position to help DHBs

develop Service Provision Frameworks, either in regional services, or in local DHB services.'

This informant valued these contributions and rate the impact as medium positive, but also saw collaboration as happening 'sporadically and opportunistically, driven by one DHB being passionate about that topic.'

One informant spoke of the implicit benefit of the regional access project being the demonstration that such mutual gain was possible from cooperative and collaborative agreements, coupled with a monitoring and transparent complaints process.

Provider Managers gave mixed ratings: neutral and moderately positive.

Impacts on the Public's Confidence in the MH Sector

Eight out of the ten informants rated the impact on the public's confidence as neutral, while two attributed a mild positive impact. One Provider Manager observed that the public's confidence in local services was boosted by the knowledge that regional experts had been consulted. Another referred to the deliberate policy of working with the media to keep them informed during the Alcohol and Drug services review.

Promoting Safe and Sustainable MH Services

The informants gave very mixed assessments of the impact on sustainability and safety within services. The Network participants rated the impact of having accessible regional services as moderately positive but some made a distinction with the more general services where they rated the network's impact as neutral. The Network's commitment to maintaining quality and addressing issues of capacity were noted. One informant identified the moderately positive gain from having a structure and process to enable the districts to call attention when they have concerns about the effectiveness of service delivery.

The Provider Managers gave ratings of neutral and mildly positive with specific reference to the regional access.

By contrast the NGOs rated the impact as negative or neutral. Three referred to major issues with the funding levels for NGOs which they considered unsustainable. One rated this as a major negative impact which made their services not viable and threatened safety. This informant considered the NGOs were prevented from negotiating as a regional group, thereby weakening their bargaining power. It also makes the costs of contract negotiation much higher as it means negotiating with three DHBs who define even basic terms quite differently.

Another informant also cited the unsustainability of their contract terms as an issue. They found the DHB concerned totally intractable and wedded to their provider arm, which is perceived as being over funded and very medically oriented. Furthermore, the contract

terms were found to be significantly different than in some other parts of the country. For example, the position of support worker is funded at $47-48K in the SI but $60-70K in the NI. This informant was unsure what was due to the regional influence and what was due to the DHB, but observed there is no demonstrated willingness or ability to have a more equitable level playing field across the SI.

A third NGO informant also talked about needing to widen their contracting base to increase viability as they had been threatened with their contract being withdrawn, despite receiving an excellent audit. This informant saw it as a prevailing culture emanating from one influential DHB in the Network.

These informants were from two different DHBs and may not have represented the Network view but while they are held at arms length from the Network and the regional processes, may attribute a culture and role in contracting to the regional network which is in error.

Impact on Consultation, Engagement and Transparency

NGO informants rated the impact of the SIRMHN on consultation, engagement with stakeholders and transparency as a major (three informants) to moderate negative. Three informants independently commented the Network actually works against transparency. One said 'PHO development is going to have major implications for MH services so this is a fairly crucial time so that is quite scary.'

Two Network participants gave a neutral rating as something the Network does not do. One qualified the rating with the comment that 'My personal perspective is that leaves something to be desired as there are processes occurring regionally it would be beneficial to have a wider range of stakeholder input on.' The other made mention of the project groups drawing on reference groups, which was rated as a medium positive.

One Network participant rated it as a mild negative, noting consumer groups have felt quite let down, and have made representation to the CEOs on that matter. This informant also stated 'We have made no traction with the PHOs and this DHB would not allow that as the relationship is between the DHBs and the PHO, not the Network.'

One Network participant rated the impact as a medium positive, citing that because of the lack of regional consultation, that DHB has strengthened the local consultation, holding both a Local Advisory Group and adding a Mental Health Advisory Committee to the list of statutory committees. While the latter was about to be combined with the DSAC, the informant described it as having made a useful contribution.

Impact on Promoting Innovation

Seven out of ten informants gave a neutral rating on this dimension (including two "don't know" responses). The remaining three ratings included one general positive rating, one

moderately positive rating and one moderate to high positive rating. Network participants referred to this as an implicit rather than explicit outcome but that the meetings give a forum for sharing innovations introduced by specific DHBs. There was also comment that the project groups consisted of a striving for best practice and dissemination of information. Projects referred to included the regional access project, the alcohol and drug project, and a project called "Knowing the People" around supporting high use consumers. One informant stated more could be done to promote innovation, though had rated the impact between moderate and high.

Promoting Culturally Safe MH Services

Seven out of ten informants gave this a neutral rating (including two "don't know" responses). This included the Māori NGO informant who had been on the reference group that had drawn up the Māori MH Strategic Plan. 'My concern is we put a lot of effort into that regional strategic plan but there is no indication of whether it will be implemented, or just kept as a showcase.' This informant gave credit to improvements brought about by certification and standard setting but saw that as a national process rather than a regional process.

Three informants rated the impact as positive: two Network participants gave a moderately positive impact, conditional on the kaupapa Māori services being implemented (indicating this in not certain). One Provider Manager referred to a lot of work being done for Māori, giving a small positive rating, but was not aware of any improvements for Pacific and other cultures.

One NGO informant, who is a Pacific person, spoke at length about the lack of culturally sensitive services for Pacific peoples 'For some odd reason 95% of Pacific people presenting at MH services are diagnosed with schizophrenia. Most Pacific people are of big build, and they access services late so they go into the Forensic services, to be greeted by tired, overworked staff who don't have a clue about culturally sensitive services who take one look at this big person coming in and they go into defense mode which creates aggression on the other side.'

Overall Efficiency of the Regional Network

Informants were asked to make a rating on the overall benefits as compared to the costs of running the Network.

Three of the four NGO informants rated this as neutral or "don't know," the fourth saying 'from where I sit, I see minimal impact at best and actually some negatives.'

A Network participant gave a more measured "neutral" rating: 'The jury is out on that. We have issues around funding. There are high costs for these services we only need occasionally but when we need them we need them.'

A Provider Manager gave a "significant negative" rating, because the payment for regional service access was perceived as far greater than warranted by utilisation. 'I don't believe the regional Network is addressing that as yet.'

Three Network participants gave moderately positive ratings, citing relatively constrained costs but significant cost-effectiveness, particularly flowing on from the Regional Access project. One stated 'I believe the projects we have done have been enormously beneficial in terms of sorting out some long-term regional fights. Alcohol and Drug are also getting some traction now.'

The Views of the NGO Stakeholders

The NGO informants, including consumer and family organisations, all expressed frustration at being excluded from the Network, without necessarily understanding well its actual role and purpose.

The NGOs interviewed were drawn from two DHBs only, but at least two of the three networked widely throughout the SI. In both of these DHBs informants were dependent on their Local Advisory Groups (usually referred to as District Advisory Groups in the SI) for the limited information they received about the Network's activities. The links were through the Network participant reporting to the meeting on the regional activities, but did not involve passing opinions back to the regional forum. Informants in both DHBs spoke of recent signals from the DHBs that their local meetings were to be reduced in frequency, resources withdrawn, or to be disestablished, even though the members themselves found the meeting valuable. This was perceived as reflecting the same culture as prevailed at the regional level, with little value placed on consultation or networking to integrate the sector.

One stated the NGO sector does not feature in the thinking of the SI MH sector. The regional discussions represent a part of the sector which is totally closed to them.

> 'The danger of that is that we continue to have services which fly in the face of research and best practice, which is about innovative community based services, whether it is accommodation, community participation and integration. It is not around inpatient beds and medicalisation. With greater connection to community based organisations, the views of the region would shift and they need to. At the moment it is tunnel visioned, medically oriented and the structure of the Network encourages that.'

Another saw the lack of connection at NGO–Provider arm level as potentially counter productive or creating a competitive environment which is really not intended or helpful.

The NGO informant who had been involved in the reference group to draw up the Māori MH Regional Plan was proud of the thorough and well constructed document the group produced. However he expressed a high degree of frustration with the process. The group was not resourced for this process so in effect relied on donated time by the provider

organisations members were drawn from. The Network did not consult with the group or meet them face-to-face, but the plan 'has now been touted as a major success and as one of their projects and taken to Australia for a presentation.' This group is now being disestablished, but without any indication of the implementation plans or an ongoing reference group of Māori to oversee that process.

Frustration was also expressed at the lengths he and other Māori MH managers had to go to be allowed to make submissions on the review of the Forensic services, which they perceived as highly relevant to Māori because of the prison population being weighted towards Māori.

All four NGO informants expressed frustration at the funding environment which was perceived as unduly favouring the Provider arms of DHBs while NGOs were kept on unsustainable contract terms (three of the four informants complained of this), and one spoke of being told their year by year contract was likely to be disestablished, despite receiving good audits. Two referred to the much lower rate paid for support workers than the equivalent job in the SI. With no forum for expressing how dire the funding terms were, provider organisations were pushed back into negotiating separately. Regional negotiation of providers grouping together was seen as preferable for the greater strength in numbers, as well as reducing transaction costs. The mixing of Portfolio Managers and Providers at the Network level was seen as further evidence of the enmeshment between funding and planning and the providers at DHB level.

The lack of interaction with other organisations in the sector means the Network may act in ways oblivious to others' efforts. One informant mentioned workforce development initiatives through Ngai Tahu and funded by ALAC. The Network was surprised to hear a particular workforce development contract had already been negotiated with an organisation when they were just about to embark on the same process. 'That is crazy stuff as it duplicates and is wasteful of resources.'

Advantages of the SIRMHN

One Network participant emphasised the value of the regional approach. As a small DHB they are heavily reliant on the services provided by others. Whereas it was more of a 'grace and favour arrangement' in the past, now access has been strengthened and formalised, and established as a right. This equalises the power differences between small and large DHBs. This informant regarded the regional forum to debate issues and reach consensus as so beneficial that it was recommended other tertiary services adopt regional networks.

Whereas under the HFA the SI would make up one region, the skills and expertise are now split between six DHBs. The regional approach is a means to collaborate. 'We are too small, we all need each other, we together make up a whole.'

The SIRMHN was described as 'small and discreet' and as a MH think tank. By being very streamlined and focused on clear objectives, it is relatively efficient.

Others perceived the SIRMHN as having amplified and clarified regional collaborations, addressing sustainability and viability issues, increasing consistency of quality, making services more comprehensive, and making access more equitable. In the case of the forensic service it has been a matter of reframing the existing service as regional rather than local.

NGO participants saw potential advantages in the regional approach. One saw it as the infrastructure which would support regional contracting which would reduce transaction costs and simplify the process.

A Māori NGO informant described the Māori community as fragmented. A regional forum would be an impetus to overcome those divisions, as long as there was a prevailing culture of valuing diversity and working collaboratively. A families' organisation informant also saw the regional forums as potentially providing a unifying focal point as the efforts to network up until now have been constrained by a lack of resources and infrastructure so the various communication networking "cogs" have not meshed well.

Disadvantages

In this region there continues to be great deal of tension between DHBs being charged with looking after their populations and the regional approach to service development. 'So it is a bit like pushing magnets together to get it to gel.' The strategic direction of the Ministry encourages the regional collaboration as the lead but in the SI the districts considered the regional approach did not always take the local perspective into account. This was resolved with an agreement the districts lead and the regional approach complements. The Ministry's and MHC's expectations about what the RMHN should be doing has on occasions created a level of antagonism and hostility that is then a barrier to resolution.

'From Joe Public I still pick up angst about there being regional services.' Although the reasons why regional services for specialist skills are clear, this does not change for some the strong preference for their family member to be treated within their local DHB.

The Network has lacked power and has had difficulty effecting change. Sometimes it has been difficult to achieve sign-off or else there has been distrust and suspicion at DHB level. The regional process can raise unrealistic expectations that do not eventuate.

Despite the regional access protocols, there are still pockets of resistance to overcome within the host DHB that the local population does not have first call on services. Similarly the other DHBs need to feel confident that it is worth referral. The discharge process back to the referring DHB also raises issues.

Future Directions

Some informants stated the previous HFA structure had been far more efficient and productive. Although not necessarily suggesting a return to that system, views expressed included reducing the numbers of DHBs, pragmatically grouping skills and expertise to achieve greater economies of scale and scope, and seeking to recreate the single focus, high calibre organisation for funding and purchasing. Of those who commented on it, some considered there to be merit in separating off MH into a stand alone service, whereas others saw that option as increasing stigmatisation, and reducing the access of MH consumers into other parts of the health sector.

One informant wanted the RMHN to continue with a great deal more freedom and flexibility. Another wanted more connection to the Provider Managers and Clinical Directors 'who carry 90% of the risk and use 70% of the funding.'

Appendix three.
Central Region Mental Health Network

Regional Services

Regional services include:

- Some adult inpatient specialist care
- Forensic services- Capital and Coast
- Maternal MH services- Capital and Coast
- Dual diagnosis, MH and Intellectual disability- Capital and Coast
- Dual diagnosis, MH and Alcohol and Drug services-Capital and Coast, Hawkes Bay
- Specialist child, youth and family services- Rangitane at Porirua or Hutt
- Some Alcohol and drug services
- Eating disorders -Hutt
- Personality disorders- Capital and Coast and Hawkes Bay

Some of the above services have regional and local components.
Psychogeriatrics is funded under Disability/Health for Older People services in the Central region.

Structure and Meetings

The Central Regional Mental Health Network is made up of the Network Executive and the larger network of stakeholders, CRMHAN. In addition there is a parallel forum of Māori, Te Arawhata Oranga, to advise and provide leadership to the rest of the Network on matters pertaining to Māori. There are links with the regional consumer network, Central Potential, though for the purpose of this research that group is regarded as a stakeholder group, rather than part of what is being evaluated.

The Executive consists of the six DHB Portfolio Managers and one representative from the General Managers group, joined by the Shared Service Agency (TAS) MH team and chaired by the TAS MH manager. This group meets for a full day each month. Its functions are to develop policy, to advise and make recommendations to the General Managers forum for sign-off or further discussion with the CEOs.

The CRMHAN includes a representative from each of the Local Advisory Groups in the participating DHBs, three consumer representatives, one family member, five NGO representatives, two Provider Managers, four or five Māori representatives, one Pacific representative and the six Portfolio Managers. This group has an all day meeting at six monthly intervals, reduced from the earlier commitment of two days per quarter. The purpose of this group is to give advice and consultation input, to set priorities for the

work programme and to make some input into projects. This was described as 'a very good group, the work is outside the square, creative, some very sensible people are on CRMHAN from NGOs and stakeholders who come up with some really good ideas.' And by another informant

> 'CRMHAN is made up of extremely experienced and knowledgeable people from the sector who are committed to the sector. There will always be factions but there is good discussion, there is good debate, there is good consensus before something is recommended up.'

Te Arawhata Oranga (TAO) includes representation from the Ministry of Health, the NGO sector and the DHB provider sector, combined with a Māori project reference group of funders and planners, providers and TAS staff members. The purpose of TAO is 'to provide advice and Maori leadership to CRMHAN and other key stakeholders; to progress and to provide advice on Māori projects, strategic planning, key projects like workforce and child and youth, and any other relevant projects.' There are twelve TAO members and six on the reference group, meeting quarterly for two days. One informant stated they 'are getting some traction for Māori in the region' with linkages developed to other Māori networks at local, regional and national levels. TAO has representation on both CRMHAN and the Executive.

Speakers Day is an all day meeting that occurs once a year. 'It is an opportunity for organisations to parade the good things they are doing and showcase innovations.' As many as 200 attend.

CRMHAN discussions inform the Executive meeting which in turn passes recommendations and "decisions" on to the GMs and CEOs for sign-off. Some informants expressed frustration with the decision making process: the lack of transparency beyond CRMHAN, 'all our recommendations go into an abyss,' and the lack of power to effect decisions directly. One expressed it as:

> 'The recommendations that are forwarded from CRMHAN are generated by the more operational people, the DHB and NGO providers, which are recommendations on what we feel we can do reflecting the desired direction and quality, are then passed through several layers of bureaucracy so the decision makers are quite distanced from the service delivery. That can generate certain frustrations as it both slows the process down and also the actual decision makers may lack a sound knowledge of the implications of the decisions and what can or cannot be achieved.'

Another emphasised the creativity of the CRMHAN group but also the limitations of the advisory nature of that group as there needed to be a serious commitment from General Managers upwards to effect any change. This informant thought the Executive group was too constrained by being answerable to the GMs and CEOs and therefore 'there is a lack of willingness to look at these creative ideas which protects the status quo'.

At the time of interviews the review had been conducted but was not as yet accepted The review has since been accepted and will bring in some structural change, including replacing the CRMHAN and Executive structure with a more combined Providers and Planners forum which will adopt a more proactive service development role. In addition a forum of Provider Managers and Clinical Directors has been set up. As this review is only just being accepted, it is beyond the scope of this research to comment.

Resourcing

The total budget for CRMHAN is $560 K a year. This includes $20 K allocated to administer meetings and the remainder is the cost of implementing the work of the RMHN.

The $20K operational budget covers the $10K to produce the regional plan; $5K for Speakers Day; $2K for travel and accommodation to travel for liaison with the region; and $3K to cover catering for meetings.

The remaining $540K pays for the project managers, 3.4 FTEs of TAS staff, plus a one year project manager.

The workforce coordinator is paid by the Ministry on a separate contract. Another one year project manager role is paid for by HRC.

The infrastructure and operating costs are covered by the SSA, which is resourced by its owner DHBs. The $560 was initially top-sliced from the 2001 Blueprint funding then was continued for two years, and for a third year was paid out of under-spend.

Travelling to CRMHAN meeting,s and the time allocated to the preparation and meetings, is borne by individual DHBs or NGO. There are no unemployed stakeholders involved at present but there is provision to pay $175 per day for people in this category.

Protocols are now in place to guide the sharing of collaborative costs between DHBs.

Aims and Objectives

A range of aims and objectives were attributed to the RMHN:

- Having a shared vision for MH and addictions.
- Sharing information.
- To plan out regional services, to coordinate regional with local; the District Annual Plan follows the lead provided by the regional plan.
- Try to avoid duplicating what happens regionally, then plan the local to be complementary.
- Exerting a governance role over regional services to ensure smaller DHBs can get access.
- About DHBs working together for service provision and funding and planning.

- An opportunity to share expertise and 'do it better.'
- About collaborating regionally, tapping regional issues common to all such as workforce, quality, regional service development, using resources more effectively, supporting each other to cover clinical risks.
- Mission is the recovery as a right.
- To look at how MH and addiction services are delivered better, improved and using creative ways, not just responding to gaps, but how to move the services in ways that people are better looked after.
- Building inter-sectoral relationships.
- Sharing innovations and information around what's working and what's not working.
- Providing regional leadership with the regional plan.
- Coordinate and collaborate between providers to make your life a bit easier and so you are not duplicating what others have done.
- Accessing resources others have developed appropriately, therefore time and cost saving and creating colleague relations with others in the MH sector.

Functions Performed

Planning

Most informants saw planning around the use of Blueprint Funds as the major function of the Network, though some saw the regional planning as having much wider implications for service development. The process of the regional planning was summarised as establishing the strategic direction, prioritise with regard to the goals for the region then consider how that can be achieved. That may include development or reconfiguration of the regional specialty services, quality, and workforce issues. One defined regional as anything which goes through more than one DHB.

The interface between local and regional planning was smooth for most, but not all DHB informants. 'There is an issue over the timelines. Last year the strategic plan, the District Annual Plan and the regional MH Plan, the timing did not align well. We get input from our LAG, then that informs the regional discussions, then that has to come back and influence the DAP.' In practice these are parallel processes of drafting plans and consultation.

Another DHB informant found regional and local plans quite different, 'they are different beasts.' The regional plan is only one of the strands that feeds into the DSP, such as the Ministry strategies, the Ministry's Blueprint funding model, 'plus what our local people are saying should be the priorities and we are not going to ignore that for what the regional plan says.'

CRMHAN has now developed a regional framework for planning which can be applied to local and regional planning to improve the interface between the two. This is a new development so has not been tested as yet.

Funding and Purchasing Decisions

Generally informants agreed the role of the Network in purchasing decisions was minimal, although the regional pan does provide a guide and 'what ever we purchase needs to be aligned with regional priorities.'

Consultation

Consultation was seen as an important aspect of the Network's functioning, as it is 'driving change from a consumer and family perspective.' The LAG representatives on CRMHAN and the other CRMHAN members representing organisations have the responsibility for maintaining the two way flow of information to the wider MH sector community. More systematic consultation is expected to be built in as reference groups are developed around the project groups.

There has been little 'clinical input' to date although that is expected to change once the review is adopted.

Service Delivery

The general consensus from informants is that service delivery is not the focus of concern for the Network even though there are projects with service development implications, including the Risk Management project and the Alcohol and Drug services review. The service delivery changes that arise from the regional planning and task groups are mainly still coming to fruition as they are implemented.

Although there has been a regional risk management plan worked on over the last two years, 'it has not been a natural fit for that to be lead by the Portfolio Managers, as ownership really needs to rest with service managers and their Provider Managers.' Since the review, a regional forum of Provider Managers and Clinical Directors has started, which may support collaboration on service delivery. One informant observed they are in a transitional phase of moving from relying on historical collaborations and bilateral agreements to the network playing more of a role to provide a safety net. Others saw the Regional Response to a Crisis (the Network's emergency response plan) undermined by the lack of spare capacity and by high turnover of key staff, who take the knowledge of the newly established system with them.

The Alcohol and Drug service review will have implications for service delivery if implemented.

Service delivery change also emerges from grass roots innovation supported and facilitated by the Network. One spoke of the 'power of bringing people together from across the sector' which, in his view, was not as yet fully tapped. For example, a joint proposal between two CRMHAN members was developed after discussions revealed gaps in services for the clients of the two agencies concerned.

Other initiatives arise from members innovative approaches receiving support from the regional group, for example, the consumer lead case management scheme which is now being piloted in Hawkes Bay. Initially spearheaded by local leadership and vision, it was then taken to regional discussions. The feasibility study and the first year of the pilot has been funded by the regional Network. Although it is delivering mainly local benefits, it is of interest to the region as a project to be potentially repeated in other DHBs.

Workforce Development

A workforce development strategy "Valuing people" was developed as a priority and is now at 'take-off point.' Under this workforce stream a project manager has been employed to roll out a new training programme for all staff, from volunteers to NGOs to highly qualified clinicians. This aims to achieve an attitude change.

> 'It is all about getting clinical and community services understanding each other better, breaking down those barriers, it is about understanding the whānau ora and recovery as a right approaches, and how it can be translated into their work.'

There are barriers to implementation still to be resolved: staff generally being short of time and needing to be persuaded to make this a priority, and the filling in by others while staff go through training.

In addition, a regional workforce coordinator has been appointed, funded by the Ministry, to oversee the strategic component of workforce development.

A Māori health hui is planned for around March 2005 to promote Māori health and whānau ora.

CRMHAN has recognised the strain on Portfolio Managers as a pivotal role. Discussions are now underway to consider how more training and support can be offered to these personnel. 'There is a huge learning curve as MH is very complex, and there is no training for Portfolio Managers to tap into.'

Another project is examining what are the essential skills for people working in MH and addictions, coming up with the model that some basic personality attributes are the most essential, then skills and training, then the ongoing skills development. 'Some people are just not suited to working on this sector.' The national MH workforce development committee has now given some funding to CRMHAN to develop this as a pilot for the whole country.

Some training had occurred two or three years ago 'but did not really go anywhere.' There was also some training around accreditation.

Currently supervision and peer review is organized within DHBs, though it was anticipated the newly formed Clinical Forum may pick up this issue in the future.

Bringing stakeholder together and holding discussions also has the implicit benefit of raising awareness of policy issues and national strategies.

One informant observed issues around the linkage between national regional and local workforce initiatives:

> 'Here in Central region there is a little bit of the national projects going on, the regional has slipped a bit, and the sector is probably moving ahead faster than the Networks. Because of the fact that we have standards and issues we need to tackle operationally, we put things in place and then we are waiting on the strategy to catch up. That's how it feels when you have a workforce plan coming out nationally with its objectives, regionally its over there but at the DHB local level, you are already delivering some of this. What you actually need is the practical funding and support, not the theory behind it.'

Another stated 'the Network has a huge potential to make a big difference but it is not there yet.'

Task Groups

CRMHAN has a number of task groups or projects underway:

Te Arawhata Oranga
Alcohol and other drug intensive treatment review
Regional workforce advisory group
Response to prevent a crisis
Videoconferencing project
Consumer run case management advisory group
Specialty services review
Pacific peoples group
Child and youth group
Forensic services

Impacts

Equity of Access

Eight out of the ten informants rating this dimension awarded a mild to moderate positive impact, with reference to the reviews focusing on gaps in services, the work on access to regional services and the moves towards equalising the Blueprint funding model guidelines. Qualifying comments included 'I see no difference for Māori, Pacific and rural people as yet'; 'I haven't seen any meat on the bones yet'; and 'we are starting to get momentum but it is a big job.'

Two informants gave small negative ratings, with reference to disappointments regarding not being able to access regional services and the poor access for Pacific peoples respectively.

Coordination of Clinical Services

Three rated this as a moderately positive impact, including two NGO informants who appreciated the greater integration arising from mixing with other providers (one observed the DHBs were slower to pick up on this opportunity for joint projects) and an informant who referred to the good feedback on the regional emergency response plan but 'it now needs to be turned into reality.'

Three gave this dimension of impact a small positive rating, with comments including 'it is still early days'; 'we don't do enough of that'; and 'it is probably overall a small positive but the times [the coordination of regional services] does not work, it has high negative impact and so the disappointment factor is large.'

Four gave a neutral or don't know rating, with two referring to the lack of involvement of Provider Managers and clinical people up to now, and the possibility of this changing as the review is implemented.

Integration of the Regional and Local Planning

Although two NGOs observed the integration as neutral or mildly positive, most informants more closely involved with the planning at DHB level rated the integration of planning regionally and locally as a moderate to major positive, with a qualifying comment from one that the new planning framework is still in it's first year of use, so this rating reflected the anticipated result, rather than a proven path.

Workforce Development

Four of the ten informants rated this as neutral with some referring to the "Valuing People" project, which is expected to make a difference but has not been implemented as yet. The remaining six gave either small positive or medium positive impact, with many of these referring to the anticipated benefits from the implementation of this programme. Two of the positive ratings were linked to the benefits gained by bringing such a wide cross section of the MH sector together in forums because of the exposure to others' knowledge and skills, with the potential for cross-agency supervision arrangements; and the strategic perspective afforded by the Workforce coordinator.

Effective Use of Scarce Resources

Informants gave wide-ranging responses, from moderately negative to moderate to major positive at the other end of the range.

One NGO informant felt the tendering process elicited strongly competitive responses and at that point collaboration disappeared, so gave this a moderately negative rating. Greater transparency around the tendering information, plus discussion of the shared values and objectives that are desired outcomes, were suggested as ways of improving that process. Another DHB informant observed any collaboration promoting effective use of scarce resources that occurs is because of relationships between Provider Managers, rather than anything to do with the Network.

Two informants rated the impact so far as neutral.

Six informants rated the impact as small to moderate positive impact, with reference to the reviews fine tuning regional services, with particular reference to Alcohol and Drug services, Child and Youth and Forensic services. One commented 'The progress has been good, given the complexity.'

Public Confidence in the MH Services of the Region

Six informants considered the impact neutral. One considered there to be a small positive impact from the informal communication channels in the liaison with Central Potential, the regional consumers' forum, and Speakers Day showcasing best practices, though it was difficult to measure these impacts.

The other three informants all gave moderately high to strongly positive impacts, but for differing reasons. One small DHB informant thought it increased the public's confidence knowing there was the backup from regional services. One consumer NGO informant described the major positive impact of the national "Like Minds" project which the regional network has supported. Another observed major positive impact from the MH Awareness Week activities which attracted people not normally directly involved in MH services.

Safe and Sustainable MH Services

This dimension elicited widely different views and ratings, ranging from the mildly negative, 'it looks good on paper but when you try to implement there are problems,' through three neutral ratings to five mild to moderately high ratings.

One of the neutral raters stated 'there is a lot of work intended that would take us to a high rating but currently the rating is about a five [neutral] as it has along way to go.'

Comments supporting the positive ratings included the observation that it has taken a while for the DHBs to really grasp working collaboratively but now they are starting to do that; the regional plan incorporating a broad range of views from within the sector improves quality and buy-in, particularly when it includes those quieter or previously marginalised groups; the strategic framework 'ensuring we are developing a safe, positive and quality service; the workforce planning; developing stronger clinical linkages; and

the regional response to crisis.' This latter informant stated a major aim for this year was to establish triage criteria for bed management and admission to regional services.

One declined to rate, given

> 'we struggle to reach the 3% let alone the other 17% in primary care, so it is hard to think our services are safe and sustainable when we are so far from reaching our target groups. We are building from a very low base so there is still a lot of dissatisfaction and families desire quite a different service than we aim for.'

This informant perceived a trade-off between the choice and autonomy wanted by consumers and the community requiring safety. 'We are more sustainable than five years ago but there is along way to go.'

Consultation, Engagement with Stakeholders and Transparency

Five out of the eight informants responding rated this as strongly positive, with the majority agreeing this was a strength of the Network. One of these strongly positive raters qualified it with the observation for those not involved it is moderately negative as they end up with partial and distorted information.

Two gave a moderately positive rating, including the consumer NGO informant and the Pacific NGO informant, who gave credit to the effort put into consultation.

One informant thought the impact was neutral to negative, saying 'you need to ask the stakeholders.'

Promoting Innovation

Five of the ten informants rating this dimension gave a strong positive, and a further three gave moderately positive ratings, followed by one a small positive and one a neutral rating. CRMHAN and Speakers Day were seen as promoting innovations in particular.

> 'That has been one of the star elements in the regional network, because of the best practices and competencies CRMHAN has been involved in sharing. That has had a major positive impact for the region.'

Others spoke of 'some fantastic local innovations' including NGOs and DHB providers sharing arrangements. The project groups were also seen to be about sharing best practice ideas.

One informant who gave a relatively low positive rating stated that 'bottom-up innovations' happen locally and that it could not be assumed those same developments could be picked up and replicated elsewhere.

Some noted barriers to implementing innovations: 'everybody has a lot going on so it can be slow to progress' and being innovative means taking risks which can be in conflict with being safe and sustainable.

Promoting Culturally Safe MH Services

Informants generally saw Te Arawhata Oranga as providing a leadership and platform for impact with six out of ten informants rating either moderate or strong positive impact for Māori. Some made a distinction for Pacific with comments on the capacity and capability building that needs to occur there.

Two others gave a neutral rating but with optimistic comments for the future. One informant did not rate this but commented on the distance still to be travelled to build capacity for Māori and even more so for Pacific.

The Pacific NGO informant did not rate the developments for Māori but gave a moderate to strong negative rating for Pacific because of the absence of services for Pacific, though the start of the project addressing the building of capacity and capability for Pacific people was welcomed.

Overall Efficiency: Do Benefits Outweigh Costs?

Six out of ten informants rated this dimension as either moderately or strongly positive, with reference to the benefits of sorting regional access, sharing ideas and avoiding working in silos. One referred to the evidence that MH consumers tend to move around a lot and therefore it was essential there was a regional approach.

However two informants gave negative ratings, with a moderate to major negative impact. Both these informants considered the regional network very expensive, given the small benefits achieved. One attributed the regional services to the HFA and nothing to do with the current regional arrangements. The other said 'there are better ways of doing things.'

Two informants did not rate this, one saying 'don't know' and the other considering it was too early to rate.

Perceived Disadvantages of the CRMHAN

The disconnection between the legislation and the regional approach does raise problems. According to one informant, 'at each Board level the CEOs and GMs are grappling with regional versus local issues.' If a regional priority does not match with local priorities there is no clear path through that. This is seen to be an issue for other parts of the health sector as well, and this informant considered MH to be doing relatively well at using the regional approach, which other parts of the health sector could learn from. However the reality is the regional MH issues are only a small part of what DHBs need to be concerned about, which one saw as out of step with the expectations of the stakeholder

community. This informant explained the Network was set up 'with huge fanfare' and those involved were keen to get into 'making policy to make a difference' but then needed to be scaled back and focused on the advisory nature of the Network.

Some informants did express concern that the recommendations passed onto the decision makers would be debated by people who do not understand the complexities or what is feasible.

> 'There is a risk that at the DHB decision making level they could easily disregard the community view or make decisions removed from this regional network knowledge and so make decisions based on their world view.'

However in general informants seemed accepting of the advisory nature of the regional discussions.

Informants referred to a lack of power to get sign-off on occasions; that the regional role is not included in performance contracts for some, therefore when they get busy that part of their role is dropped; and competing demands for time from local and regional projects.

One planner participant spoke of damage done at DHB level through the regional projects, due to the project not delivering what it was expected to, complaints from some they were not consulted and overall the project was poorly managed and communicated. 'It felt like a big boot stomping over our district rather than benefiting us.'

The CRMHAN infrastructure and support staff at TAS were seen to have the luxury of project management resource while the DHB staff were overloaded with multiple projects, which reduces their capacity to supervise and oversee what was happening in the regional projects.

The work programmes were initially over ambitious and then lost credibility from stakeholders and the DHB community. This has been corrected over the evolution of CRMHAN and there is now a much more compact set of projects with work streams signed-off at the beginning. The tightened deliverables has helped establish the benefits and credibility of CRMHAN.

One informant found the meetings not strategic enough, being too focused on operational and management issues, and therefore did not add much benefit. This informant suggested that possibly reflected the lack of experience in the group from the Portfolio Managers who have high turnover. Another informant also observed the meetings to not suit Portfolio Managers well, but attributed the problem to the agenda being set by the larger CRMHAN group. What ever the reason, there is an issue of the regional process not strongly engaging all Portfolio Managers, and the overall benefit questioned by at least one. This informant suggested there would be a lot more joint solutions generated if there was more scope to brainstorm solutions and share ideas, whereas the time is taken up by reporting back and working with the larger regional group.

Future

The adoption of the review was expected to lead to more connection to the Clinical Directors and Provider Managers, and to reduce any lack of transparency between CRMHAN and the Executive. There was widespread optimism that would lead to positive changes.

There were mixed views on the future of the Network. One suggested the current structure and the review reforms needed to be left for at least a year to follow through on processes already underway to get the benefits of those changes. However if starting again, this informant preferred a less cumbersome structure and the freedom for each region to design their own Network, with streamlined consultation. There also needs to be clarity around the relative roles of the Ministry, the RMHN and the DHB.

Some informants saw the RMMHN as now well positioned to expand its role to focus more on service improvement. For Māori one would like to see a Centre of Excellence established to offer leadership for Māori health in specialist aspects and the integration with primary care to develop whānau ora. This vision is for a centre to share innovation, capacity, skills, expertise, research capability and consultation.

Another would like to see far fewer DHBs, suggesting the public health groupings could be followed, giving eight or nine regions. This would improve efficiency and increase the capacity and capability of any one team.

Another informant would like to see RMHNs having more mandate, and to look at seeking improvements in existing services as well as the regional services.

There was a plea for more consistent leadership from the Ministry of Health, who were perceived as encouraging regional approaches but then acting in ways that cut across that. 'They don't walk the talk.'

One informant considered MH does not align well with acute sector hospital care, that it would be better strategically aligned with primary care and NGOs' more community orientation to care. This informant favoured the MH sector being in a community partnership process with the PHO structures with its own accountabilities.

One informant suggested a Regional Director who could offer leadership and guide toward strategic direction.

Appendix four.
Midland Regional Mental Health Network

Services Delivered Regionally

Forensic services delivered through Waikato DHB and Hauora Waikato are the only regional services.

A range of specialist services are sourced outside the region:

- Eating disorders is supported by the Auckland DHB clinic.
- Alcohol and Drug services are largely provided out of the region.
- Child, youth and family inpatient services are provided by Starship Hospital
- Some beds are available through Ashburn Hall for intensive therapeutic community inpatient care

A project looking at High and Complex Needs is underway through Waikato DHB with the objective of setting up services for this group.

Structure and Meetings

The Network of decision makers is defined as the five CEOs and five Funding and Planning GMs, who meet monthly. Underpinning this is a structure of regional and local advisory groups who advise the decision makers. Five regional forums for consumers, family, Māori, Pacific and Alcohol and Drug Services meet twice a year, then each send five delegates to come together at a regional planning group held once a year in October to inform the regional planning process. This is followed up by a meeting early the following year to check the follow through on the advice given in October.

In addition there is an operational group charged with implementing the regional plan, the Midland Regional MH Network Operational Group (MRNOG) which meets bimonthly. This group consists of the five DHB Portfolio Managers, two General Managers, and the five chairs of the Local Advisory Groups (LAGs).

There is also a regional meeting of Provider Managers and Clinical Directors which is not part of the Regional Mental Health Network but which sends a representative Clinical Director to the MRNOG meeting, and all members of this group are invited to the regional planning forum. This group has been meeting for the last six months to discuss more operational, service delivery matters.

Each of the separate stakeholder regional forums includes a Portfolio Manager representative to increase the linkage between MRNOG and those advisory groups.

Resourcing

The budget for the current financial year is approximately $350K, excluding the cost of travel and the time of those involved.

Of this approximately $60K is spent on the meetings, which includes meeting fees, travel, catering, venue hire, administration and facilitation.

There are three FTEs employed to directly support the Network and associated costs, including car hire and cell phones.

The costs of travel to meetings and accommodation is paid by the DHB for DHB employees, but paid by the RMHN budget for those from other organizations. Meetings are mainly held at Waikato as the most accessible for travel routes.

There is in additional $100K income from the Ministry of Health for workforce development.

Lakes, as the lead DHB, manages the budget on behalf of the other DHBs, who each contribute on the basis of their portion of the regional population. As other projects are approved, contributions will rise. For example, there are Pacific models of care, Alcohol and Drug services, and consumer projects in the pipeline which will add another $200K to the costs.

Some projects are "donated" by different DHBs carrying out pilots or projects, then sharing the results with others. There are a series of regional reviews which the RMHN is committed to doing which will occur over the next five years at an estimated cost of $600K. Currently the Alcohol and Drug services are under review, to be followed by a review of the Health of Older People. These projects are decided by consensus as they are issues in common to the region. If the reviews are not addressed regionally, each DHB would have to do the same review but acting alone. For example, the Alcohol and Drug review is estimated to cost $25K but it would cost each DHB $15K to do it separately.

Functions

Planning

The Midland RMHN carries out planning with regard to the Blueprint funds rather than general MH budgets 'as until we get higher up against Blueprint we still regard the old silos of services, as organised under the HFA and RHA.'. LAGs make input which is then forwarded to regional forums who send delegations to the Stakeholder planning Workshop in October where they meet with the Funders and Planners and Clinical

Directors from DHBs. 'Every part of the sector participates in that and next year we want to improve that by including other agencies, to look at inter-sectoral relationships.'

There is a high degree of commitment to follow through on the stakeholders' direction and priorities identified at the October planning meeting. 'We are committed to serving our region, meeting the expectations of our stakeholders.'

Most agreed the interface between regional and local planning was relatively smooth 'as we have a number of people on both regional and local forums so the thinking coincides' but two NGO informants who are more peripheral to the planning processes found the process lacked transparency. One observed although the Blueprint funds are discussed (at LAG), the decisions are made elsewhere, that there are now too many layers which obscured processes, and relative to the HFA days it is now difficult to know what is going on. The other commented on an abrupt change in the Blueprint level, as assessed by the Ministry of Health, which raised questions of "what's going on?" with speculation it suited the DHBs to not have as much Blueprint funding to avoid under-spending and because they preferred more flexible PBFF funds which could be siphoned off to reduce deficit.

DHB planners found the reporting requirements to the Ministry raised timing issues, as both the Regional Strategic plan and the DAP are required at the same time in March. Therefore, although the Ministry requires the Regional Strategic Plan to be implemented through the DAP, in practice they are being developed and consulted on in parallel.

Funding and Purchasing Decisions

Although the RMHN does not directly make funding and purchasing decisions, the strategic direction as expressed in the regional plan feeds into the prioritisation recommendations for GMs and CEOs to consider. At one DHB, when recommendations are forwarded to the Board, it must be accompanied by information whether the LAG and regional discussions support it or not. The Portfolio Manager concerned stated there is a real effort made to stay with the recommendations of those stakeholders in the regional forum and 'if we say no, I try to be transparent about why not, as they need to know their investment of time has not been in vain.'

In the first two years of the RMHN, there were many meetings but poor connection or commitment by decision makers. 'It was very frustrating, if it resulted in funding and purchasing decisions it was almost by coincidence.' However the introduction of the MRNOG focused on implementing the regional plan reflected much greater commitment from the decision makers. There has been an evolutionary development of the DHBs who were initially more focused on getting to grips with the local health needs, contract management and building relationships with providers. But now, according to one informant, they are ready to consider the bigger picture and service development and to think more strategically. This informant observed the regional forum is

> ‘now sharing information, sharing best practices, building relationships, sharing ideas about projects in their districts and what’s working for them, what are their frustrations, what are the gaps and what are the issues, what are the commonalities across the region, then out of that are able to come together nearer the planning process to address those issues, to close those gaps to meet those needs.’

The next phase of development of the RMHN will see the ‘movers and shakers’ of the region brought together into focus groups.

By contrast an NGO informant complained the discussions did not flow through sufficiently into purchasing decisions, and that ‘I don’t think we are delivering strategically to the degree we need to be.’ In particular this informant considered there should be much more attention to the Recovery Model promoted by consumers.

Consultation with Stakeholders

Consultation is a major function of the RMHN. The LAGs draw together representatives of the local stakeholders, then the chair of the LAG acts as the conduit between the LAG and the MRNOG operational group, to report the local views and in turn to monitor progress on implementing the Regional Plan and report back. It was described as ‘a very inclusive process.’

Again, there were divergent views from some NGO informants, with statements such as ‘consultation is really inconsistent’ and ‘I don’t believe our view is being adequately represented.’ The former cited the reduction in frequency of the regional forums and the regret that a consumer voice and that of other major stakeholders were not represented at the MRNOG forum. The latter considered if the regional discussion had really heard the concerns and issues of those providers at the frontline, ‘I would have expected more support, either financial or otherwise but it is not there.’

Making Changes in Service Delivery

Generally it was agreed the service delivery developments occurred locally, but as the work-streams arising from the regional plan progress, these will have implications for service development. Service reconfiguration happens initially at a local level then, if it is to be a regional service, the matter will go to the regional forums. For example Waikato has been developing a service for High and Complex Needs clients, a project first recommended in the regional discussions. That has been developed through the Provider arm of the DHB in conjunction with Funding and Planning, with input from the LAG, the Clinical Directors forum and the General Managers’ Forum, then it will go to the RMHN. The adopted process of development work usually being undertaken within an individual DHB was seen as resulting from the lack of assigned project manager funds sitting with the RMHN historically, though that has now being corrected.

The response to a crisis situation is worked out informally between members or within the Clinical Directors meeting, rather than being a planned emergency response process. A number of informants independently confirmed this was a region with a high degree of cooperation and collaboration, with examples given where DHBs have helped one another out.

An NGO informant observed there to have been a lack of follow through over the history of the RMHN. The advantage of the regional discussions was that it allowed a sharing of the regional issues, for example, 'what are the significant issues in Ruatoria, which put in perspective other issues as lesser' but that was not followed through by increasing the capacity there. The High and Complex Needs project has been talked about for two years or more and is, therefore, 'way overdue.' The barrier to follow through initially was the fact that Funders and Planners were too busy to carry out work assigned to them, then the project was out-sourced but not to the appropriate people 'so those key documents and information to inform the purchasing decisions just haven't materialised.'

Workforce Development

There is now a workforce coordinator funded by the Ministry to take a more strategic view of workforce development. However the region had already developed a plan and has been proactively engaged with this issue. The workforce coordinator is expected to begin with a stock-take of current staffing resources and skills level, examine retention information, then coordinate regional strategic training and staff development. This role will help clarify the priorities within the existing regional workforce development plan.

Although there is a high regional commitment to workforce development, the plan had not progressed far due to the plan being 'huge' and relatively unfocussed, given it had come through from consultation with the sector; lacked resources; had nobody to drive it and because the task was given to Portfolio Managers who have a heavy operational workload and were already overloaded.

Some training has been organised through the RMHN, including support for the accreditation process and an Essential Skills Tool Kit, piloted in Taranaki but intended to be rolled out to all staff. Some staff also accessed the national initiative on Leadership training which is funded from Blueprint.

Task Groups and Workstreams

A number of task groups are in process:

- Review of the forensic services
- Seeking regional solutions to the High and Complex Needs group of clients
- Alcohol and drug services review
- Workforce development
- A review of specialist services

- Developing outcomes measures through the MH Smart national project and working on developing shared information systems
- Detoxification services review
- Pacific initiatives review
- Residential providers review

Impacts of the RMHN

Equity of Access

Five out of the ten informants rated the impact on equity of access as neutral or "don't know" with some saying the information and feedback had not been gathered and others saying it was a priority issue but it has not happened as yet. One stated 'It has been identified as a priority issue and is part of our vision with values on responsiveness' but has not happened yet as discussions still take place in silos with consumers talking to consumers, for example, but that the next phase of focus group discussions held more promise of traction. One said there is the potential for a major positive impact but it is still being implemented.

One had seen an improvement due to collaboration over the last year, lifting the rating to a small positive, whereas three gave a moderately positive rating, citing reasons of the RMHN seeks regional consistency, shares knowledge of each others services and Blueprint funding levels, aims to ensure community services for rural people are dynamic and of adequate quality, the regional discussions help remind new Portfolio Managers of regional services (though this can actually lower access for local clients of the host DHB) and making explicit the variations in components of services and between districts, thus creating a pressure towards uniformity.

One rated the impact as moderately negative as regional solutions tended to be about supplying a residential unit in part of the region rather than choosing to contract and purchase those skills through NGOs.

Coordination of Clinical Services

Four of the ten informants rated this impact as neutral or "don't know." One rated the impact as moderately positive, citing strong relationship with the Waikato which is the DHB delivering regional services. Three gave a small positive rating with associated comments 'I would like to see it better'; 'is early days but promising' because of the GMs meeting and NGOs and DHBs building relationship; 'good planning leads to good coordination of clinical services'; and 'we have that linkage between the national strategic direction, regional vision, taken down to local planning which is all quite critical.' Another informant gave a 'hopefully positive' rating due to the recent appointment of a regional psychiatrist.

One informant rated the impact as 'mildly negative' but thought there was potential for coordination to grow, particularly through the clinical directors' meetings.

Integration on Regional and Local Planning

All four informants closely involved with the DHBs planning processes gave moderate to highly positive ratings, though one qualified with the comment the time frame was 'pressurised regrettably.' The planning cycle was seen as having improved and the plans are 'useable.'

Two of the NGO informants commented on the lack of feedback on what was achieved from the previous plan prior to drawing up the next plan, and the other two NGO informants rated "don't know" responses, suggesting a lack of transparency for these stakeholders. One stated

'The regional Plan has only just been written so it is too soon but there is no overlay of the regional and local plans, and how do we monitor against these plans, particularly as one is a DHB's responsibility and one is the regional, which sits with Lakes. So I am not sure where the accountability sits.'

Workforce Development

Nine out of ten rated the impact currently as neutral, though a number tempered the rating with optimism for the future and referred to the good things that were starting to happen but which have not built up momentum as yet to allow a higher rating. There was also a comment that the stock-take of workforce initiatives had uncovered there is 'more happening' over the region than previously thought, but the use of this information in a coordinated strategy had not got under way as yet.

One informant gave a moderately positive rating because of 'the good things happening.'

Effective Use of Scarce Resources

Five out of the ten informants gave a "neutral" or "don't know" rating. Three gave small positive ratings because of the regional services allowing economies of scale; the potential to use scarce resources effectively but they were still gathering information on the regional specialist services; and because of some moves towards considering sharing resources between a DHB and an NGO.

One informant gave a moderately positive rating because the 'indirect impact of the regional discussions is the sharing around of resources.' One informant rated this dimension of impact as moderately to strongly positive because of the opportunity to help train up new Portfolio Managers (three out of the five Portfolio Managers are relatively new to the role) to use Blueprint funds appropriately.

One NGO provider spoke of training to assist residential providers achieve accreditation, organised through the Network, which was not contracted directly to them but through an

intermediary which introduced a seemingly unnecessary middle man, therefore reducing the cost effectiveness.

Impact on the Public's Confidence in the MH Services

Eight out of ten informants gave a neutral or "don't know" rating, with one commenting the public's confidence is highly political and very subject to the media. One paid tribute to the positive impact of the "Like Minds" project but expressed concern she still heard on occasions negative comments from within the MH sector.

Another informant gave a moderately positive rating because they have avoided events blowing up into major incidents and considered they had a good relationship with the community and the media.

One gave a small to moderately positive impact because

> 'the consumer movement draws enormous strength and encouragement from the regional forums and relationships which in turn helps public confidence…but if you mean Joe Bloggs in the street then I don't think it would have any effect.'

Promoting Safe and Sustainable MH Services

There were predominantly positive ratings on this dimension: one strongly positive, three moderately positive, two small positives and one mildly optimistic. There was reference to the willingness to offer mentorship between stakeholders; the spirit of cooperation between DHB provider arms and some linkage with NGOs 'though we could do a lot more there'; and optimism that there will be progress on addressing major issues which could have major fallout in the community. Having fall back plans for managing emergency issues to manage risks was regarded positively, but consumer safety and clinical safety were regarded as 'all together quite hard.' One Provider Manager considered there were huge gains to be made by providers making much more transparent the information about what each offers in the way of service delivery, but this 'just did not happen' at the moment. An NGO informant observed 'there are real issues around sustainable services and around quality.' There has been a little support offered to the sector around quality standards but this was rated as only 'a little positive.'

Two informants rated the impact as neutral, one NGO informant explaining 'as a responsible provider we work at providing safe and sustainable MH services but we are doing it all ourselves.'

One informant gave a moderately negative rating because the regional processes had fewer 'checks and balances,' so was perceived as easier to siphon off MH funds into other services.

Consultation, Engagement with Stakeholders, Transparency

All four informants directly connected in to the DHB processes rated this as moderately or strongly positive, because of the emphasis on consultation and then the high expectations of accountability back to those who have invested their time. It was referred to as a 'very inclusive and transparent process.'

The ratings from the NGO informants were less positive. One expressed optimism because of the clearly articulated processes but was also suspicious because the MRNOG meetings did not include Māori, Pacific, consumers or families. The other three gave neutral to moderately negative ratings.

Promoting Innovation

This dimension again prompted divergent responses, depending on the perspective of rater. Those closely involved with the regional discussions gave moderately to strongly positive ratings with comments 'there is good sharing of ideas, I can see it happen at every meeting' and 'I want to formalise that more to really harness the creativity of the region.' One noted

> 'it is easier to be innovative regionally than at the local level as it is …higher level and driven by principles, whereas at the local level you tend to be more constrained by the Board, and the more you get down to the minutae of contracts, it is harder to hold onto the original vision.'

However, three of the four NGO informants gave neutral or moderately negative ratings, with one perceiving the cutting back on consultation as stifling innovation.

The two Provider Managers gave neutral and small positive ratings. One spoke of the regional discussions as sometimes frustrating, and covering a very wide range of views. 'What is one man's innovation is another person's folly.' The other manager commented in that DHB the innovation was largely emerging from the relationship between the Provider arm and the NGO sector, not from the regional discussions. 'However, from a strategic point of view, the more forums you have to share ideas, that's got to be good for the sector.'

Promoting Culturally Safe MH Services For Māori, Pacific and Other Cultures

Six of the ten informants rated this as a moderately or strongly positive impact because of the high priority placed on this, particularly for Māori. Culturally sensitive services for Pacific peoples were at a much earlier stage of development but a start has been made. One qualified the moderately strong positive rating with the observation the sector does not always know how to implement, and the provider sector are not as far ahead as expected so that when they ask for Māori health plans and plans regarding sector development, 'they don't know how to proceed.' Therefore groundwork on training still needs to happen. Another informant considered there has been a 'big impact' but as a kaupapa Māori organisation they did not always feel well supported regionally.

One other informant gave a general positive rating without specifying the degree of positivity.

Three informants rated the impact as neutral or "don't know', with one commenting that what looks good on paper is neutral in impact in reality.

Overall Efficiency, Benefits Versus Costs

Six of the ten informants either did not rate, said "don't know" or gave a neutral rating. Comments included 'We put in a lot of effort because we believe there will be benefits' and 'I don't think operations benefit vastly from that regional approach. They tend to look for their local resolutions.'

Three gave moderately or major positives.

One informant gave a negative rating, stating 'I think we can do things a lot smarter, the rating is even negative, it is a very heavy Network, and we won't get the benefit for some years.'

Disadvantages, as Perceived by Informants

In the DHB environment the success of taking a regional approach depends on good support at GM and CEO level. That support was perceived as generally good across the region with the exception of one of the DHBs, which was perceived by this informant as dragging down progress for all.

For some of the DHB informants, their personal performance and KPIs was based on their local role rather than the regional role. The Portfolio Managers are often over loaded with work and when under pressure the regional work was more likely to be dropped compared to the local work.

There was also the need to work with the Board which is susceptible to the election cycle changing the focus.

There are some issues around the consultation processes, managing expectations and finding the balance point between consultation, reaching consensus and getting on with implementation. There can be difficulties for NGO providers challenging Portfolio Managers due to commercial sensitivities.

The regional discussions were seen as adding layers of obfuscation for NGO providers as it made less transparent the locus of decision making.

The Future Direction as Perceived by Informants

Those who wished a regional approach to continue perceived the need for:

- More robust research and analytical capacity.
- Greater clarity about what can be done regionally and what should be done locally. 'The Network can not do everything but needs to focus on a few things and to do them well.'
- Define more realistically the roles and expectations.
- Greater integration with clinical and technical expertise, involving a range of professional people from the sector.
- Devoting resources to a region rather than a DHB.
- Developing more the community services.
- Using focus groups of movers and shakers to move into the next phase of service development.

Not all favoured the continuation of the regional approach. Two informants suggested it created too many disconnects within the local model and made decision making less transparent respectively. One of these informants still saw the need for MH to be kept separate from other parts of the health sector: 'if it was not separate the deficits would dominate and it would get lost.'

Appendix five.
The Network North Coalition

Regional Services

Regional services are defined as those serving more than one DHB.

- Alcohol and drug services are provided by Waitemata for the three DHBs of the greater Auckland area, but Northland has their own service.
- Forensic services are currently provided by Waitemata but planning is underway to address the changes introduced by the Northland prison, due to be opened March 2005.
- Eating disorders expertise is supplied by Auckland DHB.
- Dual diagnosis Alcohol and Drug –MH is provided by Waitemata
- Dual Diagnosis for Intellectual disability- MH consumers is provided from Counties Manukau for the three Auckland DHBs
- Te Tamaki Oranga, a high level rehabilitation service, is run by Counties Manukau
- Buchanan Clinic, rehabilitation service, is run by ADHB for Waitemata and ADHB
- Specialist psychotherapy services are run from ADHB
- Acute inpatient beds are used as a regional resource

Structure and Meetings

The NNC consists of a series of interconnected meetings and consultation forums. The NDSA employs the Regional Director who is answerable to the Regional CEOs to work on behalf of the DHBs. He chairs the monthly meetings of the NNC which is widely inclusive of stakeholder groups from the sector, including representatives from the DHBs Funders and Planners, General Managers from the DHB Providers, Clinical Directors, Older Peoples services, Child and Youth services, Alcohol and Drug services, NGOs, Māori, Pacific, consumers, families/ whānau, primary care sector, two from each of the Local Advisory Groups and union representatives. Thirty–forty people attend these monthly two hour meetings, reduced from the earlier phase of half day meetings.

The primary focus of the NNC is to promote regional planning consistency to help ensure people with serious mental health issues can access effective, efficient services and supports to help them recover quality of life. The bringing together of key stakeholders is to improve coordination and promote more integrated service development and provision across the region.

In addition there is a fortnightly meeting of the regional Funders and Planners who meet for a half day. This meeting decides ‘more of the day to day decision making’ and ‘where

we are going as a region' for the allocation of Blueprint funds and funding decisions, then takes recommendations back to the larger NNC forum for endorsement. However the NNC discussions are not a "rubber stamping" exercise as this process often changes and refines the decisions.

Most participants on NNC have reference groups, including the regional forums for Māori, Pacific, consumers, family groups, Health of Older People, Clinical directors, the General managers, the DHB Local Advisory groups and Alcohol and Drug services. These forums both support and advise the delegates as to what to take to the larger NNC meeting. The representatives are explicitly charged with representing the views of their reference group and being an information conduit back to the group.

In addition there are separate meetings for each of the work-streams. The timing of these is generally dovetailed in with the main NNC meeting to reduce travelling time for participants.

Māori are included in both the NNC and the Funders and Planners meetings, and two of the four General Managers for Māori sit on the NNC as well. According to some non-Māori informants, there have been some difficulties with representation as individuals are over committed. Furthermore there are factions within the Māori representatives. However this has resolved over time as the Māori regional forum has addressed these matters.

Although most informants were positive about the meetings as inclusive and open to contrary opinions, not all informants found the meeting structure of the NNC conducive to contributing or debating issues, using words such as 'intimidating,' 'daunting,' 'the meetings are more geared up to tell us rather than to hear information.' A consumer representative spoke of repeatedly placing an item on the agenda, only to have it dropped off several meetings in a row, which she concluded was because it did not fit with the preferred direction of others.

Meetings are time consuming. For example the consumer informant included in the research process contributes an estimated 16 hours a month of unpaid time. Although committed to participating as the way to seek improvement, the role is not without difficulty as she juggles the process of getting heard in a large forum and the high expectations of her reference group to get their preferences incorporated into decision making.

For small NGOs the costs of participating can be prohibitive and two of the four informants in this section of the sample either could attend only sometimes or kept a watch on the agenda and chose when to attend.

Resourcing

The NNC has no separate budget allocated to it, although the Regional Director has an expenses allowance to cover the operating costs. These include a Project

Manager/Coordinator role in addition to the Regional Director plus catering, payment for the consumer representatives and administration overheads. This amounts to approximately $58 K. Consumer representatives who are not employed are paid $150 per meeting.

The Northern SSA covers the infrastructural costs and the employment of the MH team, some of whom are also involved in the NNC. The DHBs of the Northern region contribute to the costs of the SSA on a population basis.

In addition the NNC generates projects which are funded by the DHBs on a population basis. In the last year these were funded by regional under-spend.

The total budget for the Regional Director and NNC activities was set at $490K for the 2004-05 year.

Aims and Objectives

The overall aim was summed up as 'pointing MH services in the same direction' as voiced in the Vision statement: "Local delivery but regional consistency.'

Others elaborated around this core objective:

- To engage the sector in representative ways for planning and to inform them how services should be delivered.
- To take advice from the local networks, feeding those views up to the larger group.
- To look at overall regional development, and plan services within that regional view
- To ensure services are well coordinated with one another.
- To look at innovative projects that can be sustained.
- Translating the wish list into a reality.
- To bring the key players together and to ensure good communication.
- To get people to understand that poor services often are the outcome of a lack of specialist services.
- For people to get to know each other better and work better together.
- To ensure a consistent message to the Ministry of Health and Mental Health Commission.
- To guide decision making around MH services and to give an overall direction.
- Advising on the planning and funding of MH and addiction services.
- Undertaking projects to develop services across the region.
- Communicating with key stakeholder groups.
- Advocating on behalf of MH and addiction services.
- To promote the understanding that greater community development as part of comprehensive services would reduce the need for crisis management.
- To offer leadership to the MH sector.

Tasks and Functions Carried Out by NNC

Planning

The NNC has developed the Regional plan for the year 2004-2005 and has also drafted the Northern Region Strategic MH 5 year plan (now referred to as the Strategic Direction as distinct from the planning carried out by the Funders and Planners). Both make recommendations for the use of Blueprint funds but also have some wider implications for general MH funds. 'The strategic document addresses not only the new money but also how are we going to drive change with the $307 million that already exists.' The role of the NNC is to advise about the service gaps and to set the direction for service development to overcome these gaps.

Although some NGO informants found it 'meaningful' to be involved in regional planning, one NGO considered the planning did not mesh well with a Northland NGO perspective.

Funding and Purchasing

The Funders and Planners makes recommendations on the regional plans to be progressed, then seek sign-off from the NNC. There is general agreement on the direction but some discussion on which are the higher priorities. With a longer term plan now in existence, there is more acceptance if one project does not progress this year, there is scope in the medium term. As the Funders and Planners are present in the NNC discussion they are able to make clear their reasoning. The actual purchasing decisions remain with the Funders and Planners, keeping a clear delineation between their role as purchasers and the advisory role of the NNC.

One informant explained that, although the Regional Plan is a key document identifying the priorities for the region, it still needs to be a

> 'living document, local funders still need to work with their local stakeholder groups and develop and implement their local plans with due regard for local population needs and considerations. It is part of a bigger process.'

Consultation

As previously outlined, the NNC is strongly consultative. One DHB informant emphasised the care they took to work up from a LAG perspective, to present a DHB wide view rather than those of the individual representatives.

The NGO stakeholders have four representatives included in the NNC. It is recognised this group is not naturally cohesive with one another as they are normally competitors in tendering for service contracts. A project manager has been assigned to the NGO Stakeholders' forum to work on an NGO Futures Project to consider ways those organisations can work together better.

Service Delivery Developments

Informants gave mixed accounts about the role of the NNC with regard to service delivery changes, though there was more widespread agreement that bringing people together allows relationships to develop which generates collaborative approaches flowing from that. The NNC has largely focused on planning up until this point but implementation is now underway. This includes service reconfiguration as new funding is awarded.

Some service changes have occurred already, driven by the combination of NNC, local developments and by people sharing information. For example Counties Manukau has developed a different type of Community Living Service based on DHB providers and NGOs working closely together. This innovation is now being picked up in some other DHBs.

Mentoring relationships between NGOs have been used to share capacity and knowledge, for example kaupapa and Pacific providers have been partnered with larger DHBs with more developed policies and protocols. This has been mutually beneficial as one acquires greater cultural sensitivity and the other is assisted towards meeting certification. Some attributed this development to the NNC, some attributed this to Platform.

Similarly, other informants were unsure what changes had come about through the NNC and what had arisen from other forums. The Provider Managers and Clinical Directors have been meeting for two and a half years and through that forum had already developed ways of collaborating, including managing demand by treating all inpatient beds as a regional resource with clear access criteria and triage to determine admission rights. This forum, drawn from clinical and operational managers, also had been the instigators of regional uniformity for pay and condition rates for Senior Medical officers to take some of the competition out of the labour situation. They had also allowed the sharing of capacity when there have been pressure points. Others saw the NNC as being instrumental in sharing capacity. It is likely the NNC has picked up the solutions and collaborations already present, either as ideas or existing arrangements, then amplified these or given a platform to formalise and integrate these with other developments.

The regional Information Systems also had originated in the Provider Managers forum but has now been picked up as a regional project under the NNC.

The planning process and work-streams falling out of the Regional Strategic Plan will draw people from across the region into joint projects and will lead to the more consistent service delivery frameworks. The MH Services for Older People has clarified core business and best practice, which is seen as providing an example of how regional collaboration can lead to developing more efficient and effective ways of doing things.

Others commented that the NNC allows people to hear from all the stakeholder groups which ultimately leads to a more balanced viewpoint. While the services sit below

Blueprint funding model guidelines, problems exist but 'what has changed is how people address those problems. There is much more colleagiality, much more helping each other out.' With regard to funding decisions, 'people are more willing to see funds go to the pressure points, rather than fighting for every last bit of the pie.'

To conclude, the NNC is having a direct effect on service delivery through the work-streams arising from the regional planning, and will do so increasingly as the NNC moves into that more implementation phase. In addition the NNC amplifies the pre-existing collaborations by providing the vehicle and meeting place to facilitate that. Thirdly innovations can be stimulated, supported or shared in the regional forums.

Workforce Development

The NNC has drawn up a workforce plan and there is now a recently appointed workforce coordinator, funded by the Ministry. Some action has been taken already but 'to date it has been ad hoc, but there is now the foundation to do something tangible.' Some work has been done on up-skilling staff and equalising employment conditions and terms across the region to reduce the poaching between DHBs. Training for the region has included Alcohol and Drug competencies, governance training for NGOs for trust boards, and leadership training.

Competency training for NGO workers has been one focal point, as strategically increasing capacity and capability within NGOs is expected to reduce the reliance on DHB providers. This raises the risk of NGO staff being poached by DHBs as they become more clinically competent. Efforts have been made to increase the contracting rates for NGOs to enable them to pay the same rate for the equivalent job and skill level as the DHBs pay.

The workforce coordinator is expected to increase the regional training, though one DHB informant qualified the enthusiasm for this development with the caveat that training is most effective when merged with local knowledge to make it very applicable locally.

Supervision and mentoring does occur across the region but is organised through Provider Managers and other professional leaders, rather than through the NNC.

The inclusion of PSA representatives has allowed them to be more informed, so they can respond to local issues with knowledge of the regional context.

Task groups

There are five themes to the task groups:

- Child and youth
- Older persons
- Primary care
- Alcohol and drug

- General Adult

Running across these there are Māori, Pacific and Asian work-streams.

Other additional projects are:

- The regional information management systems.
- Regional needs analysis, repeating the Camberwell Assessment to check progress, then to set up an ongoing Health Needs Analysis system.
- A series of work groups around NGO development, with an allocated half time position.
- A project initially directed at working with NGOs to achieve certification as part of risk management, then to be continued as a quality management framework.

The different professional groups also are task groups:

- The regional Funders and Planners
- Clinical directors and General managers meet regularly to look at operational issues
- Clinical directors and district inspectors meet every second month to look at the MH Act, quality, safety and accreditation.

This is a comprehensive set of work streams, 'we have all our bases covered.' Some commented that the task groups and work streams are where the real work occurs, with opportunity to share ideas and generate best practice agreements.

Impacts of the Network North Coalition

Equity of Access

Eight out of the twelve informants rating this dimension gave a moderately positive rating; one gave a small positive rating and three gave neutral or "don't know" responses. One of the positive raters spelt out the moderately positive rating was for consistency of access, but for planning against the Ministry's Blueprint funding model, a major positive rating was due.

The reasons cited for the positive ratings included the open debate about deficiencies, raising awareness of gaps and the guidance afforded by the planning against the Ministry's Blueprint funding model. As new money has come in, it has been allocated on the basis of using a combination of Blueprint guidelines and PBFF data, which brings in the demographic information, to keep resources relatively equal.

One commented the IDF system works against equity of access as it creates funding pressures and risks which distort clinical choices. The moderately positive rating from this informant would have been even higher if DHBs were not prompted into risk management by the financial implications of the use of regional services. 'I am of the view the funding model does not promote the regional approach.'

One Provider Manager pointed out the scope and volume of services is less relevant than the consistency of service delivery models for a baseline quality and minimum service, then any specialties over and above that based on clinicians expertise and preferred approaches are enhancements. The Provider Managers forum had started to address this issue but it was now being picked up as part of the collaborative regional approach.

Coordination of Clinical Services

Nine of the twelve gave between small positive and moderately high positive ratings with medium positive being the modal response. Bringing clinicians together and involving them in planning, achieving agreements around access, best practice, and referral protocols were all seen as helpful. Some work has been done on clinical pathways but the progress on this is 'still patchy' and 'still needing buy-in.' Further work is needed in increasing consistency of contract specification and service delivery in some services, with Child and Youth services mentioned by more than one informant as needing more attention.

A regional coordinated information management system is planned and predicted to have big impact but is not implemented as yet.

An NGO provider who has been involved in joint ventures with the DHB and other NGO providers to second staff across agency boundaries gave a moderate to high positive impact but cautioned those developments cannot be rushed.

> 'The environment has to be right for planting, you cannot expect regional programmes to flourish if you have not turned the soil. If you invest the time you get further, I feel some of the ground work is not being done.'

Three informants gave "don't know" or neutral ratings.

Integration of Planning Between the Regional and Local Levels

Three gave major positive ratings and three moderately positive ratings out of the nine who rated this dimension. One stated "moderately hopeful" because of the concern about the lack of power of the NNC to make decisions, which leaves the group vulnerable to developments being blocked by DHBs. Another spoke positively about the thoroughness of the planning process, that it included both "bottom-up" and "top-down" approaches and that 150 were consulted on the Regional Strategic Plan, but did not give an actual rating.

Only one gave a neutral response, explaining the regional approach sometimes was counterproductive for the particular needs of that DHB population, whereas on other occasions the regional approach was helpful. This created a certain amount of tension for that informant between the regional role and the local role.

Promoting a Stable and Supported Workforce

Five gave moderately positive ratings, with reference to there being more optimism; morale has lifted; the longer term planning and confirmed Blueprint funds enable people to see a path forward; people getting together; training opportunities; employment relations are good, people involved in planning allows them to feel engaged; and hearing each others' points of view can help explain the current position, constraints and opportunities.

Five gave neutral ratings because the NNC has done a lot but there is still work to be done in a planned, coordinated way and it is too early for impact; 'it has not kicked in as yet'; the major influence is still the workforce being as stretched as it is; and the four DHBs are so diverse and have quite different workforce issues so a regional approach to workforce issues offers little.

One gave a moderately negative rating because the speed of change has dragged down morale for some of the staff directly affected, with specific reference to the reductions in residential care and the process of certification. Although there may be agreement about the broad direction of change, the process still needs to be managed in a way that is realistic and sustainable. Regional development processes also need to recognise different organisations have 'hugely different levels of resourcing' and high level planning needs to be resourced to make sure it happens.

Effective Use of Scarce Resources

Although seven out of the twelve gave positive ratings as compared to the five "neutral" ratings, there was quite a variation in response.

Two gave strongly positive ratings because the regional discussions focus explicitly on the best use of scarce resources, and because of the Community Living Service development effectively combines the DHB provider service with three NGO services. The latter development gave this informant real hope that 'the silos are being broken down' and that 'talking will stir others to different ways of thinking.'

Four gave moderately positive ratings, with reasons being that getting that highly skilled group together has been a huge achievement as it gives a platform for taking a strategic overview; and because the region works collaboratively on service development initiatives to share learning from pilot projects. One questioned whether both local and regional consultation processes were necessary as it increased the risks of "talk-fests" without it translating into people volunteering to do the work.

One gave a small positive rating because there was more that could be done to pool resources, as that informant wanted to see those with special interests and skills sharing more in a regional pool.

Five gave neutral ratings, or only slightly better than neutral. This group including all of the three General Managers in the sample, two of whom cited the lack of capacity meaning there is not the scope to shift resources around. One of these acknowledged the economies of scale offered by having regional services, lifting the rating just above neutral.

Other raters gave neutral ratings. One observed 'people guarding their patch is more dominant at the moment' (a consumer informant) and 'you have to be able to marshal resources to direct them effectively,' which is easier for NGOs as compared to DHBs..

Promoting People's Confidence in the MH Services

There was a preponderance of positive ratings: three strongly positive, two medium positive and two positive but not rated for degree of positivity. Most of these gave reasons around common themes of the Regional Director speaking on behalf of the sector and taking a proactive approach with the media; being a united group with a clear way forward; and challenging negative perceptions in the media. Other reasons for positivity were the genuine attempts at consultation and the Like Minds project improving peoples' attitudes to MH.

Four gave "neutral" ratings because of the intangible influences on the public's views and because 'complaints are so highly individualised.' The latter rater added it was probably helpful having a regional spokesperson who could speak about MH in a generic way which informs the public there is a regional approach and would be viewed as relatively neutral, whereas any provider spokesperson would be potentially viewed as defensive.

Promoting Safe and Sustainable Services

Positive ratings predominated, with three giving strongly positive ratings, six moderately positive ratings and one positive but not rated. Two of the four NGO informants gave high ratings with specific reference to the adoption of the recovery approach and the commitment to improvement of the MH services for all. One noted the safety would be significantly enhanced if the consumer recommended initiative of consumer advisory groups for each PHO and the plan to increase GPs' awareness of MH issues are implemented. Other positive raters spoke of having the plan to follow through to address issues; moving closer to Blueprint funding model guidelines; and the network of consultation provides a safer system for consumers. One noted they are still working out how to truly operationalise the recovery approach: providers and consumers wanted the same types of services but it was a matter of working out how to make it happen.

One informant gave a moderately positive rating but cautioned there were risks inherent in the MH sector: unsuitable staff, 'when patients were deinstitutionalized, the staff weren't'; the difficulties cause by wide spread use of illicit drugs which pose problems of diagnosis and danger to staff; and the changing attitudes in society means there is less respect now for staff, therefore greater risk of assault.

Two informants gave neutral ratings, stating it is the responsibility of the DHB and nothing to do with the NNC to be safe and sustainable (a General Manager); and an NGO informant who observed there was still a "blame culture" around. This informant did not have confidence the sector stands together when the inevitable risks occur, stating 'our business is people and people do funny things.'

Consultation

Eight of the nine informants rated this as strongly positive, with comments including 'everybody is at the table,' 'there is very wide engagement', 'it is all transparent.' One informant acknowledged the regional director as a 'good communicator, approachable, open and straight.'

One NGO informant who is less directly involved gave a small positive rating, saying the NNC tries to consult.

Promoting Innovation

Ten of the twelve informants rated this dimension as moderate to strongly positive. The comments attributed the work-streams as being particularly useful to bring people with different backgrounds and experiences together to pool ideas on shared problems. These groups also promoted wider sector stakeholder engagement than would otherwise occur. Secondly, the Funders and Planners were credited with being willing to invest regional money into pilot schemes as a way of testing out service innovations.

Two informants gave neutral ratings. One said it was too early for the innovations to have been implemented but once the regional plan is followed through, the impact was likely to be a major positive. The other NGO rater considered the NNC was too constrained by lack of power, central Government directives, and the DHB environment which was not as free as the NGO sector to be innovative.

Promoting Culturally Safe MH services

There was widespread recognition amongst the responses that more needed to be done. Six gave neutral ratings or a small advance over neutral. One Pacific informant stated all the cultural competence talk needed to be grounded in the actual grass roots practice, 'as clinicians and culturally competent workers would clash on some aspects.' This was seen to have direct bearing on clinical outcomes but 'the NNC has not embraced that as well as they could have.' The Māori informant acknowledged there was a will to deliver culturally sensitive services but was unsure how effective the efforts were. One Northland informant observed the plans for this part of the work programme were along time in coming but so far have made no difference to their predominantly Māori population. A General Manager informant stated the NNC's only contribution was a regional plan for kaupapa Māori services. This informant considered each DHB has taken responsibility for developing responsive services but these have been developed on quite different lines, further confirming this is local rather than regional initiative.

Five informants gave small to moderately positive ratings, with reference to the representation on the NNC and other groups, and the plans drawn up to promote this.

One gave a moderately negative rating, explaining they have not gone backward, and there have been some service specific projects to map use by Pacific peoples involving a few providers, but the Māori and Pacific representation is 'not right yet.'

Overall Efficiency of the Regional Arrangements, With Benefits Versus Costs

There were wide ranging responses to this dimension. Two gave moderately high or major positive impact. One informant saw major cost savings arising from the pooling of knowledge, skills and experience; carrying out projects once rather than four times and the sharing of resources between DHBs, in addition to the wide ranging benefits arising. The other rated the impact slightly lower, qualifying the approval of regional approaches with the comment that there needs to be a commitment to share the financial and other risks.

Four gave moderately positive ratings due to costs shared, avoiding duplication, the IT and other projects generating large benefits. One gave a small to moderate positive rating, noting they could be more efficient. In particular, there was potential for more synergy at least in the greater Auckland area to consider, for example, whether there should be three on-call services and three maternal MH services.

One who rated the current impact as a small positive predicted the next few years should deliver considerable benefits. People who were previously "knockers" have been turned around in their opinion because they can see benefits for both efficiency and effectiveness of services.

One gave a mildly negative rating because of the high costs associated with participation for their small NGO, suggesting emails could be used to communicate when the meeting is just to inform, and to use focus groups and sending out reports for written submission as ways of making consultation more cost-effective.

One Northland informant stated currently the benefits are small compared to the big costs, but recognised there was the potential for big gains as the regional plan is implemented and as those changes are integrated with the existing services.

A General Manager informant was unsure if the benefits outweighed the costs, though there were benefits generated due to the more integrated stakeholder group and developing shared understandings about issues. However that informant considered the solutions emerging were more from local levels as the Provider arms of DHBs were striving for efficiencies regardless of regional approaches. That informant would like to see the NNC doing more on developing regional pricing and agreement on service delivery models, as a means to improve efficiency and also as a quality check.

Two informants responded "don't know."

Other Comments About the Regional Approach

A number of informants gave strong positive endorsement of the importance of the regional approach to MH for the Auckland region. It is seen as giving a consistency and a regional direction. One stated it is "efficient and effective and protective.' Although there are numerous examples of collaborations that preceded the NNC, there are other reports of competitive relationships. There is no doubt the NNC has been a positive force towards collaboration and cohesion.

For those involved, the main benefits identified included understanding the direction of the sector and building relationships. Another said she was not always heard but it 'gives a foot in the door.' Information sharing and peer support were also regarded as important. Organisations build relationships to work together better, and by focusing on desired outcomes 'it lifts the bar.'

Disadvantages of the Regional Arrangements

A number of disadvantages or areas of concern were identified by informants.

- The NNC has no direct power and can only achieve decisions by influence. Although that also means the DHBs cannot duck from taking responsibility for MH, it slows the process down and makes it less efficient. Including influential people helps smooth the process of persuasion.
- Projects could potentially flounder through individuals being overloaded and not freeing up sufficient time to devote to the task. This is managed by pairing credible people with project manager resources.
- There are some disconnects between regional and local roles for some informants. One described DHB colleagues as having some negative attitudes towards the regional approach, that the 'regional tail was wagging the dog', that some hold a perception the HFA staff are still driving the region, and not all regional initiatives sit well with the local approaches.
- There are concerns the IDF funding formula will undermine the regional approach by generating risks of regional services becoming not viable for the host DHB if other DHBs withdraw support.
- The struggle to take a regional approach was perceived as relatively straight forward compared to the much larger struggle with the day to day reality. The NGO sector has even less buffer from the financial realities 'whereas if the Provider arm is in deficit, the rest of the organisation will bail them out.'
- Not all found the meetings conducive to sharing.
- Some regretted the opportunity costs imposed by the regional approach and the agenda of the NNC being so dominant, as it stopped the stakeholder forums from considering ideas afresh and some more radical initiatives.
- The regional approach takes a helicopter view,

> ‘whereas the emphasis around the person’s whole health, relationship with primary care and the developments there towards community development approaches and the embeddedness in the local population are all good reasons for not taking regionalization as a mantra.’

The Future Direction of the NNC

All informants wanted the regional approach and the NNC to continue. One stated ‘it is not feasible to change, things are starting to work well.’ Any improvements were seen to be about making more inclusive, rather than any drastic change. ‘We’re on the right track.’ A recent suggestion to reduce meeting frequency had been rejected by members.

One informant strongly endorsed the regional approach because of the overall vision and integrative approach but would like more research so decision-making is based more on evidence.

Several were frustrated by the lack of power and would like to see the NNC having more mandated authority, which would make decision making more efficient and allow the NNC to take more of a ‘development centre role’ with a regional change management team to facilitate the service development changes in the DHBs, while respecting the role of DHBs as autonomous and responsible.

A provider manager informant saw the future of the NNC as doing more to promote regional service consistency by developing regional service frameworks and offering leadership to service development.

One summed up the NNC as ‘It is easy to see gaps and criticise whereas in truth all the people involved are of good heart and good intentions.’