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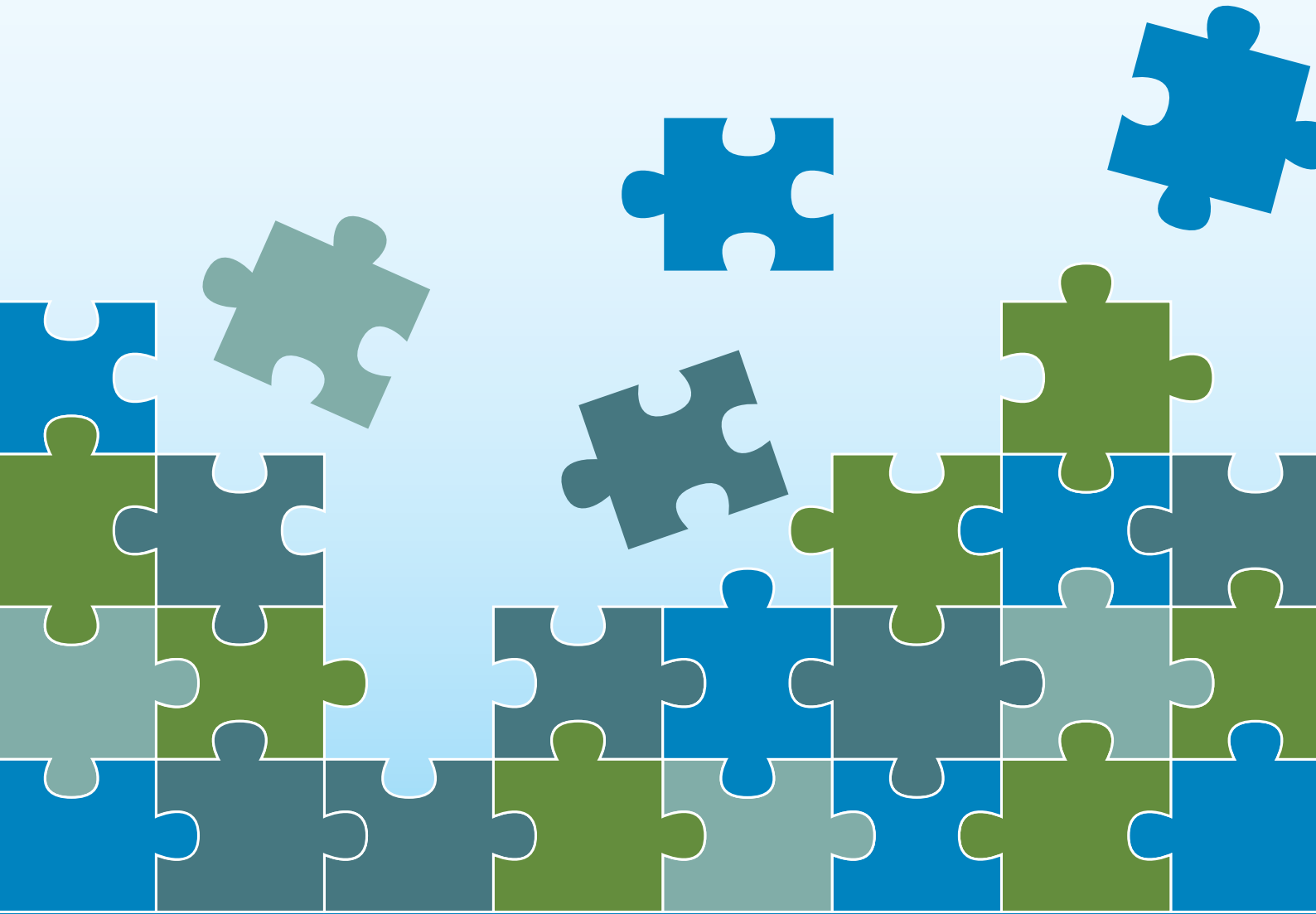
PLATFORM

NGO STORIES & STATISTICS

A profile of the mental health & addiction
NGO sector in New Zealand



PLATFORM TRUST

Purpose

This publication describes the part that community non-government organisations (NGOs) take in New Zealand's Mental Health and Addictions (MH&A) service system. It describes some of the activities of these essential services and offers some key facts.

The purpose of this publication is to provide greater insight into the work of the sector and to encourage greater dialogue and engagement between policy makers, funders, sector workers and the Government.

Acknowledgements

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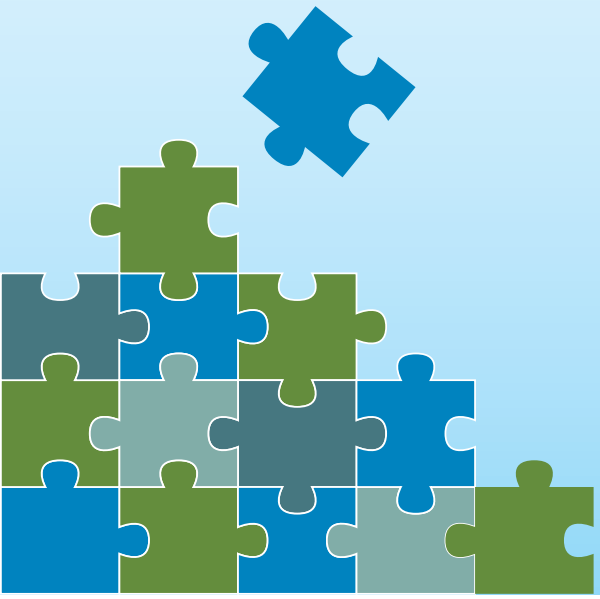
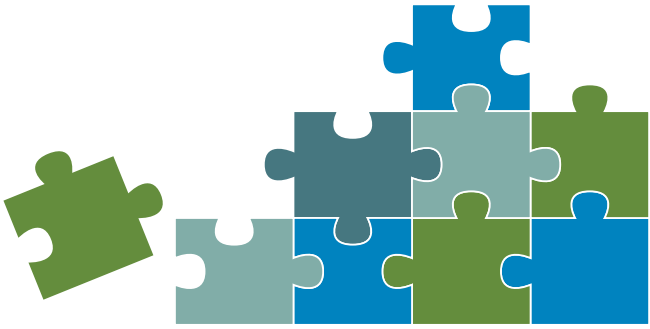


NGO STORIES & STATISTICS

Contents



1. Introduction to Platform Trust

Introduction

Platform Trust is a national network of community organisations that provide a wide range of mental health and addiction support services across New Zealand.

Platform Trust champions change and knows that community organisations play a crucial role in contemporary mental health and support service systems. From its own experience, it has learned that individuals and communities succeed best when the talents of many are harnessed.

Platform Trust:

- represents the interests of members who work in communities throughout New Zealand and have a critical interest in mental health and addictions. Most members receive funding from a range of government departments in addition to funding from the District Health Boards (DHBs)
- provides trustworthy advice, support, information and analysis about the non-government sector
- contributes a community perspective to national policy that impacts on members or the lives of the people that they support.

Fast facts about Platform Trust

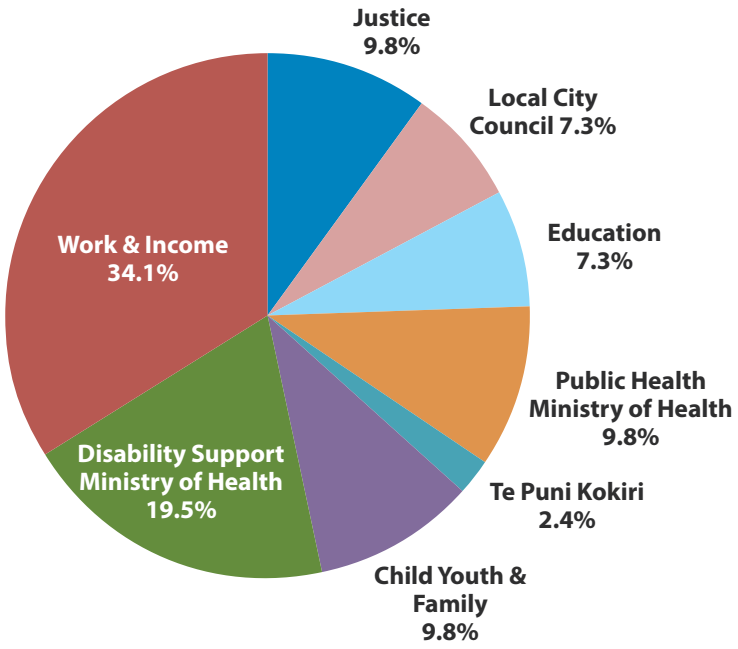
Platform Trust informs, shapes and influences

Figure 1. Agencies that fund the members of Platform Trust

Non–DHB Funding Sources - Platform Members

Source: Platform Member Survey March 2012

Survey respondents = 38; 20 answered this question so it appears that the remaining 18 NGOs contract with DHBs only.



2. A Description of the NGO Landscape

An overview

New Zealand has a long and rich history of health and welfare support provided by community organisations that have, in many cases, undertaken functions that in other countries are carried out by the state. This has created interesting relationships between the Crown as the funder, national policy and direction setter and the organisation as the contractor and provider of services. However, as Tennant (2007)[1] points out 'the relationship between voluntary organisations and the government has never simply been a matter of financial transfers'. It is also a reciprocal arrangement between community organisations and state that has mutual benefits.

… a relationship is formed; its future dependent, in part, on the survival and life-cycle of the organisation concerned, and on a mix of personal and political fortunes.
(Tennant, 2007, p 12)

Organisations in the community mental health and addictions sector take a significant part in the delivery of services and by using publicly available information this report seeks to describe the impact of this work.

Public funding for all mental health and addiction services increased from $270 million in 1993/1994 to $1.2 billion in 2009/2010[2]. Approximately 30 percent (379.9 million) of total funding was allocated to NGOs in the 2010/2011 year.[3] This increase in funding has helped to boost NGO initiatives. However, an ageing population, growing economic pressures and global demands for health skills – among other factors – mean that resources for the mental health and addiction sector are not sustainable.[4]

To meet existing and future demands on mental health and addiction services, the Mental Health Commission's *Blueprint II; Improving mental health and wellbeing for all New Zealanders (2012)* is advocating for changes in clinical practices, greater collaboration between service providers and agencies and more flexible funding arrangements. These changes would deliver better outcomes for service users.

Key messages

- Community staff complement the work of clinical staff.
- Partnerships between community staff and clinical staff help people access relevant, appropriate and effective levels of support, delivered as required in local communities.
- Community mental health and addiction organisations keep people engaged in their communities. They apply their skills to helping people regain their wellbeing (good health, food, housing, jobs). This reduces the use of more intensive and costly health services.
- Community staff balance the need for clinical expertise with the need for social support.
- Community organisations often choose to work with the most marginalised groups of people in the population.

Fast facts

New Zealand's investment in NGOs, as a proportion of the total mental health and addiction budget, is one of the largest in the world

In 2010/2011 approximately 30% ($379.9 million) of all mental health and addiction funding ($1.252 billion) purchased NGO services[3]

This means that on average, $83 out of every $280 per head of population of mental health and addiction funding was directed towards NGO services[5]

In 2010/2011 there were 395 NGO providers offering a wide range of mental health and addiction services[6]

Who uses community services?

Community organisations are a valuable and cost-effective part of the fabric of society and assist people to lead productive and meaningful lives. This helps individuals and communities and New Zealand as a whole.

A person's journey of recovery might include a wide range of health services – primary care, DHB clinical services, social services and community agencies.

In 2008 the Ministry of Health began to collect information from 265 mental health and addiction organisations about the utilisation of these community services by people who are affected by mental illness. This is called the national Programme for the Integration of Mental Health Data (PRIMHD).

The following information is a summary of what is now known about the profile of service users who attend those community programmes that also report data to the Ministry of Health via PRIMHD. When reviewing this information it is important to remember that the PRIMHD collection is still in its infancy and that data quality will improve over time as community organisations develop user expertise (see related caveats in Appendix one).

Comments

The statistics show that existing NGO service provision is heavily weighted towards adult service users (ie, people over the age of 20 years).

Given the Government's emphasis on the provision of services for youth and vulnerable children and their families,[13] it is expected that funding for NGO services will be reprioritised over time. This will result in a more balanced service response that focuses on:

- meaningful results for all segments of the population
- timely access to services
- early intervention, especially for children and youth
- risk reduction
- promotion of wellbeing (to reduce the impact of violence and neglect at an early age).

Fast facts

14,452 service users (10.6 %) were seen only by NGO services in 2010/2011[7]

A further **18,203** service users (13.4%) were seen by both DHB and NGO services[8]

The remaining **103,355** service users (76 %) were seen only by DHB services in the same period (2010/2011)[9]

NGOs saw more service users aged **25 to 44 years** in 2010/2011 than any other age group[10]

In 2010/2011 Māori were **33%** (10,833) of NGO service users and 22% (26,547) of DHB service users[11]

5% (1,525) of NGO service users and 1% (1,633) of DHB service users were seen by a kaupapa Māori team/provider in 2010/2011[12]

Section Endnotes

1 Tennant, M. (2007) The Fabric of Welfare: Voluntary Organisations, Government and Welfare in New Zealand, 1840-2005. BWB Publishing Trust. Wellington.

2 Ministry of Health (2010) Mental Health and alcohol and drug sector performance monitoring and improvement report 2009/2010. Wellington: Ministry of Health.

3 Ministry of Health (12 October 2012) Information for Platform Trust.

4 Mental Health Commission (2012) Blueprint II: Improving Mental Health and wellbeing for all New Zealanders – Making Change Happen. Wellington.

5 NDSA (2012) Final KPI Data Workbook: June 2012. Retrieved on 2 Aug 2012 from http://www.ndsa.co.nz/OurServicesWhatWeDo/MentalHealth/KPIFramework.aspx

6 Ministry of Health (2011) Master NGO PRIMHD Readiness Worksheet.

7 Ministry of Health (12 October 2012) Information for Platform Trust.

8 Ibid

9 Ibid

10 Ibid

11 Ibid

12 Ibid.

13 Minister of Social Development (2012) The White Paper for Vulnerable Children.

3. Community Service Delivery

Community services are diverse and dynamic

In this section we profile the activities of a number of community organisations to give some insight into the diversity of mental health and addiction community services operating in the community. Each practice example focuses on the real gains that are being made with people who are experiencing a mental illness and/or addiction problem.

All services aim to improve lives at every level; however, as every person and situation is different the success of this work depends on the skill, experience and approach of the organisation and the people it employs.

3.1 Peer support services

Peer support is widely recognised as a valuable and important mental health and addiction service. It is defined as 'a non-clinical intervention for people experiencing mental distress and/or addiction, based on a formal therapeutic relationship between peers or people who have experienced similar adversity' (Mental Health Commission, 2011, p 2)[1].

In their recent report, *Towards the Next Wave in Mental Health and Addiction Services and Capability (2012)*, Health Workforce New Zealand said that a significant increase in peer support services is warranted and should be prioritised.

> ***Across the spectrum of health promotion, supported self-care, e-therapies and whānau/ peer support we need a fivefold increase in this area. This is an area of high priority development to develop coherent, multi-level and scalable approaches of support and to build the capacity of both people themselves and the self-care support workforce."***
> (Health Workforce NZ, 2011, p 28)[2]

A wide range of peer support service models operates in New Zealand.

> ***Peer support is incredibly variable in Aotearoa New Zealand. There are different types of services, operating within different understandings of peer support, with different training for peer supporters, and in different organisational contexts.***
> (Scott et al., 2011, p 125)[3]

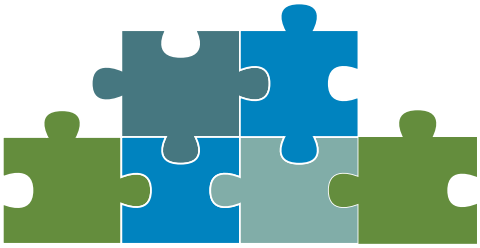
Despite these differences, some features are integral to all peer support services. The approach has been described by Mead et al (2001)[4] 'as a system of giving and receiving help, founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful'.

Fast facts

In 2012, at least 25 mental health and addiction NGOs were identified as being a peer support service

Funding for peer support services in 2010/2011 was $24.6 million[6]

Peer support services decrease the need for inpatient care (MHC, 2011)[5]



Practice example: Comcare Trust Warmline

www.comcare.org.nz

Warmline helps me get through the night

(Caller feedback)

Every year over 4000 calls are made to Warmline in the Canterbury and West Coast region. Around 50 percent of the callers are in a high level of distress when they make the call and statistics show that almost all callers report feeling better after telephoning the service.

When the call is received Warmline provides a listening ear, helps callers to understand their feelings and experiences, and helps them deal with their issues in an appropriate way. In extreme situations the service may also include telephoning emergency services.

Warmline is an invaluable resource for people who are experiencing mental health and addiction problems, but integral to its success is the fact that the people who are attending the phones have themselves experienced mental health and addiction issues. The peer support they are able to offer callers provides a perfect example of the mutual benefits that NGO peer support services can deliver.

In addition to the support given to callers, approximately two-thirds of the volunteers involved with Warmline over the last three years have either gained or increased their employment as a direct result of being involved with Warmline.

Practice example: Connect Supporting Recovery – Mahi Marumaru service

www.connectsr.org.nz

Mahi Marumaru is a peer support service for people with alcohol and other drug issues that has been operating since October 2010. It is thought to be the first intentional peer alcohol and other drug support service of its kind in New Zealand. By forming peer relationships, the service promotes an environment where people can learn from one another and also develop a sense of responsibility.

Currently the service works one-to-one with 55 people, with another 21 people visiting the service on a regular basis. Mahi Marumaru has recently undergone a major evaluation by Counties Manukau DHB which shows that the service is effective and offers value for money. Satisfaction among service users, peer support workers and sector stakeholders is also high. These are positive findings for a relatively new service that has been operating for a little over 18 months. The service is also well utilised by Māori, and feedback from service users indicates that the service is culturally responsive for Māori.

3.2 Kaupapa Māori NGO Services

Kaupapa Māori NGO providers have a long history of engaging with local communities to help members who are struggling to overcome a variety of problems, including mental health and addiction issues. Kaupapa Māori mental health and addition staff commonly combine their skills in the area of mental health and addictions with their experience of working across a range of other sectors in the community (eg, social sector, housing, justice, employment) in order to support individuals with mental health and addiction problems, build whānau capability and to foster a strong sense of whanaungatanga – connectedness.

The Government's Whānau Ora initiative is an example of a comprehensive approach to whānau as a whole, with the objective of increasing the health and wellbeing of individual whānau members.

Whānau Ora is an inclusive interagency approach to providing health and social services to build the capacity of all New Zealand families in need. It empowers whānau as a whole rather than focusing separately on individual family members and their problems.
Te Puni Kokiri

This type of integrated approach, that focuses on the needs of people and their whānau, is also supported by the Mental Health Commission's (2012) *Blueprint II*[7] , which is the mental health and addiction sector's vision for improving mental health and wellbeing for all New Zealanders over the next 10 years.

Fast facts

Funding for Kaupapa Māori services was $73.1 million in 2010/2011

The different types of services are described in Table 1 below

Table 1. Kaupapa Māori funding by type - source: Ministry of Health (2012)[8]

Category	2010/2011 $M
Alcohol and drug beds	0.3
Alcohol and drug community FTEs	13.9
Adult inpatient beds	5.1
Adult residential beds	3.2
Child and youth community FTEs	8.1
Community mental health FTEs	28.1
Community support FTEs	10.6
Forensic beds	3.1
Forensic community FTEs	0.6
Specialist community FTEs	0.1
Non Blueprint	0.03
Total	**73.1**

(FTE = full time equivalent)

Practice example: Te Rūnanga o Kirikiriroa – Rongo Ātea Youth AOD Residential Treatment Service

www.terunanga.org.nz

Rongo Ātea is a 24-hour, seven-day a week, abstinence-based, kaupapa Māori alcohol and other drug programme that embraces all adolescents. The residential programme is structured into 10-week blocks with an open-ended individualised recovery treatment programme that enables youth to enter into the residence as their needs dictate. The facility is purpose built and accommodates 16 young men and women at any one time.

Piki ki te Ora Whānau Ora Service (also under Te Rūnanga o Kirikiriroa) facilitates entry into the residential treatment service and also offers follow-up for those young people who have completed the programme. Support and education is also provided to whānau on how best to support their young person to maintain a clean and sober lifestyle.

The service caters for youth between the ages of 13 and 17 who have severe problems with the misuse of alcohol and/or other drug dependence issues.

Rongo Ātea believes in setting youth up well to achieve optimum results while in treatment and a safe environment when returning to the community. Thus the service has comprehensive admission criteria and works with existing positive influences in the young person's life to achieve these outcomes.

3.3 Alcohol and other drug NGO services

Many New Zealanders use substances and gamble at a level that is problematic and hard to change, either by themselves or with support from their friends and family.

Oakley Browne, Wells & Scott (2006) found that in New Zealand alcohol abuse (2.6 percent) was 2.3 times more prevalent than drug abuse (1.2 percent) and that alcohol dependence (1.3 percent) was 1.8 times more common than drug dependence. Drug users were much more likely to experience disorder than alcohol users, but alcohol caused more disorder in the population because of its more widespread use (p39).

In addition, comorbidity between substance use disorders was common, with 45.3 percent of those with a drug use disorder also meeting the criteria for alcohol abuse and a further 30.7 percent meeting the criteria for alcohol dependence (p72).[9]

Youth, in particular, are very vulnerable to the negative effects of addiction. Some people also use alcohol and other drugs to lessen the symptoms of an existing mental illness, with further negative consequences for their mental health.

The National Addiction Workforce Development Centre, Matua Raki (2012),[10] has reported the following statistics:

- 17.7 percent of adults drink alcohol hazardously
- 3.5 percent of adults experience harmful effects from their drug use
- 1.7 percent of adults experience problematic or moderate risk.

Community organisations have a long history of helping people recover from alcohol and other drug abuse and addiction problems (including gambling). In each local community a wide range of services and support caters for people with different needs. For information about specific services see the New Zealand Addiction Treatment Directory at www.addictionshelp.org.nz.

While the majority of addiction services are focused on the individual service user, increasingly community NGOs also provide services to family, friends and colleagues who are adversely affected by the behaviour of the people in their lives who have problematic addiction or gambling issues.

Fast facts

In 20010/2011 alcohol & other drug NGO services saw **12,425** people[8]

Over the same period, a further **912 people** were seen by both mental health and alcohol and other drug NGO services[9]

NGO alcohol and other drug services accounted for about **17%** of total NGO funding for mental health and addiction NGO services in 2010/2011[10]

In 2010/2011 about 43% of people were seen by alcohol and drug teams, 6% by kaupapa Māori teams and 11% by residential teams

Note: Those people seen by kaupapa Māori alcohol and drug teams were counted in both alcohol and drug and kaupapa Māori percentages.

Practice example: Phoenix Centre – Recovery Solutions Services Limited

www.recoverysolutions.co.nz

Addictions differ remarkably from person to person depending on what kind of substance is being abused and an individual's personality type. Addiction is also complicated by a number of physical, psychological and/or social issues. Due to these factors, addictions are intrinsically difficult to treat. The Phoenix Centre caters for these many variables by offering intensive assessment, treatment and support for those people with the most severe alcohol and other drug problems.

Formed in 2011, the Phoenix Centre caters to adults aged between 18 and 65 years old who live in the Counties Manukau area. People usually refer themselves to the Centre but it also gets referrals from community groups and from DHB community mental health teams. The Centre is currently staffed by four alcohol and other drug clinical staff and four peer support specialists who work collaboratively so people are offered a comprehensive service.

Over 200 people use the service annually, with most people using it on a weekly basis. On average, people work with the Phoenix Centre for 233 days. Approximately 45 percent of its visitors are Māori and 47 percent of the service users are female. The Phoenix Centre is achieving positive outcomes for service users and is planning to further develop its model.

3.4 Child and youth NGO services

The United Nations (UN) *Convention on the Rights of the Child* (1989)[12] called for the provision of specific resources, skills and contributions necessary to ensure the survival and development of children to their maximum capability. The articles of the Convention also required the creation of means to protect children from neglect, exploitation and abuse. Except for the United States and Somalia, all countries have ratified the Convention.

In New Zealand, the actions outlined in the *White Paper for Vulnerable Children* (MSD, 2012)[13] constitute the most comprehensive changes to policy and services for children who are vulnerable to maltreatment since the establishment of the Children, Young Persons and their Families Act in 1989, the same year as the UN Convention was ratified. The *White Paper* highlights the need for early, preventative responses for children who are vulnerable and at risk, as well as coordinated action across the social sector for those children and youth already involved with social, justice and/or mental health and addiction services.

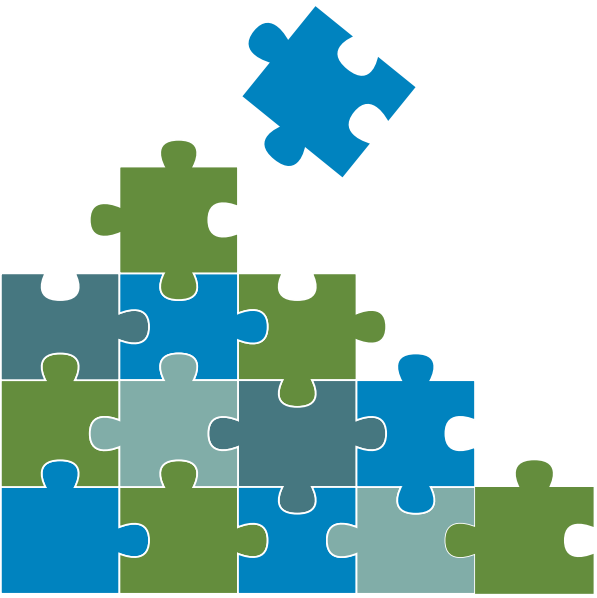
Blueprint II (2012, p 25)[14] acknowledges the role that all mental health and addiction NGO services play in helping to mitigate the lifelong impact of social, emotional and cognitive development issues on infants and young children. In addition to providing more prevention and early intervention programmes for children and their families, mental health and addiction NGO providers also need to work more closely together and with other sector partners to reach out to increasing numbers of youth who are either not identified or not treated by conventional health, education or social services. Community NGOs are well positioned to offer alternative mechanisms for connecting with young people in both school and local community settings.

Fast facts[15]

6,396
people under the age of 20 were seen by NGOs in 2010/2011

Approximately
4.7%
of mental health and addiction services funding in 2010/2011 went to designated child and youth services in the community

Of the mental health and addictions funding allocated towards mental health and addiction child and youth services, 79% of services are provided by DHBs and 21% by NGOs



Practice example: Children's' health camps – Te Puna Whaiora

Te Puna Whaiora provides a range of services and programmes based on current research and their own experience working with children and families over the last nine decades. Te Puna Whaiora's success working with our most vulnerable children is based on a commitment to five key values around being: child centred; family respectful; trauma aware; solution focused; and culturally competent. These values, along with the ability to offer an experience of 'village', is integral to their practice.

An important goal of Te Puna Whaiora service is to partner with families and community stakeholders to support and enhance our most vulnerable children's lives in their homes, schools and communities. The service believes that both families and local communities are strengthened in this process. Services include: home and school-based social work services; therapeutic residential care for children and families; child and family mentoring; respite services for grandparents and foster parents; a range of family development programmes; grief and loss programmes; and, more recently, involvement in the disaster recovery efforts in Christchurch. All the services are designed to enhance family life and enable children to experience safe, healthy, hopeful relationships with adults.

Programmes provided by Te Puna Whaiora include family development programmes such as Te Puawai, Keeping the Magic Going, Stepping Out, Family Friends, and Family Return on Investment (Family ROI). Programmes for children and young people include Kidzacool, Seasons for Growth, Storm Birds, Journey of Hope, Kids with Incredible Potential (KIP), Healthy Heroes and a variety of other programmes that address the individual health, education and social needs of children.

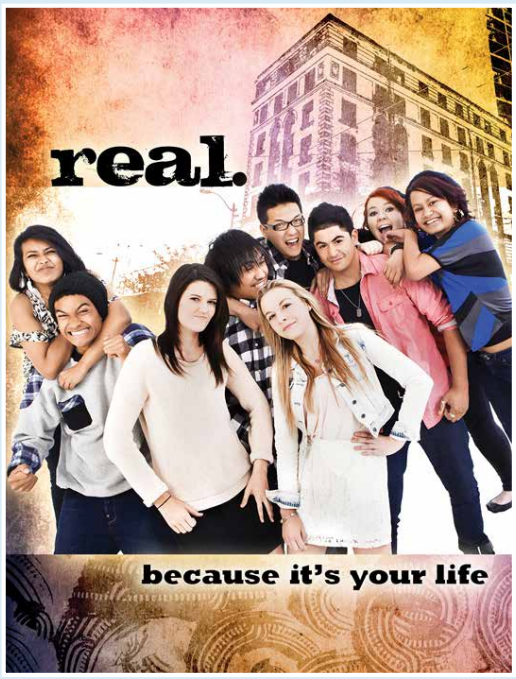
Te Puna Whaiora seeks the following measurable outcomes from all the services they provide:

- child development achieved
- parenting capacity improved
- use of resources maximised.

Practice example: WISE Youth Service – Formative Evaluation

www.wisegroup.co.nz

The Wise Group's youth service 'Real' aims to help young people with existing mild to moderate mental health concerns and social stressors to combat their problems before they grow worse. Efforts to deal with emerging mental health and addiction issues will include, among other initiatives, educating young people, their families and whānau about mental health, and the linking of community and peer support groups to those individuals and families who need help fostering stronger mental health.



This programme is funded by Lakes DHB and will initially begin by targeting young people in schools and the community within the Rotorua district.

The service is a blended model of clinical and support provision and will comprise two current clinical psychology positions and an additional integrated youth worker position.

In the first year a formative evaluation will be undertaken to ensure that the programme is on track and delivering against its objectives. Te Pou is assisting the Wise Group with this evaluation, the results of which will be used to consider the potential for increased service provision and identify the resource requirements for up-scaling service provision in future years.

3.5 Children of parents with a mental illness

Up to 50 percent of people who experience mental illness are parents. The development of services specifically for the Children of Parents with a Mental Illness (COPMI) represents a reasonably new approach to service delivery in New Zealand. These services aim to promote better mental health outcomes for children (0–18 years) of parents who have mental health issues.

Practice example: Connect Supporting Recovery – Family Service

www.connectsr.org.nz

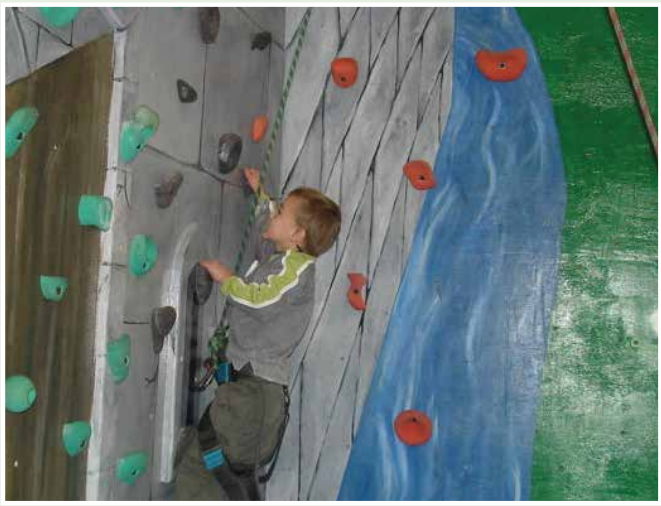
Connect is working collaboratively with the Kari Centre (Youth Early Intervention Services, Auckland DHB), focusing on the children of parents with mental illness. A pilot project was started by the Kari Centre 3½ years ago and was based on similar programmes that have been successfully operating in Australia for the last 10 years. Studies showed that children living with parental mental illness were experiencing:

- higher rates of emotional, developmental and behavioural problems
- higher cases of abuse and neglect - 33 percent of Child, Youth and Family cases had at least one parent with mental health issues
- increased rates of psychiatric disorders based on genetic and environmental grounds.

The evidence[16] suggests that successful interventions for this population group include:

- age-appropriate psycho education
- peer support for children
- parenting groups especially tailored for parents experiencing mental illness
- community support.

Connect was chosen to provide the community support intervention, including the provision of support to the whole family. The different types of support include helping parents with schooling issues, facilitating access to holiday programmes, helping with childcare, accessing children's peer support groups, providing parenting programmes (run by the Kari Centre), accessing Kidsclub run by Supporting Families in Mental Illness (SFMI) as well as offering general community support.



3.6 Family and carer support

A supportive and loving family unit plays a crucial role in providing people with the skills and confidence that they need to lead well-adjusted lives.

> ***What the research tells us is that family-functioning and circumstances significantly affect not only the wellbeing of family members but also the functioning of communities and society generally, as well as the economy. Families carry out various functions that are critically important to society. They share resources, and support their members financially; they care for the young, the elderly, the sick and those with disabilities. They are a critical mechanism for the transmission of values across generations.***
> (Families Commission, 2011, p 2)[17]

In promoting the health of the family, in whatever form the family may take, we are promoting a broad and inclusive perspective of wellbeing. When family relationships are strong and functioning well, it is more likely that individual family members will report higher levels of wellbeing. It is this mutually supporting element that makes family and carer support services so important.

Fast fact

Community organisations offer families the support that they need so that they are better able to support family members who are service users

Practice example: Atareira – Family Support

www.atareira.org.nz

Having a family member who is experiencing mental distress presents challenges for the immediate and extended family/whānau.

Atareira provides information, support and advocacy services for family members throughout the Wellington region (including the Hutt Valley, Porirua and the Kapiti Coast).

Atareira works across all age groups. Last year it supported 950 service users between the ages of three and 90+ years of age. It works in partnership with other NGOs, tangata whenua, families, consumers and their communities and, in the last year, this agency worked with over 50 agencies.

Other key features of Atareira include its Family Whānau Support Service, which offers face-to-face contact, support groups, and educational courses for those affected by mental health and addiction issues. Another highlight service is its Whai Kahurangi Learning Centre, which has dedicated staff to help service users develop new skills and increase their employment possibilities.

Practice example: Supporting Families in Mental Illness (SFMI) Auckland

www.sfauckland.org.nz

SFMI efforts have enabled us as a family to remain together and continue to have hope in our son's recovery.
(Parent)

Supporting Families in Mental Illness (SFMI) supports family and whānau members of all age groups, (including children) of people in the Northern Region who are affected by mental illness. SFMI has contact with around 2,500 individuals every three months, with services ranging from responding to enquiries for information to offering long term support for people with complex problems. At any given time SFMI is actively engaged with about 300 families.

SFMI also runs the only Kids Club (for children of parents affected by mental illness) in the Northern Region. In addition to obtaining written feedback on the service, SFMI periodically completes an outcomes tool with families, which helps track family member improvements in specific critical areas.

SFMI also receives many unsolicited letters from families, telling stories about their own personal journeys and how SFMI services have helped them.

3.7 Employment support

Employment is a key part of helping people get well and stay well; it builds self-esteem and confidence and is important for building relationships as well as the independence that an income provides.

Employment support services are provided by community organisations and specifically designed to help people with experience of mental ill health and addictions to be employed and to stay in the workforce. This is good for an individual's health and wellbeing and takes pressure off the health care and benefit systems.

WELFARE: for every $1 spent, $1.11 would be returned in the first year alone HEALTH: each $1 spent would be returned in full within the first year. Evidence-based employment programmes will bring gains to both Health and Welfare departments.
(Lockett, H. & Elwin, W., 2012)[19]

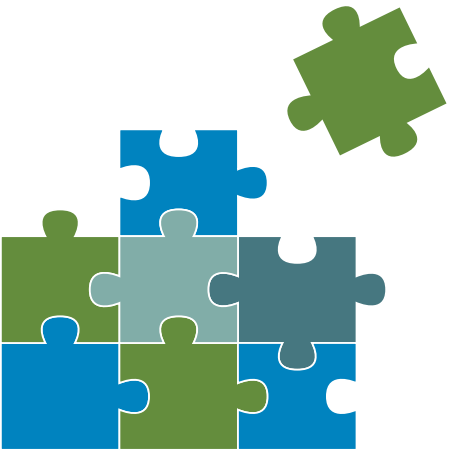
Fast facts

People who are in contact with mental health services have an employment rate of less than **20%**[20]

Having a job not only improves the symptoms of a mental illness, but it reduces the amount of support that people need from mental health teams

Having a job also reduces the number of hospital admissions, as well as the length of those admissions[21]

Given the right support, the evidence shows that over **50%** of people who are interested in working could gain and maintain employment[22]



Practice example: Workwise –Supported employment service

www.workwise.org.nz

In its most basic form, Workwise helps people throughout New Zealand with mental health and addiction issues to get a job. But it does much more than that. As well as ensuring that people get placed in decent, long-lasting positions that both employees and their employers are happy with, Workwise provides benefits for the family, the community, the health and welfare sector at large, and the New Zealand economy as a whole.

When people first approach Workwise they get individual support and advice so they can be placed in appropriate jobs that fit well with their emotional and situation-specific needs. Support is also given to both employers and employees during the duration of an individual's employment.

In the last year Workwise provided services for 1,998 people, experienced a 28 percent increase in referrals and secured 754 new jobs for people (one-third of which were 30+hr/ week positions). Moving forward, Workwise wants to further prevent the negative spiral of unemployment, poverty and health deterioration that so many people with mental health and addiction issues experience when they are out of work for extended periods of time.

Practice example: Mana Recovery Trust

www.manarecovery.org.nz

Based in Porirua, north of Wellington, the Mana Recovery Trust helps people with various forms of mental illness secure work. While an obvious advantage of finding work is money in the pocket and a sense of personal independence, regular employment also helps mental health and addiction affected people stay out of hospital, develop new friendships and connect with their local community. Ultimately, it can also improve their overall mental health.

Currently the programme has 70 trainees, many of whom are Māori or Pacific peoples who live in and around the Porirua area. Core functions of the programme include giving participants vocational and living skill training, and by working with other NGOs and businesses to help find suitable employment for trainees.

Twenty-eight of the Mana Recovery Trust's 50 staff have come through the Trust's training programme, with most working 30 or more hours per week. This means they no longer rely on government benefits. Some trainees have also gone on to obtain NZQA qualifications.

To provide more employment for trainees, the organisation is constantly increasing business opportunities and is working with the Ministry for Social Development on a project to move more trainees and staff into mainstream employment.

3.8 Education and skills development

Practice example: Atareira – Whai Kahurangi Learning Centre

www.atareira.org.nz

This service demonstrates how health and employment services can interact to help improve people's connections to the community in which they live. The Centre is a learning environment offering workshops, programmes and computer-based learning to help prepare people for work, to further their education and to increase their level of participation in the community.

This service is funded by both the Ministry for Social Development and Capital & Coast DHB. It works with Whitireia Polytechnic to offer the National Certificate in Computing (level 2) to people with mental health and addiction problems.

Referrals are received from all sources, including self-referrals. Work and Income New Zealand is the largest referring agency followed by the DHB community mental health teams.

A variety of survey and evaluation measures have been used by the service over the years and consistently show that people value the service and find it helpful in achieving their goals. In the last year approximately 75 people attended the service for a total of 8000 hours.

Wellington's Whai Kahurangi Learning Centre is open from 8:30am until 4:00pm Monday to Friday and accepts referrals for those aged 16 years and older in the greater Wellington region. The service offers morning and afternoon sessions which people can attend flexibly to accommodate work, family and health issues.

3.9 Supported accommodation

Many community organisations have a long history with service users, family members, communities and government-funded health organisations. This positions them well to continue to provide community mental health and addiction services.

NGOs offer viable alternatives to hospital admission

Fast facts

NGOs work with service users who are also sometimes admitted to acute inpatient units[21]

NGOs assist many service users to make successful returns to the community after an inpatient admission[22]

NGOs support people who have complex needs to live in the community

Photo courtesy of PhillipC

Practice example: Connect Supporting Recovery – Waatea Service

www.connectsr.org.nz

People with complex mental health and addiction needs do not always get the care they require and sometimes seem to have exhausted all available support services. There can be many reasons for this, including administrative oversights or poor community support networks, incorrect medical or mental health and addiction assessments. When this happens, the Waatea Service can help.

The Waatea Service, which is offered in partnership with Connect Supporting Recovery and Waikato DHB, offers an environment where support is available 24 hours a day, seven days a week. It is intended for people with complex mental health and addiction needs, many of whom also have other physical or learning needs. The service provides:

- a safe and comfortable environment where people can begin to set their goals and start working towards more independence
- support of others who have similar mental health and addiction journeys.

While housed in a safe and comfortable rehabilitative environment, participants can set goals and work towards living more independent and satisfying lives.

NGOs support good continuity of care between inpatient and community settings

Practice example: PACT – Housing and Recovery Services – Helensburgh Road

www.pactgroup.co.nz

PACT's Housing and Recovery Services works closely with the Southern DHB's clinical services to help transition people back into the community. Some people need a safe and secure environment for a period of time while they regain their confidence. By living and working with others who have experienced similar problems, people are able to share their successes and improve their general wellbeing.

Over the last year, 13 people have moved from various locations (supported accommodation, inpatient wards, and community settings) to flats in Helensburgh Road. During the same period, nine people have successfully moved back into more independent accommodation in the community.

3.10 Rural community services

Practice example: Te Whare Mahana Trust rural employment project

www.twm.org.nz

NGOs provide support in all communities

For holiday-makers and casual visitors to the area, New Zealand's Golden Bay is often an idyllic escape from their regular lives and can seem a wonderful place to live year-round. However, for locals with mental health and addiction issues it can be a difficult place to find employment and housing. The Te Whare Mahana Trust rural employment project helps people find work and also builds the resilience of the local community by working closely with other community agencies.

I find that I am doing things now that I would not have done before. I am happier now than I have been for a long time.
(Programme participant)

Over the last three years an average of 37 people in a total population of 3,678 have gained casual employment through the Te Whare Mahana Trust rural employment project, equating to over 10,500 work hours per year. Additionally, on average, about 19 people annually have gone on to take up other employment opportunities.

The programme is slowly boosting the prospects of local people and, in the process, is helping New Zealand's rural economy. Due to its successes over the last five years the project has also opened its doors to include those people who are looking for work but who do not have a history of mental health issues.

There are currently 60 people using the service.

Photo courtesy of Johndierckx

3.11 Community support in people's homes

Inpatient admissions are expensive ($776.56 per bed day)[23] and account for about 30 percent of all mental health and addiction services. By providing better community care, overall costs would reduce and the health outcomes for service users would improve.[24]

Key message

- NGO providers are serious about improving their quality of services and increasing the impact of their work alongside a diverse range of agencies, including other health and disability providers.

NGOs have an important role to play in an efficient health care system

Fast facts

A total of **2,621** residential community care beds were funded in 2010/2011[25]

On average, 37 community residential rehabilitation beds per population of **100,000** were funded in 2010/2011[26]

There were **1,320** inpatient beds funded in 2009/2010, with an average occupancy rate of 89%. This equates to a total of 187,208 inpatient bed days for that year[27]

A large proportion of the cost of acute inpatient care is generated by long and repeat admissions for a small number of service users (eg, a total of 69,747 bed days for long term acute inpatient clients aged over 20 years was recorded in 2009/2010)[28]

The average length of stay in a residential rehabilitation bed cannot be accurately determined at the moment, due to a number of data quality issues (refer to caveats in appendix one). This situation is expected to improve over time as NGO providers gain experience using the data

Practice example: Pathways – Waikato Home Based Treatment Services (HBT)

My family would have admitted me to hospital as they could no longer cope with me so they were really pleased to have support to keep me at home. They felt included and part of decision making.
(Participant comment)

For people dealing with mental health and addiction issues, a hospital or inpatient unit isn't always the best environment for people to recover their health. Sometimes, with the support of those who love them the most, an individual's road to recovery is best dealt with in the community where they already live.

HBT works with those individuals recognised as able to be treated in their own home. This programme offers a good alternative to an inpatient setting and is particularly relevant for those who have familiar support groups that can work alongside HBT staff and other NGO service providers. Not only is this service less obtrusive, but it can relieve the feelings of anxiety and pressure that some people experience when being admitted to inpatient wards.

The programme is open to adults and last year it had 145 referrals. Of these, 125 people were supported by HBT and 20 people were transferred to the care of the hospital.

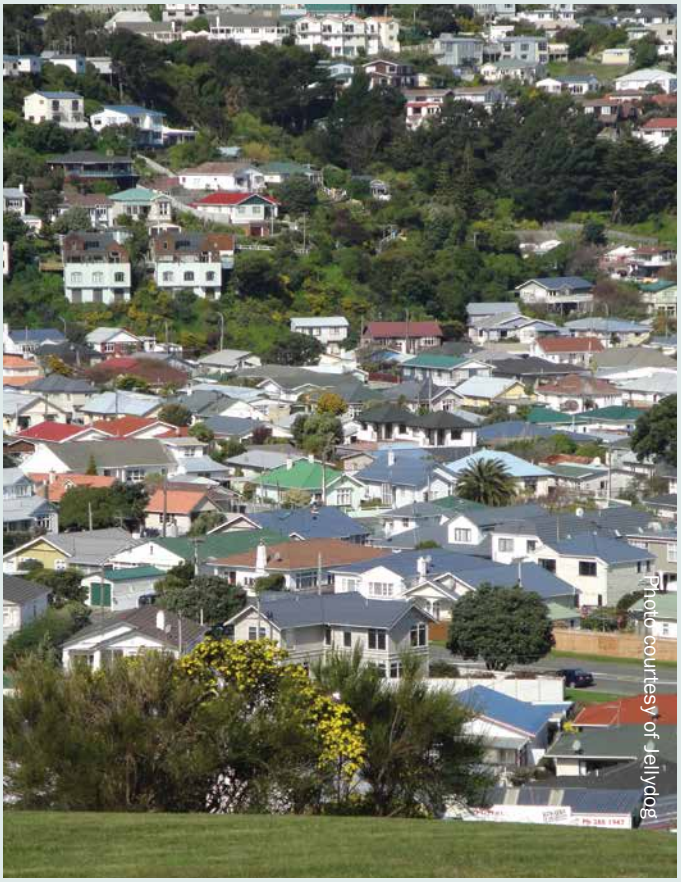


Photo courtesy of Jellydog

3.12 NGOs are part of the front line response in cases of civil emergency

Practice example: Richmond Services Ltd participation in a response to maintaining mental health and addiction service delivery following the Canterbury earthquake

On February 22, 2011, when a 6.3 magnitude earthquake struck New Zealand's Canterbury region, the life of those with mental health issues had the potential to become increasingly complicated. NGOs feared their resources would not cope and that the mental strain of living through such a destructive natural disaster, as well as the physical ruin of accommodation, would lead to a rise in the need for mental health and addiction services.

In response to this catastrophe, Canterbury's DHB's Planning and Funding Department and the four largest residential mental health and addiction service providers came together to make sure that people who needed support would receive it efficiently and effectively. Partnering organisations included Canterbury DHB, Richmond Services Ltd, Stepping Stone Trust, Comcare Trust and Pathways. Weekly meetings between the groups were held in order to deal with individual group member needs, and to ensure resources were shared so that service users were catered for in the best way possible.

By working cooperatively, the organisation has developed new processes and protocols and met the needs of service users as best able. Among other outcomes, the Residential Options Group (ROG) has been formed for mental health and addiction-affected people who require access to a residential service.

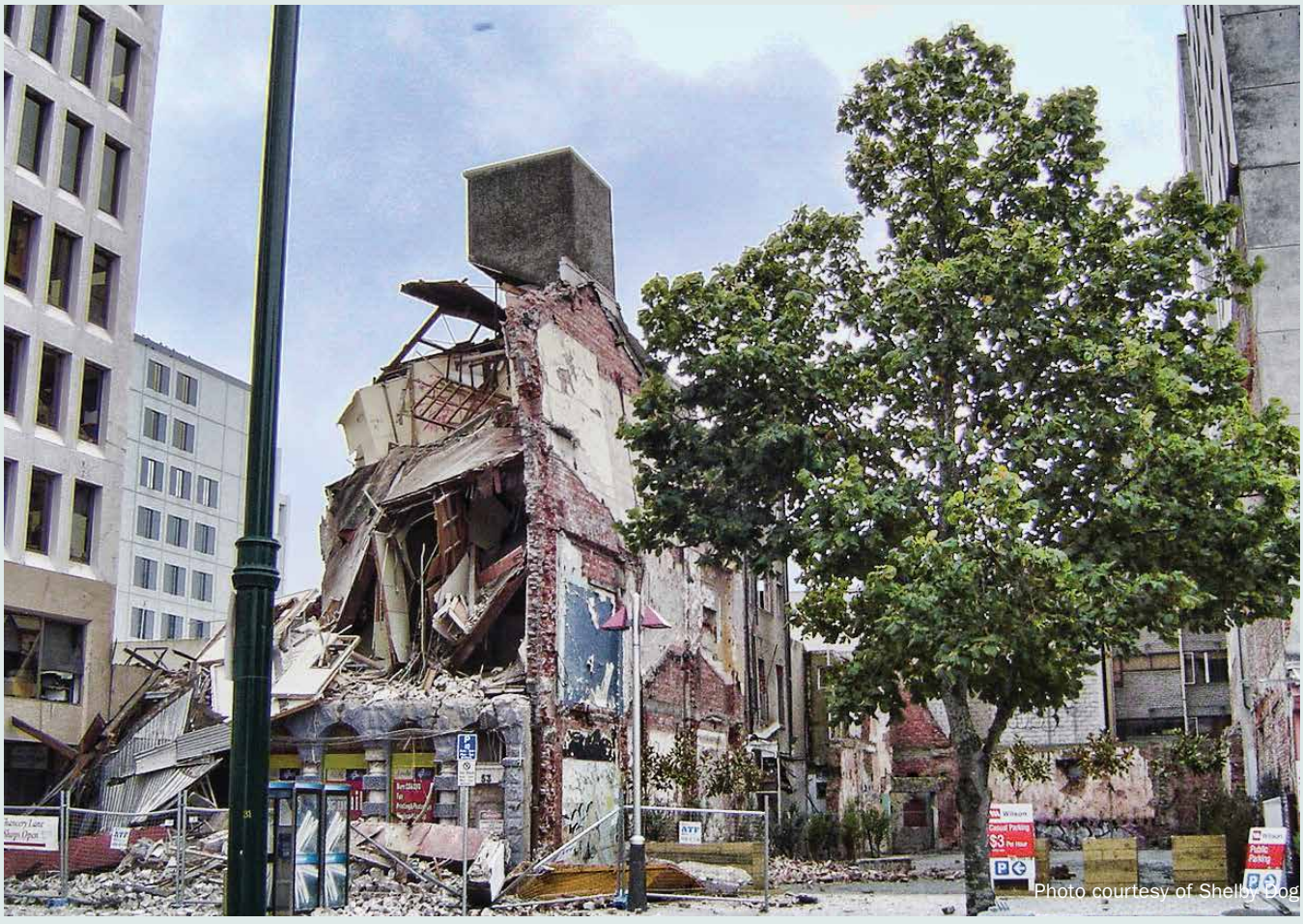


Photo courtesy of Shelby Bog

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4. Primary Mental Health NGO Initiatives

Primary mental health initiatives are essential for the assessment, treatment and management of people with mental health and addiction issues. NGOs working in this area help promote health and wellbeing, and prevent illness, as well as intervening to support those who need help.

Platform Trust has brought New Zealand's NGO mental health and addiction community into the primary health discussion with their NgOIT publication *Towards Integration: Building an integrated mental health and addiction service* (2012).[1]

Platform Trust believes that by building on each other's strengths the capacity of NGOs and primary care can be extended, leading to improved outcomes for the people living in our communities. This report outlines six key directions that will enable the sector to progress towards this goal. The directions are to:

- change our language and concepts of need
- address the barriers to collaboration
- focus on navigation and coordination
- explore community service options
- explore brief intervention options
- focus on workforce development.

Fast facts

It is predicted that 46.6 % of the population will meet the criteria for mental disorder sometime in their lives[2]

Studies have found that 36 % of people attending general practice had one or more of the three most commonly presenting mental health disorders[3]

There is a strong connection between mental health and other physical health conditions, especially chronic illnesses[4]

Case Study: Connect Supporting Recovery – Unstress course

www.connectsr.org.nz

Stress is a fact of life and can affect one's physical, mental and emotional wellbeing. It is particularly damaging for those people with mental health and addiction issues. The trick, however, is to learn how to manage it.

The Unstress course is available to residents of Waitemata district and appointments can be made through local GPs. The course is also available for workplaces and community groups.

Unstress began in 2007 and offers an accessible and practical tool for those who experience stress. Through cognitive behaviour therapy, participants learn how to recognise and manage the thoughts, emotions and behaviours that make up their own response to stress. Once they can recognise their responses, they are given the tools to successfully manage stress when it does arise. Participants are also given relaxation strategies, self-confidence exercises and communication tools to work with. Because the course is offered in a group setting, it is also helpful because participants understand that their experiences of stress are often no different to those of others. This can make it seem less confronting and more manageable.

TAMA TŪ TAMA ORA
CONNECT
SUPPORTING RECOVERY

Section Endnotes

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5. The NGO Workforce

Community organisations employ a trained and skilled workforce

Realising the vision outlined in the Ministry's recent Service Development Plan *Rising to the Challenge* (2012)[1] will require sufficient numbers of trained staff who are able to work collaboratively across both health and social service settings.

NGO providers have a crucial role in implementing this Plan. They will need to commit to working closely with their DHB partners to improve outcomes for people with the highest needs. They will also need to use their skills and experience to work alongside DHB and primary care providers in delivering seamless, well integrated services.
(Ministry of Health, 2012, p 7)

The qualification pathway for the NGO workforce includes core and advanced competencies. In 1988 the National Certificate in Mental Health Support Work (MHSW) created a minimum core qualification for support staff working in the mental health area[2]. Later, the National Diploma in Mental Health Support Work was developed for those staff who wanted to develop more advanced skills. However, there has been very low uptake of this qualification.

In the addictions field, a new Addiction Competencies Framework was published in May, 2011. This Framework outlines educational pathway, values, attitudes and skills for key groups working within the addiction treatment sector. It is primarily aimed at:

- alcohol and other drug practitioners and support workers
- problem gambling counsellors
- Quit programme coaches and others who provide smoking cessation treatment.

Key message

- The NGO workforce is trained to help people take charge of their own recovery and to engage with a wide range of community-based supports.

Fast facts

NGOs employ the second largest workforce working in all mental health and addiction services

Support workers make up the majority of the NGO workforce, but NGOs also employ clinical staff and a few also use volunteers. In addition, some support workers are employed by DHBs

In 2005 approximately **29%** of NGOs employed 10 to 49 staff and a further 9% employed more than 50 staff[3]

In 2007[4] approximately **77%** of survey respondents who classified themselves as belonging to the support services workgroup, reported that they had a tertiary qualification and of those 15% had a Bachelor's Degree[4]

In 2007, approximately 21% of students undertaking the MHSW certificate identified as service users[5]

NGO workers are talented and qualified professionals who make a difference in the lives of individuals, families and communities

Section Endnotes

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2 Note: this does not relate to addictions or to other service areas.
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5 Careerforce Statistics (November 2007).

6. The Value of Community Services

NGOs are constantly finding new ways to demonstrate their value. Outcome frameworks, performance indicators and other types of performance and quality reviews are being developed and implemented to help meet the demand for increased accountability from funders, government and local communities.

Encouraging a person's wellbeing, recovery and participation in society leads to the outcomes being sought. However, one of the challenges for community organisations is to find ways of demonstrating these outcomes within the limitations of the current contracted measures of success.

For example, the Government has proposed to measure the success of Whānau Ora interventions with two sets of indicators. Individual indicators (such as health status or employment) will provide measures relevant to individual whānau members. But in addition, outcome indicators associated with the whānau as a whole are needed. While whānau satisfaction will be an important indicator of provider effectiveness, there will be greater reliance on indicators capable of measuring increases in whānau strengths, such as a capacity to care for each other, to transmit knowledge and values, to model healthy lifestyles, provide access to society and to te ao Māori, and to transfer language, culture and ethics between generations (Whānau Ora Taskforce, 2009)[1].

This is an ambitious undertaking which has not yet been translated into practice, possibly because it involves:

- measuring things that are inherently hard to measure
- contributions from multiple agencies.

This initiative is also an example of how traditional measures of success struggle to capture the 'social value' that community agencies provide to individuals, their families/whānau, local communities, and society as a whole. It is this concept of 'social value' that Platform Trust is interested in exploring further over the coming year.

NGOs are worthwhile and make valuable contributions to thriving communities

6.1 Outcome frameworks and evaluative thinking

A number of community agencies have either adopted or developed an outcome framework as an integral part of how they measure their performance. However, many existing tools and guidebooks reflect dominant conceptions of community agencies and normative measures about what matters most in their work.[2]

In 2011/2012 Platform Trust and Te Pou worked together to support 10 NGOs to implement DoView (visual outcomes modelling software).[3] The main objective of the two pilots was to assist the community agencies to develop a strategic outcomes framework that was specific to the goals of their organisation and, in the process, increase their awareness about how their high-level outcomes linked to their frontline work.

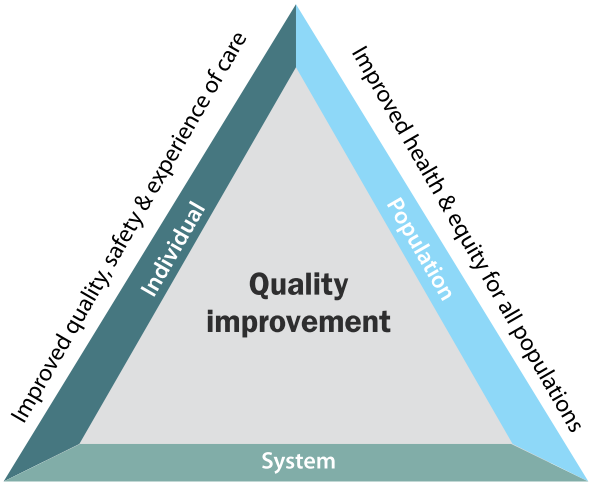
Te Pou conducted an evaluation to determine the usefulness of the DoView approach and the extent to which the use of DoView supported the development and use of an outcomes system. The evaluation found that the use of DoView supported outcomes thinking and the creation of strategic outcomes frameworks in organisations.

Fast facts

Things to think about:

- No economic analysis has been taken of all secondary mental health interventions in New Zealand, so demonstrating the cost-effectiveness of NGOs compared to other services is very difficult at this time.
- The time is right for funders and community agencies to be developing accountability frameworks that include measures of social value.
- When assessing NGO service performance, it would be helpful if related statistical information (eg, funding per head, cost per contact hour, community service-user related time, percentage of contact time with service user participation, community support days per service user, etc) were all displayed alongside one another. This would help with the interpretation of the data and would more clearly highlight differences to do with funding and the frequency/intensity of service delivery.
- Quantitative data on NGO cost-effectiveness should always be considered in conjunction with service user experiences of care, as per the New Zealand's version of the Triple Aim (see Figure 2 to the right).

Figure 2. The New Zealand Triple Aim (MHC, 2012, p7)[4]



Best value for public health system resources

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Appendix one – caveats relating to PRIMHD data:

PRIMHD (pronounced 'primed') is a Ministry of Health single national mental health and addiction information collection of service activity and outcomes data for health consumers.

The data is collected from DHBs and NGOs. It is stored in the PRIMHD datamart, which is part of the Ministry's national data warehouse.

PRIMHD data is used to report on what services are being provided, who is providing the services, and what outcomes are being achieved for health consumers across New Zealand's mental health sector. These reports enable better quality service planning and decision-making by mental health and addiction service providers, at the local, regional and national levels[1].

Given that NGO reporting to PRIMHD only became mandatory in 2008, the following caveats need to be kept in mind when reviewing the statistics generated with the use of PRIMHD data.

- All the information in this document relating to the number of service users that are seen by NGOs is provided via PRIMHD data.
- The NGO data reported for 2009/2010 is incomplete, representing only 40 percent of all NGOs.
- Also, within the 118 NGOs that reported to PRIMHD in that year, not all teams supplied data and not all NGOs reported for the entire 2009/2010 period.
- A total of 265 NGOs (representing the majority of total funding for NGOs) have been identified as able to report data to the Ministry of Health's PRIMHD database.[2]
- A further 130 NGOs deliver mental health and addiction services but are considered to be 'out-of-scope' for PRIMHD reporting because they are not able to assign service activity to individual service users.
- The reporting of NGO data is a phased process and coverage will improve in the future.
- As at September 2012, 239 NGOs were reporting data to PRIMHD, representing approximately 90 percent of all NGO funding.
- The quality of data will also improve over time, with use.
- NGO data should be considered alongside DHB data for each district. This provides an opportunity to look at service activity across the sector from a systems viewpoint.
- There are considerable variations in resourcing and models of service delivery between NGOs. Comparisons between similar organisations are of greatest value.

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PLATFORM