

The Journey Forward

Mental Health & Addiction

Action Plan 2011- 2014

“There is no health without mental health”



Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

Capital & Coast District Health Board's Strategic Direction

Analysis of our organisational and environmental context and the current and likely future health status of the people in our district have led us to focus on four strategic areas in our District Strategic Plan. From July 2010 – June 2015 our central focus is on:

From July 2010 – June 2015 our central focus is on: Improving the health of our local people, families and communities – and reducing inequalities within our population

To support this we will be:

- Developing infrastructure that supports the integrated delivery of services
- Ensuring both financial and clinical viability of services, facilities and support
- Focusing on the culture of our organisation and providers and how we work together locally and across our region.

Our purpose at Capital and Coast District Health Board is to ensure:

“Better health and independence for our people, families and communities”

Our Organisational Values

To guide our people in pursuing our vision and outcomes, we are committed to the following values:

- Focusing on people and patients – to collaborate with others in the health and related sectors to provide services that address the needs of our patients and our communities
- Innovation – actively improving what we do and being open to new ideas
- Professionalism – through leadership, honesty, integrity and collaboration
- Respect – through behaviour that demonstrates that we value individual and cultural difference
- Action – making decisions and keeping promises
- Excellence – ensuring safe, effective and timely services
- Living the Treaty of Waitangi – recognising the status of Māori under the Treaty of Waitangi and working to address inequalities in health.

What Capital and Coast District Health Board will focus on until 2015

Strategic Focus Area 1

Improving the health of our local people, families and communities and reducing inequalities within our population through activities aimed at:

- Ensuring equitable and affordable access to health
- Addressing barriers to health and disability services
- Encouraging healthy lifestyles and environments
- Integrating services for older people and those with long-term conditions.

Strategic Focus Area 2

Infrastructure that supports the integrated delivery of services across the district through activities aimed at:

- Developing our workforce to meet the changing needs of our people
- Improving information technology capability in the district
- Improving facilities and services across the district.

Strategic Focus Area 3

Financial and clinical viability of services, facilities and support through activities aimed at:

- Improving efficiency and productivity
- Ensuring patient and clinician safety
- Strengthening clinical governance and quality.

Strategic Focus Area 4

Improving the culture of our organisation and our providers and how we work together locally and across the region through activities aimed at:

- Developing our position as a lead DHB
- Improving performance of the health and disability sector
- Actively engaging throughout the sector about addressing our health and disability support needs.

Executive Summary

The Journey Forward Action Plan 2011-2014 provides guidance and direction to Capital and Coast District Health Board (C&C DHB) as it reconfigures mental health and addiction services, and responds to the mental health and addiction needs of our community. This Action Plan continues to progress The Journey Forward 2005 – 2010.

Key challenges in mental health and addiction services are:

- To strengthen the way services and agencies work together at a system level to meet the needs of mental health and addiction service users and their families/ whanau within C&CDHB's population
- To ensure effective and efficient recovery focussed mental health and addiction services that benefit service users and their families/ whanau
- To foster a culture where the needs of mental health and addiction service users and their families/ whanau are heard and addressed collaboratively by the sector.

The actions in this Action Plan are generally focused on a service user centred system and service changes rather than changes related to various types of service providers, such as secondary, primary and NGO providers. In many instances the action will be relevant to all providers, with the impact on each provider varying depending on the action.

Priority populations for service development are alcohol and other addictions, children and youth, older persons, and Pacific people. However our financial situation means that to enable investment in these populations, we must first reconfigure general mental health adult services. Therefore while there are a number of actions that are relevant across the sector, there is a predominance of actions related to the general adult population accessing specialist mental health services.

Our planned priorities for mental health and addiction services from 2011-2014 are:

DHB Priority	Mental Health & Addiction Priority
Improving health and reducing inequalities	<ul style="list-style-type: none"> • Shared assessment and planning processes • Realign services to meet identified population need and national requirements • Reconfigure supported accommodation and community services
Integrated delivery of services	<ul style="list-style-type: none"> • Single point of entry and transition between services • Shared electronic health record
Financial and clinical viability	<ul style="list-style-type: none"> • Quality information • Workforce
Improving the culture and working together	<ul style="list-style-type: none"> • Intersectional collaboration & partnerships with other agencies • Implementing local, regional and national plans

Contents

Capital & Coast District Health Board's Strategic Direction	2
Executive Summary	3
Contents	4
Introduction	5
Future Directions in Mental Health.....	6
Priority Populations.....	7
Range of Services	8
Action 2014	12
Improving the health of our local people, families and communities and reducing inequalities within our population through activities aimed at:	12
Integrated Delivery of Services	18
Financial and Clinical Viability of Services	20
Improving the Culture and Working Together	24
Financial Analysis	27
Appendices.....	28
Te Kokiri – Leading Challenges and Actions	28
Glossary of Terms.....	28
Abbreviations	32
Guiding Principles.....	32
Range of Services.....	33
Our Partner Agencies.....	34
Our Population	35
References.....	36
The Journey Forward Logo	37

Introduction

It is predicted that nearly one in two New Zealanders will have some kind of mental health experience and or addiction problem by the age of 75 years. Mental health problems on this scale have major implications. To meet the population needs, a truly integrated approach to service delivery across a range of supports and services – promotion, prevention, treatment, rehabilitative and supportive – and a new level of coordination and connectivity is required.

C&CDHB is responsible for the funding of health services, and for the provision of hospital and related services for the people of the Wellington, Porirua and Kapiti regions as set out in the New Zealand Public Health & Disability Act 2000.

The Journey Forward Action Plan 2011-2014 provides guidance and direction to C&C DHB as it reconfigures mental health and addiction services, and responds to the mental health needs of our community. This Action Plan continues to progress The Journey Forward 2005 – 2010 Plan with the two key directions that mental health and addiction services should be primary care focussed and recovery oriented. This approach was reconfirmed through a series of forums held with service users and service providers during 2010. The Journey Forward Action Plan (Action Plan) has been developed in conjunction with service users, DHB and NGO providers and planners and funders.

This Action Plan sets the next steps for progressing the broad direction and framework of The Journey Forward Service Development Plan 2005-2010. The Action Plan identifies specific actions, timeframes for achieving the actions and measureable outcomes for each action.

In developing this Action Plan, consideration has been given to the C&CDHB population characteristics and mental health and addiction needs, the services currently funded, national, regional and local strategies and projects, feedback from people who use our services, their families and providers of mental health and addictions services within the district.

The vision underpinning this Action Plan is a society that promotes mental well being and resilience; mental health services that promote recovery. The population outcomes developed with the sector have been used alongside our guiding documents to provide a framework to present planned priority actions and to relate these to the wider DHB outcomes.

We have a commitment to improving health outcomes by ongoing review of our progress against targets and service delivery. Our priorities in the C&CDHB District Annual Plan 2009/10 – 2011/12 are:

- Developing integrated systems of health service delivery
- Intersectoral approaches
- Regional collaboration
- Responding to demographic change
- Primary care
- Value-for-money.

These priorities also reflect those identified by the mental health sector in our region through a series of forums in 2010.

Scope

The Action Plan continues to progress The Journey Forward Service Development Plan 2005 - 2011. The Action Plan is a guide for planners, funders, providers and service users (tangata whaiora) of mental health and addiction services. The Action Plan brings together the strategic directions of a number of foundation documents, including *Te Tahuu*, *Te Kokiri*, *Our Lives in 2014*, *The Central Region Strategic Plan for the Development of Mental Health And Addiction Services* and the *Capital and Coast DHB Strategic Plan*. The Action Plan aligns these foundation documents with the aspirations of local mental health and addiction service users (tangata whaiora) encompassing disabled people and those with additional health issues, and services, and outlines steps to improve and extend services for C&CDHB population, with a particular emphasis on addressing wider system issues.

Strategic Documents¹

A range of documents guide the development of this Journey Forward Action Plan. These include but are not exclusive to:

- Te Tahuu: Improving Mental Health 2005 - 15: The Second NZ Health and Addiction Plan and Te Kokiri commit the Ministry of Health and District Health Boards to building and broadening the range and effectiveness of services and supports that are funded for people severely affected by mental illness and/or addiction. Te Kokiri also commits DHBs to strengthening linkages between specialist services and primary care.
- Te Puawaitanga: Maori Mental Health National Strategic Framework
- Mental Health and Addiction Action Plan 2010
- Our Lives In 2014: A Recovery Vision From People with Experience of Mental Illness
- The New Zealand Disability Strategy: Making a World of Difference – Whakanui Oranga
- UN Convention on the Rights of Persons with Disabilities
- Kotahi Tatou: Valued Lives, Full Participation-Implementing the New Zealand Disability Strategy (C&CDHB)
- The Primary Health Care Strategy
- Service Coverage Schedule
- C&CDHB Strategic and District Annual Plans
- Central Region plans such as the Clinical Services Plan and the Eating Disorders Plan.

The actions in this plan address the strategic aims and sector recommendations, and are also consistent with progressing Te Kokiri and other strategic documents. Service providers in conjunction with service users will work more closely together to jointly develop solutions to problems, and to work towards improving outcomes for people with experience of mental health and addiction problems.

Future Directions in Mental Health

We expect to see the following changes in services available to C&CDHB population over the term of this Action Plan.

For the Whole Population:

- Services are responsive to need and population changes, address disparities and barriers
- Distribution of and access to services is equitable and accessible across whole of life
- Whanau Ora models are supported
- Increased inter-sectoral collaboration is evident
- Services are aligned to the Service Coverage Schedule
- Shift away from supported community residential mental health services towards more provision of services to people in their own homes.

For the Service User

- Accessible, responsive, reliable services for individuals and their families/whanau
- More participation of people in their own recovery and development of resilience
- Service users receive most effective and efficient services to recover and develop resilience
- Evidence based services are matched to assessed need
- Individuals receive safe, high quality and culturally responsive services
- Service users are well informed about their treatment and support choices
- Services are integrated and collaborative for the benefit of individual service users
- Services are realigned to meet the changing demographic of the population, i.e. a reduction in general adult services with increases in services for children and youth, older people, Pacific people and people with alcohol and addiction issues
- Primary care is the constant provider with access to specialist mental health and addiction as need arises.

¹ References in appendix

Providing Value for Money

- Comprehensive and integrated system
- Transaction costs are minimised
- improved delivery against contracted volumes and improved productivity
- Information is shared appropriately
- Robust purchasing and evaluation framework including increased purchasing of services based on outputs and outcomes
- Services align with population need and service coverage requirements.

Priority Populations²

- Children and youth
- Older people
- People with alcohol and addiction issues
- Pacific people.

Projected growth of the C&CDHB population to 2021³ shows the 0-19 year group is expected to remain at a similar level, with a 9% growth in the 20-64 year group. There is 47% growth projected in the 65+ year group.

Utilisation of mental health and addiction services by Maori is significantly higher than their percentage of the population – in each of the 5 year age group in the 10-60 year age range Maori account for 2% of all mental health service users but only account for 0.5 – 1% of the population. This means Maori are accessing mental health services at twice the rate of other population groups. Conversely Pacific people are accessing less than their percentage of the population in almost all age groups and are therefore a priority group. It should be noted that utilisation does not necessarily reflect need.

Other ethnicities access services at a similar rate to all ethnicities with those younger than 10 years and between 50 – 75 years using less than their population share. When this information is considered with the projected growth in the over 65 year age group, the priority groups in this graph are children and youth and older people.

When utilisation of DHB specialist mental health services is compared to twelve month prevalence in Te Rau Hinengaro, it shows higher provision of services for mental health service users than for addiction service users. To realign access to this estimated prevalence, a reduction is required in adult mental health service provision, with an increase in people accessing substance use/ addiction services.

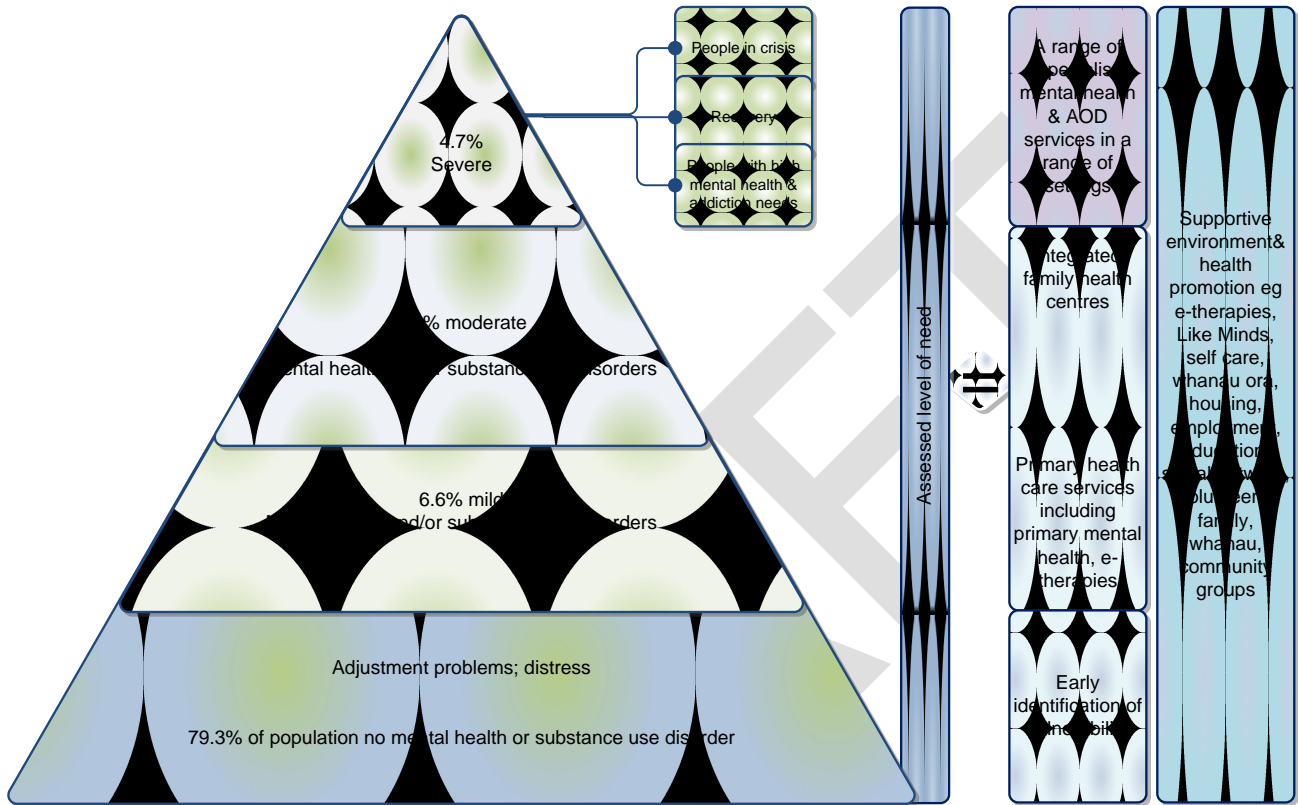
Priority populations for service development are alcohol and other addictions, children and youth, older persons, and Pacific people. However our financial situation means that to enable investment in these populations, we must first reconfigure general adult services. Therefore while there are a number of actions that are relevant across the sector, there is a predominance of actions related to the general mental health adult population accessing specialist mental health and addiction services.

²

³ Census population data projections.

Range of Services

People experience mental health and addiction problems at different levels of need and a range of services and responses are required to address these needs. When a full range of services are available, people are more likely to be able to access early intervention and crisis services at times appropriate to their need. People's needs change, and they may need to access treatment and support from different services at different points in time.



Stepped Care Model. See appendix for a larger version of this diagram

The majority of the population have no mental health and addiction problem, and for this group the key actions are the promotion of mental health and well being, reducing risk factors, providing information about mental health and addiction problems and reducing stigma. Approximately 20% of the population have a high risk of developing a mental health problem, and of these many will self manage or be managed in primary care with additional support from specialist services, and family and whanau will receive support and education. Approximately 4.7% of people experience extreme distress, and may require specialist assessment and treatment through crisis teams and respite, or acute admission⁴.

Regardless of the level of mental health and addiction need, the main care and support needs to be in primary care with specialist mental health and addiction advice and support as and when required. A range of treatment, and support options need to be available across a range of services. As a person needs change, they may require to access support from different parts of the range of services at different points in time. This means that the range of service requires to be supported by common service protocols and procedures, and clear roles and responsibilities for what they provide. There is an emphasis on collaboration between services and agencies rather than provision of services from one organisation.

A stepped care model as shown in the illustration above is one in which:

- There are interventions of different levels of intensity available to the service user
- The service user's needs are matched with the level of intensity of the intervention

⁴ Evaluation of the Primary Mental Health Initiatives: Summary report 2008.

- Service users usually move through less intensive interventions before receiving more intensive interventions (if necessary)
- There is careful monitoring of service user outcomes, allowing treatments to be 'stepped up' if required
- There are clear referral pathways between the different levels of intervention
- The importance of supporting self care is recognised as an important aspect of managing demand (Chapple & Rogers 1999).

The *Blueprint for Mental Health Services in New Zealand: How things need to be (1998)* provided a plan for a well functioning mental health and addiction system to ensure adequate and appropriate treatment and support for those affected most severely by mental health and addiction problems. It outlined a recovery approach in service delivery and excerpts relevant to this Action Plan are shown below.

Service users need to be able to move easily from one service to another, whether they be general health or mental health services, or services provided by other sectors. (p. 7)

Over time, there needs to be a shift away from residential services towards more provision of services to people in their own homes." (p.37)

"No single service model is the most appropriate in all situations. What is best will vary according to local needs and conditions. Local funding and service provision decisions must be based on meeting local needs in the most effective, flexible, innovative, and creative ways, so as to deliver the best possible recovery for service users.

The Commission expects the focus to be on the changes needed to achieve the best possible outcomes for those accessing mental health services in each locality, not on locking into any particular service model or set of numbers. Always, we need to seek better ways of doing things. The Commission's resource guidelines should not stifle local innovation. (P.30)⁵

This Action Plan it is recognised that the full range of services is essential, however the priority for action over the next three years are those services which support service users experiencing moderate and severe mental health issues. Primary care services are not the focus of this Action Plan, but alignment of primary care services with the services in this plan is crucial.

Determinants of Mental Health

In "Our lives in 2014", the vision expressed by service users was:

"In 2014 all tangata motuhake in New Zealand have personal power, a valued place in our whanau and communities, and services that support us to lead our own recovery."

For people with mental health and addiction problems to recover, develop resilience and rebuild their lives they need access to those social, economic, educational, recreational and cultural opportunities, and physical health services, that most citizens take for granted.

Service users express their key requirements for recovery and mental wellbeing as housing, employment, meaningful hobbies, family/whanau and medication/ treatment and support. Therefore many of the key factors that affect our mental well being are the responsibility of other government agencies. The role of health relies on influencing other agencies responsible for these determinants and the provision of linkages to these agencies such as housing, employment, disability services and social networks. A wide range of government agencies (including housing, employment and education) contribute to the Government's overall aim for mental health and well being.

Currently the DHB is purchasing a number of services that are fundamental to mental wellness but are the responsibility of other agencies to assist service users with their recovery and development of resilience, e.g. many NGOs work with service users to find suitable accommodation, assist them with training and in their search for employment. Without these important supports in their lives, service users, including those who have additional impairments will face barriers to recover their mental wellbeing and develop resilience. The DHB has accountability through the Service Coverage Document and Crown Funding Agreement to link

⁵ Blueprint for Mental Health Services in New Zealand: How Things Need to Be, 1998. 51

service users to these services. The DHB can assist with navigation to the appropriate resource in other agencies, and with closer inter-sectoral collaboration provide a joined up approach where targets are shared across different sectors, e.g., for getting people back to work, utilisation of health services and adequate housing available.

Housing

While the provision of suitable housing for mental health and addiction service users is outside the scope of health funding by the Government, it is a key determinant of mental wellbeing.

“Housing New Zealand Housing New Zealand Corporation is a Crown agent that provides housing services for people in need. It provides access to decent homes, helping New Zealanders to manage their own circumstances and contribute to community life”⁶.

Housing New Zealand’s indicates on its website that over the next 3 years it plans to:

- Ensure that housing provision is independent of support services wherever possible, but that people can access most levels or types of support within or while retaining their own home as appropriate
- Ensure tenure security for disabled people and those with mental health and addiction problems, including those that require residential care or hospitalisation
- Enable easier access to suitable existing state and privately owned housing through a best matched system
- Consider the need to enhance housing support and advocacy services for disabled people and those with mental health and addiction problems.

Employment & Meaningful Activities

“Work and Income (WINZ) provides financial assistance and employment services throughout New Zealand. WINZ offers a single point of contact for New Zealanders needing job search support, financial assistance and in-work support”⁷.

Working Together

Effective mental health services require service users, providers across the health sector, other agencies and communities to work together to enable service users to achieve the recovery goals they set. A framework that brings together choice for service users and partnership between service users, providers and agencies provides:

- The active involvement of service users and their families/whanau where appropriate
- Demand and capacity
- A mix of clinical and non clinical skills in conjunction with job planning.

Services can then do the right things utilising the right people at the right time. This approach is tailored to individuals, ensures consent and choice and incorporates service user centred planning and evidence based practice.

Working together improves services to service users by:

- Focusing on engagement, therapeutic alliance, choice, strengths, goals and treatment and support planning
- Improving access by ensuring timely appointments that are fully booked e.g. no waiting lists
- Ensuring service users are seen by the right person with the right skills
- Using outcome measures
- Facilitating transparency of capacity and services.

This means increased collaboration between providers, agencies and social and volunteer groups is essential, and that no one provider will necessarily provide all aspects of treatment and support for a service user – each provider will ensure that service users are supported to engage with the right agencies, providers and natural supports to enable them to achieve their recovery goals.

⁶ Housing New Zealand website – see appendix for more detail.

⁷ Work and Income website – see appendix for more detail.

This collaborative approach reflects the Whanau Ora initiative where whanau have a practitioner to work with them to identify their needs, develop a programme of action to address them and broker their access to a range of health and social services. A holistic approach is needed, especially for Maori for whom whanau, physical and spiritual health are inextricably linked to psychological health and life. Whanau Ora is an inclusive approach to providing services and opportunities to whanau across New Zealand. It empowers whanau as a whole, rather than focusing separately on individual whanau members and their problems. Whanau Ora is not a one size fits all approach. It is deliberately designed to be flexible to meet family needs.

Technology can be used in innovative ways to support primary mental health care such as supporting the use of electronic therapies, and increasing use of electronic sharing of medical records (appropriate levels of sharing and access).

The interface between primary and specialist mental health services is very important and can help to determine how a stepped care approach could work.

Through out all actions we are committed to looking at ways that we can support disabled people and include better support to their families. We have a commitment to The United Nations Conventions on the Rights of Persons with Disabilities⁸, and this is supported by C&CDHB's Kotahi Tatou: Valued Lives, Full Participation - Implementing the New Zealand Disability Strategy and the United Nation Convention on the Rights of Persons with Disabilities in our District 2010 – 2015.

Key Challenges:

Key challenges in mental health and addiction services are:

- To strengthen the way services and agencies work together at a system level to meet the needs of mental health and addiction service users and their families/ whanau within C&CDHB's population
- To ensure effective and efficient recovery focussed mental health and addiction services that benefit service users and their families/ whanau
- To foster a culture where the needs of mental health and addiction service users and their families/whanau are heard and addressed collaboratively by the sector.

⁸ See appendix for reference and further information.

Action 2014

Our planned priorities for action 2011-2014 are:

DHB Priority	Mental Health & Addiction Priority
Improving health and reducing inequalities	<ul style="list-style-type: none"> • Shared assessment and planning processes • Realign services to meet identified population need and national requirements • Reconfigure supported accommodation and community services
Integrated delivery of services	<ul style="list-style-type: none"> • Single point of entry and transition between services • Shared electronic health record
Financial and clinical viability	<ul style="list-style-type: none"> • Quality information • Workforce
Improving the culture and working together	<ul style="list-style-type: none"> • Intersectional collaboration & partnerships with other agencies • Implementing local, regional and national plans

Improving the health of our local people, families and communities and reducing inequalities within our population through activities aimed at:

- Ensuring equitable and affordable access to health
- Addressing barriers to health and disability services
- Encouraging healthy lifestyles and environments.

The priorities for mental health & addictions are:

1. Shared assessment and planning processes

The assessment of individuals' mental health and addiction needs determines their subsequent pathway through services and which services and resources a service user will utilise. Service users currently undergo multiple assessments, repeating their story multiple times and involving duplication in information gathered and creating a bureaucratic burden for mental health and addiction providers. Front-loading assessment at the start of the pathway with highly skilled staff, particularly for people with complex needs, is designed to maximise the likelihood that people will be directed to the most appropriate treatment and support pathway from the outset and therefore gain fast access to effective treatment and support and reduce the need for multiple assessments.

Assessment and planning processes need to be consistent across all providers to ensure a joined up approach for service users, and considerable effort will be needed to develop a process that meets the needs of service users and the requirements' of various providers. It is expected that providers will then add to the base information from the initial assessment as needed. It needs to be an empowering process that is led by service users. The assessment and planning process is a systematic, whole systems approach that has, as its focus, the strengths, needs and goals of the service user and the family and friends. The health and social treatment and support needs of individuals need to be agreed in the context of the preferred lifestyle and aspirations of service users, their families, carers and friends. Assessments and plans will need to be reviewed regularly. Options for sharing assessment and treatment planning across agencies that work with specific populations will be considered.

2. Realign services to meet identified population need and national requirements

With consistent assessment of need, we can more readily identify the services required to support people with mental health and addiction issues. Services can then be aligned with population need and our requirements under the Service Coverage Schedule. In realigning services we will build on models that focus on recovery and resilience.

Priority populations for service development are people who experience alcohol and other addiction problems, children and youth, older persons, and Pacific people. To enable investment in these services we

must first reconfigure general adult mental health services. During this period we will build on investigative work already completed for these services to better understand services already in place, the outcomes being achieved and how these services need to be reconfigured.

3. Reconfigure supported accommodation and community services

Reconfiguring recovery orientated supported accommodation and community services will mean new ways of delivering well-connected and co-ordinated services involving primary care, DHBs and NGOs.

We will actively support people towards a life well lived, particularly a life wherever possible, where mental health and addiction services are the support rather than the focus of service user's lives. This means natural supports already available in the community are utilised as the first choice for support. For example, someone currently admitted to supported accommodation might have a short term transition package with mental health and addiction support before being supported to live in their own home.

We will increase the proportion of people supported in their own homes through reduced utilisation of supported accommodation: and increased use of mental health and addiction support as and when identified as needed. Stigma will be reduced through the use of everyday activities and supports and the change will also assist in normalising life by linking service users into natural community activities.

We will increase coordination of housing activity, such as a DHB wide housing coordination service and the implementation of friendly landlord agreements to support transition to private homes.

There will be an increased focus on transitioning people into services but particularly on discharge from one service to another. This requires collaboration between providers, agencies, families and service users, and someone to focus on helping the service user to recover, and exit from mental health and addiction services where this is appropriate.

During this period of transition, it is important to monitor the use of acute beds and work on reducing unnecessary or overly long inpatient stays. In the United Kingdom, evidence suggests that one in five admissions could be avoided, and while it cannot be assumed that this is the case in New Zealand, we should ensure that our services and any changes made do not contribute to unnecessary or overly long inpatient stays.

Actions	When	Intended Outcomes	Indicators	Who is involved (Lead/ other)	Links
1. Shared assessment and planning processes					
Develop, implement and review a common assessment process <ul style="list-style-type: none"> • Develop a shared consumer led assessment process and goal oriented recovery plan for children & youth, general adult, older people, Maori and Pacific that includes an approach for primary care and disabled people • Assessment process is a systematic, whole systems assessment that has, as its focus, the strengths and needs of the service user and the family and friends who support them. • Implement • Review & update process. 	2011 2012 2013	One story = one form <ul style="list-style-type: none"> • Services work together with service users and other agencies to provide holistic & service user centred services • Collaboration and consistency in service provision and information. 	<ul style="list-style-type: none"> • By 2014, all service users are assessed with a common service user led assessment process that includes physical, psychological, social and whanau supports that informs goal focussed recovery plan • By 2014 100% of assessments/reviews include all partnership providers in conjunction with the service user and family • HONOS (or similar outcome assessment measure) is utilised as an improvement measure and fed back to service user. 	Service users NGOs DHB	MOH AP 1.6
Develop, implement and review a single service user led and held recovery plan based on the common assessment process <ul style="list-style-type: none"> • Develop • Implement • Review and update. 	2011 2012 2013	Supporting independence by services assisting service users to focus on achieving their recovery goals and/or building resilience <ul style="list-style-type: none"> • Recovery plan is meaningful to the service user, is goal focused and consistent across all partnership providers • All people requiring partnership treatment and support will have a consumer led joint recovery goal focused plan with all those involved in 	<ul style="list-style-type: none"> • By 2014, 100% of service users have a single recovery goal oriented plan with recovery and discharge expectations identified on entry to mental health services • 90% of service users are achieving their plans in 2014 • All providers are reporting on the proportion of service users achieving their recovery goals within the planned timeframe • All service users that require a 	Service users, NGOs, DHB	MOH AP 1.6 Let's Get Real

Actions	When	Intended Outcomes	Indicators	Who is involved (Lead/ other)	Links
		<p>their treatment and support. including the service user and family /whanau where appropriate</p> <ul style="list-style-type: none"> Services focus on education, well being and recovery of service users and family – enabling, them to move on from MH services. 	<p>partnership approach will have a recovery and discharge plan within one month of entry.</p>		
2. Realign services to meet identified population need and national requirements					
<p>Carry out Know the People Planning for the C&CDHB population</p> <ul style="list-style-type: none"> Map access to services against the population by ethnicity, age, gender and disadvantaged population groups Identify which population groups receive more or less service compared to population and <i>Te Rau Hinengaro</i> Identify the barriers that result in people staying longer in services than necessary. 	<p>2011</p> <p>2011</p> <p>2012</p>	<ul style="list-style-type: none"> Mental health & addiction services are aligned with population need and service coverage requirements to deliver a comprehensive continuum of services Where possible service users will access services in a location convenient to them at the time that meets their needs. Services must be accessible for physically disabled people. 	<p>Stakeholder satisfaction shows:</p> <ul style="list-style-type: none"> At least 95% of all respondents are in the service best matched to their identified needs. 	<p>DHB P&F, All providers Service users</p>	<p>DSP I MOH AP 1.7</p>
<p>Align service specifications and contracts with service user needs and service coverage requirements</p> <ul style="list-style-type: none"> Compare current services purchased with service coverage requirements to 	<p>2011</p>	<ul style="list-style-type: none"> Services available for service user match identified need and service coverage requirements Services align with other agencies services 	<p>Service changes are complete by planned time.</p>	<p>MOH, DHB, all providers, service users</p>	<p>MOH AP 3.3</p>

Actions	When	Intended Outcomes	Indicators	Who is involved (Lead/ other)	Links
<p>identify where services are fit for purpose</p> <ul style="list-style-type: none"> • Develop relevant transition plans to align services with population need (particularly the priority populations identified) and service coverage requirements • Implement changes • Support service models that utilise natural supports in the community and are closely linked to primary care. E.g. CMHT located in primary healthcare • Carry out an environment scan. 	<p>2011</p> <p>2011 -</p> <p>2012</p> <p>Annual ly</p>				
3. Reconfigure supported accommodation and community services					
<p>Increase the proportion of people supported in their own homes through reduced utilisation of supported accommodation:</p> <ul style="list-style-type: none"> • Implement increased housing coordination • Implement friendly landlord agreements to support transition to private homes • Reconfigure supported accommodation services to meet the changing demographic needs of the population • Implement transition services • Reconfigure community support 	<p>2011</p> <p>2011</p> <p>2011</p> <p>2011</p> <p>2012</p> <p>2011 -</p>	<ul style="list-style-type: none"> • Services support service users to lead their own recovery • Actively support service users towards a life well lived, particularly a life largely without mental health services but with the support required as and when needed • Reduce stigma and normalise life by using current supports available • Once people are stable, , community based supports are available until no longer assessed as necessary 	<ul style="list-style-type: none"> • 80% of service users accessing secondary mental health & addiction services will be discharged back to primary care with a comprehensive (& meaningful to service user) health recovery plan within 12 months of entry of the service <p><u>Supported accommodation</u></p> <ul style="list-style-type: none"> • By 2014, for at least 80% of people the average length of stay in supported accommodation services is not greater than 18 months • For the other 20% in supported 	<p>DHB, NGOs, service users, primary care, other agencies</p>	<p>MOH AP 1.3</p>

Actions	When	Intended Outcomes	Indicators	Who is involved (Lead/ other)	Links
<p>services</p> <ul style="list-style-type: none"> Identify and link service users to the supports required for recovery. 		<ul style="list-style-type: none"> Natural supports already available in the community are utilised as the first choice for support, e.g. short term transition package might be accommodation in a motel or flat with mental health support Services are accessible. 	<p>accommodation there will be review of need for service through the treatment and support team, NASC, service user and NGO providers</p> <p><u>Other Community Mental Health Services</u></p> <ul style="list-style-type: none"> By 2014, average length of stay in community mental health services is not greater than 2 years (? For one episode). 		

DRAFT

Integrated Delivery of Services

- Developing our workforce to meet the changing needs of our people
- Improving information technology capability in the district
- Improving facilities across the district.
- Improving linkages across agencies and other DHBs.

The priorities for mental health & addictions are:

4. *Single point of entry and transition between services*

A single point of entry for all people entering mental health and addiction services (excluding primary care) has a number of advantages. Individuals are directed to the most appropriate service for their needs, referrals are prioritised, and access to services is more equitable.

For service users to have a seamless service experience with an easy and well informed transition between services there must be common service protocols and procedures, and clear roles and responsibilities for each service element. We must develop clear pathways with other services and agencies about who offers what, so that people are directed to the appropriate services as safely and promptly as possible. For many people with multiple, complex health and social needs it is important that services do not work in isolation. People may continue to need help and support but it does not always need to be from mental health and addiction services. The sooner services engage effectively with other systems that are part of everyday life, the sooner people are enabled to recover and exit from services safely and appropriately.

Recent needs assessment have highlighted that more than half of those in supported accommodation services are receiving services at a higher level than their assessed need, and there are anecdotal reports of people staying in inpatient services longer than clinically necessary. This suggests there are barriers to discharging to lower-dependency services, and people are remaining in costly high dependency services for an unnecessary length of time.

For transition to lower dependency services to be effective, clear service protocols and responsibilities must be jointly developed and agreed between all relevant parties. Professionals need to have confidence in the quality of less intensive services, and service users and lower dependency services need to be confident they can access specialist support when a relapse occurs.

5. *Shared electronic health record*

Sharing electronic health records provides improved continuity of treatment and support for service users as it helps health care providers, including hospitals, GPs and health centres, to securely access up-to-date information. Consideration will be given to ways that information may be accessed across agencies where appropriate. Good treatment and support becomes easier and safer when records can easily be shared to enable recovery.

Other

Other integration actions can be found in other sections such as mental health and addiction clinicians being available to community and primary providers for specialist advice. This may include rostered psychiatrist phone clinics and development of virtual teams such as Community Mental Health working in primary care.

Actions	When	Intended Outcomes	Indicators	Who is involved (Lead/ other)	Links
4. Single point of entry and transition between services					
Identify barriers and strengths to entry and exit from services for the identified priority populations.	2012	C&CDHB service users have equitable and streamlined access to and utilisation of mental health and addiction services	<ul style="list-style-type: none"> • Access to mental health & addiction services for priority populations is reflective of our districts population 	DHB provider, NGOs, primary care, other agencies	
Develop a single point of entry for all services – while any door leads to the right door, all entry (including NGOs) must go through the single point – expand role of Te Haika to include all mental health services (excluding primary care)	2012	C&CDHB service users have equitable and streamlined access to and utilisation of mental health and addiction services	<ul style="list-style-type: none"> • 100% of referrals are directed to correct service • 95% of new referrals are responded to and forwarded to the appropriate service within 7 days of referral 	DHB provider, NGOs, primary care, other agencies	
Develop a shared framework for entry and exit (transition) from all services using a partnership approach (taking into account barriers to access, referral and recovery). This will include children & youth, general adult, older people, Maori & Pacific, disabled people and will take into account primary care, NGOs, specialist services, other agencies and health services.	2012	<ul style="list-style-type: none"> • Service users experience a seamless service with an easy and well informed transition between services. • The range of services offered are supported by common service protocols and procedures, and clear roles and responsibilities for each service element 	<ul style="list-style-type: none"> • 80% of service users are satisfied with their transition between services • 100% of all people that require a choice appointment will receive an appointment time within 4 weeks of referral. 	Service users, primary, secondary and NGO providers.	MOH AP 2.3
5. Shared electronic health record					
Implement shared electronic health record if financially viable – this will include appropriate levels of access and security including recovery plans	2013	Information is shared appropriately with service users, services and agencies to enable recovery	<ul style="list-style-type: none"> • All health providers are able to access electronic clinical records of service users by 2014 	DHB, NGOs, primary care, MOH	MOH AP 1.1

Financial and Clinical Viability of Services

- Improving efficiency and productivity
- Ensuring patient and clinician safety
- Strengthening clinical governance and quality.

The priorities for mental health & addictions are:

6. Quality information

Until recently, very little data was available to determine if the services in place are making a difference to service users. The introduction of projects such as PRIMHD and the Key Performance Indicator (KPI) project means some data is starting to become available but it is still some way from enabling a population wide perspective of service effectiveness. Each provider has its own data collection systems, collects different data, and generally reports at an aggregated level. Much progress has been made recently in standardising information collected and we will supplement national information requirements with local information as needed.

An information directory maintained online will enable service users and families to access up to date information about mental health and addiction services and issues. Service users also need up to date information about treatment choices and the medicines they are prescribed and any potential side effects they might experience.

Comprehensive and comparative stakeholder feedback on all aspects of the mental health and addiction sector will enable more effective monitoring of service effectiveness and quality. A consistent set of questions that can be used in all services must be developed to enable meaningful comparisons to be made and for the information to be used to improve overall service quality.

7. Workforce

Let's get real is a framework for everyone working in the mental health and addiction sector. The framework describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services. *Let's get real* is made up of seven Real Skills, that each have three levels of performance indicators. The framework is for all people working in services irrespective of their role, discipline, type of organisation worked for, or population group their service works with⁹.

We will develop our workforce to meet the changing needs of people in the district. This will include joint training between providers to assist with common understanding of processes, relationship building, and to build skills.

Secondary and tertiary mental health and addiction services are a centre of excellence providing an easy point of contact for advice for other health services and agencies. By using specialist resource less in the direct delivery of services, and more to up skill primary care and community workers, this frees up specialist time for advice and support when it is needed. Workers in lower dependency services are provided with systematic support and consultation by mental health and addiction specialist's who should make this consultative activity a core part of their work. This approach not only improves the quality of treatment and supports to more people, but also up skills others and prevents the escalation of mental health and addiction issues developing into more costly crises¹⁰.

Peer support enables service users own experiences to be used to help others, and for people using services to join the paid work force as part of their recovery. Some evidence suggests that peer support can be particularly useful at times of transition, and to deliver support to specific populations such as minority groups and homeless people. We will look at opportunities for utilising alternative types of workforces.

⁹ Let's Get Real. MOH

¹⁰ Mental Health and the Productivity Challenge.

We will encourage providers to support service users to move through less intensive interventions before receiving more intensive interventions (if necessary). For example, primary care providers may prefer to trial short term counselling or e-therapy as an alternative/ adjunct to medication.

A range of electronic supports are increasingly becoming available on line such as:

- E-therapies in primary care
- Depression website
- Drug websites
- Peer support websites.

DRAFT

Actions	When	Intended Outcomes	Indicators	Who is involved (Lead/ other)	Links
6. Quality information					
<p>Quality improvement is supported by business as usual use of information. This includes national information initiatives such as PRIMHD and Key Performance Indicators</p> <ul style="list-style-type: none"> • Supplement national information with local information as needed • Analyse and share information with providers and through the publication of anonymised league tables of service performance measures. 	2011	Information is available to continually improve service quality, to determine local need, and to monitor and evaluate service performance.	<ul style="list-style-type: none"> • All providers report NHI level information by 30 June 2011 • Publication of league tables by 30 June 2012 • 100% of service contracts reflect expected service user & service outcomes by June 2011. 	DHB, NGOs, primary care	MOH AP 2.3 KPI project
<p>Implement methods of disseminating current mental health and addiction information including developing a process for maintaining an information directory of local mental health and addiction services, This includes links to a range of electronic supports such as:</p> <ul style="list-style-type: none"> • E-therapies in primary care • Depression website • Drug websites. 	2013	Service users are informed of possible treatment and support alternatives to support their recovery.	<ul style="list-style-type: none"> • All service users, family/whanau, providers and other agencies are able to access up to date information about the range of mental health services available • 100% of service users have access to easy to understand information on their medication, treatment and support choices and any potential side effects and interactions. 	Service users, DHB, NGOs, Primary care	MOH AP 2.5
<p>Develop a system for consistent qualitative feedback on services</p> <ul style="list-style-type: none"> • Develop a set of common questions to be included in all providers stakeholder surveys • Implement • Share aggregated results with sector. 	2011 2012 2014	There is comprehensive and comparative stakeholder feedback on all aspects of the mental health and addiction sector.	<ul style="list-style-type: none"> • At least 70% of service users are satisfied with the delivery and outcomes of the services they are accessing • 90% of service users reporting they have achieved their goals within their planned timeframe • All service users, caregivers and treatment providers receive a 	DHB provider, NGOs, primary care	MOH AP 2.5

Actions	When	Intended Outcomes	Indicators	Who is involved (Lead/ other)	Links
			<p>written transition summary</p> <p>Qualitative feedback will include -</p> <ul style="list-style-type: none"> Improved experience & attitude to stay in hospital, use & availability of peer support, rates of complaints, negative incidents and readmissions, LOS, MH service intervention times, attitudinal questionnaire about recovery. 		
7. Workforce					
<p>Implement Lets Get Real in all mental health services including:</p> <ul style="list-style-type: none"> Consistent competency based and joint training carried out across the sector, initially incorporating primary, secondary and NGOs Providers use the most appropriate workforce group to support service users, in some instances this will be peer support workers and in others the development of nurse practitioners may be appropriate Skill development to implement Whanau Ora approaches. 	2012	Right People - Appropriate skill mix to support population need in all services.	<ul style="list-style-type: none"> By 2014 there is joint training available for clinical and nonclinical including peer support Additional opportunities for utilising alternative workforces are identified and actioned. 	DHB Provider, NGOs, primary care	Lets get real
Mental health & addiction clinicians are available to community and primary providers for specialist advice. This may include rostered psychiatrist phone clinics and development of virtual teams such as community mental health working in primary care.	2011	Secondary and tertiary mental health services are a centre of excellence providing an easy point of contact for advice for other health services and agencies.	<ul style="list-style-type: none"> 80% of primary and community mental health and addiction providers are satisfied with availability of specialist advice. 	DHB provider, primary care, NGOs	MOH AP 1.2

Improving the Culture and Working Together

- Developing our position as a lead DHB
- Improving performance of the health and disability sector
- Actively engaging throughout the sector about addressing our health and disability support needs.

The priorities for mental health & addictions are:

8. *Intersectional collaboration & partnerships with other agencies*

In 2014 service users non health needs will be appropriately met by our inter-sectoral partners. This will necessitate the development of further partnerships with our inter-sectoral partners such as Housing New Zealand (HNZ) and Work and Income New Zealand (WINZ). Partnerships will focus on strategic brokerage for service users helping eliminate the effects of stigma for service users who need equitable access to and utilisation of these services concurrently with mental health and addiction services.

9. *Implementing local, regional and national plans*

There are many local, regional and national plans that impact on mental health and addiction service users and services. We will implement these as applicable to develop the most appropriate sub-regional configuration of mental health and addiction services for service users. We will also work with our subregional partners to make effective use of available resources (quantity and quality), maximising economies of scale and cost benefits.

Actions	When	Intended Outcomes	Indicators	Who is involved (Lead/ other)	Links
8. Intersectoral collaboration & partnerships with other agencies					
<p>Development of partnerships between the DHB and key multi-sectoral services (education, MSD, justice, corrections, CYF), focussing on strategic brokerage for our service users - a top-down approach - helping eliminate the effects of stigma for MH service users who need equitable access to and utilisation of these services concurrently with MH services. This includes:</p> <ul style="list-style-type: none"> • the development of housing coordination for mental health and addiction service users (also part of earlier action) • policies that enable service users to retain their homes while using mental health & addiction services • Training and advice for WINZ and housing staff • Advocacy and support of policies across agencies to reduce childhood abuse and promote healthy environments for children and families. This will include how the DHB can contribute to this. 	<p>2011</p> <p>2013</p> <p>2014</p>	<p>Service users non health needs are appropriately met by our inter-sectoral partners.</p>	<p>By 2014 services and agencies collaborate to ensure service users are aware of services available in wider community and have the information to access community services</p> <p>By 2012, an inter-sectoral working group has been established with the specific aim of looking at how these partnerships can help us work together better for the common good of our community target groups with similarities.</p>	<p>DHB, NGOs,</p>	<p>MOH AP 4</p>
9. Implement local, regional and national plans					
<p>Implement local, regional & national plans as applicable in the C&CDHB region including the:</p> <ul style="list-style-type: none"> • Let's Get Real • Addiction Plan • Eating Disorder Plan • Regional Mental Health and Addiction Plan • CLAW 	<p>Dates vary by plan</p>	<ul style="list-style-type: none"> • The most appropriate sub-regional configuration of mental health & addiction services is available to service users • Most effective use of resources (quantity and 	<p>Our partner DHBs (particularly Hutt & Wairarapa) work with us to determine sub-regional configuration.</p>	<p>Central region DHBs, NGOs, service users</p>	<p>Regional Plans TK</p>

<ul style="list-style-type: none">• Pacific Plan• Kotahi Tatou.		quality) with economies of scale, cost benefit.			
--	--	---	--	--	--

DRAFT

Financial Analysis

The programme of work for C&CDHB includes implementing a robust and forward looking Financial Recovery Plan focused on containment and debt reduction. Our DHB activities to ensure value for money are a key focus of our Financial Recovery Plan and can be broadly defined as those that will achieve financially and clinically sustainable health services in the long term. Key elements of this plan focus on improving efficiency and productivity and the use of performance measures in health services for the people of our district.

Across the DHB our value for money activities include:

- Investing in effective strategies (e.g. our emphasis on reducing hospital admissions and devolving services from secondary care to primary care where appropriate)
- Improved monitoring of activities and their costs. For mental health and addiction this includes service user level data collection and increased purchasing of services based on outputs and outcomes
- Focussing on service integration as a key mechanism to improve our patient management and thereby improve our operating efficiencies and resource allocations into the future. These activities will also interact together to reduce hospital admissions
- Through regional clinical services planning and collaborating with other DHBs and other providers in our region
- Evaluations/reviews of contracts and services against specifications
- Implementing the recommendations of reviews.

Any service development will be funded from reprioritisation of current mental health and addiction service funding. The actions within this Action Plan therefore need to operate within the value for money framework and within the DHBs requirement to live within its means. Each action within this Action Plan will need cost benefit analysis prior to implementation and alignment with our prioritisation principles.

How will we know if our actions are making a difference?

It is important to understand the impact of these actions on service user wellbeing and population health. It is only with quality and consistent data that we can measure intended and unintended consequences. Therefore an explicit framework with robust and meaningful measures that are consistent across the sector must be implemented to determine change in outcomes and to quantify the effectiveness of services.

Overarching measures of effectiveness will be used for all providers recognising that these are impacted on by other services that service users are using. By holding providers accountable for these overarching measures, effective relationships and partnerships that focus on service user centred treatment and support become critical elements of service delivery for providers.

Effectiveness measures for all services will include:

- 28 day readmission rates to acute services
- Length of stay in service
- Service user /stakeholder satisfaction
- The length of stay in mental health services will be reduced so that by 2014 90% of service users have an average length of stay in mental health services of no more than 18 months.
- Number of people supported to avoid the need for an acute hospital admission.

In addition to these generic indicators, each service will also have some that are specific to the type of service provided. For example, by 2014, 90% of service users are discharged to independent living within 18 months of entry to mental health recovery oriented supported accommodation services, and 1st diagnosis will be no more than one week from referral.

On a DHB wide level performance can also be considered by the gap in mortality rates between people with and without mental health and addiction problems.

Appendices

Te Kokiri – Leading Challenges and Actions

The table below summarises the leading challenges and actions from Te Kokiri.

Te Kokiri	
Leading Challenge	Specific Action
Promotion and prevention	Promote mental health and wellbeing, and prevent mental health and addiction problems
Building mental health services	Build and broaden the range and choice of services and supports, which are funded for people who are severely affected by mental health and addiction problems
Responsiveness	Build responsive services for people who are severely affected by mental health and addiction problems and/or addiction
Workforce and culture for recovery	Build a mental health and addiction workforce – and foster a culture among providers – that supports recovery, is person-centred, is culturally capable, and delivers an ongoing commitment to assure and improve the quality of services for people
Māori mental health	Continue to broaden the range, quality and choice of mental health and addiction services for Māori
Primary health care	Build and strengthen the capability of the primary health care sector to promote mental health and wellbeing and to respond to the needs of people with mental health and addiction problems
Addiction	Improve the availability of and access to quality addiction services, and strengthen the alignment between addiction services and services for people with mental health and addiction problems
Funding mechanisms for recovery	Develop and implement funding mechanisms for mental health and addiction that support recovery, advance best practice and enable collaboration
Transparency and trust	Increase the availability of information and information systems to underpin service development, support decision-making and improve services for people
Working together	Regional and national collaboration between DHBs to promote the optimal use of resources, minimise clinical risk and maximise in-demand workforce capabilities

Glossary of Terms

The definition of terms in this glossary is taken from *Te Kokiri* to ensure consistency of language and usage in practice. Minor amendments and additions have been made to reflect local input to terminology used within this document.

Access	A potential service user's ability to obtain a service when they need it and within the appropriate time.
Accountability	A personal choice to rise above one's circumstances and demonstrate the

	ownership necessary for achieving desired results; to see it, own it, solve it and do it ¹¹ . Appropriate accountability, risk and responsibility will be inherent in all aspects of mental health services.
Addiction	In the context of this plan, addiction relates only to alcohol and other drug use and/or problem gambling. It refers to a maladaptive pattern of substance use, or problem gambling leading to clinically significant impairment or distress. Substance use disorders and pathological gambling disorder are characterised by dyscontrol, tolerance, withdrawal and salience, and are considered chronic relapsing conditions.
Ageing in place	The ability to receive the support needed to remain in one's own home or community when growing older.
AoD	Alcohol and other drugs.
Assessment	A service provider's systematic and ongoing collection of information about a consumer/ (tangata whaiora) to form an understanding of consumers (tangata whaiora) needs. A clinical assessment forms the basis for developing a diagnosis and an individualised treatment and support plan with the service user, their family, whanau and significant others.
Blueprint (for Mental Health Services)	The document the Mental Health Commission developed that defines the levels of specialist mental health services as well as the changes required to implement the Government's <i>National Mental Health Strategy</i> (Mental Health Commission 1998).
Capability	An individual, organisation or sector having the right skills, knowledge and attitudes to deliver high-quality and effective mental health and addiction services.
Capacity	An organisation or sector having sufficient appropriately trained staff and resources to deliver a high-quality and effective mental health and addiction service.
Children and young people	People aged 0 - 19 years, inclusive.
Community	This refers to the area covered by the Hutt Valley District Health Board. All health services are provided in the community, including those based at Hutt Hospital.
Consumer Kaitiaki Group	The roles of the consumer kaitiaki group are guardianship of the vision and governance of the implementation of Make It Happen (Whakamahingia). The vision is expressed in Our Lives In 2014.
Consumer /Tangata Whaiora Led	The consumer's experience of, and negotiated agreements with mental health services, and governing sector development and service delivery. Consumers as narrators and negotiators.
DAP	District annual plan.
Empowerment	A sense of one's own value and strength, and a capacity to handle life's issues.
Evidence-based practice	An approach to decision-making in which the clinician uses the best evidence available, in consultation with consumers (tangata whaiora), to decide on a course of action that suits consumers (tangata whaiora) best.

¹¹ Definition downloaded from <http://www.mrotoday.com/mro/archives/exclusives/Accountability.htm>. 25 March 2008.

Family	The service user's whānau, extended family, partner, siblings, friends or other people that the service user identifies.
Health promotion	The process of enabling people to increase control over and improve their health. It involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk for specific diseases, and is directed towards action on the determinants of health.
Hua Oranga	Māori Mental Health Outcome Measurement Tool.
Know the People Planning	A planning process that looks at the health care experience for an individual (who are the people, what are their needs and how well are they being met?). This information is then applied to a total consumer group to find what is working well and what requires attention, and will be implemented across all Hutt Valley mental health and addiction services.
Integrated approach	An integrated approach addresses the continuum of need and encompasses public health approaches and intervention services.
Local leadership & advisory group	The (Hutt Valley) local leadership & advisory group (LLAG) provides sector and expert advice to planning and funding. It takes a collaborative approach to working through key issues in the sector, provides an opportunity for representatives of the sector to have free and frank discussion, and to provide and discuss solutions to issues.
Mental health	A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community (WHO 2001). Throughout the document reference to mental health services includes addiction services.
Mental health promotion	The process of enabling people to increase control over, and to improve, their health. Mental health promotion is not just the responsibility of the health sector.
Mental health sector	The organisations and individuals involved in mental health to any degree and at any level.
Mental health service provider	An organisation providing as its core activity assessment, treatment or support to consumers (tangata whaiora) with mental illness and/or alcohol and drug problems.
Mental illness	Any clinically significant behavioural psychological syndrome characterised by the presence of distressing symptoms or significant impairment of functioning.
MHINC	Mental Health Information National Collection – the national health database.
MH-SMART	Mental Health Standard Measures of Assessment and Recovery, established to assist DHBs in outcome collection processes.
MSD-CYF	Ministry of Social Development, Child Youth and Family.
NGO	Non-governmental organisation.
NSF	Nationwide Service Framework
Ottawa Charter	Ottawa Charter for Health Promotion 1986.
Outcome	A measurable change in the health of an individual, or a group of people or population, which is attributable to interventions or services.
PHO	Primary Health Organisation

Prevention	<p>Intervention that is designed to prevent mental health disorders or problems. Prevention interventions may be:</p> <ul style="list-style-type: none"> • universal – targeted to the whole population (eg, healthy cities) • selective – targeted to individuals or groups at increased risk (eg, postnatal home visits for new mothers) • indicated – targeted to individuals with early symptoms (eg, grief therapy for individuals experiencing the loss of a close relative, partner or friend).
Primary health care	<p>Essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to and a central function of the country's health system, and is the first level of contact with the health system.</p>
Problem gambling	<p>Patterns of gambling behaviour that compromise, disrupt or damage health, personal, family or vocational pursuits. In its most extreme form it is often described as pathological gambling</p>
Recovery	<p>Living well in the presence or absence of mental illness and the losses that can be associated with it. The alcohol and other drug sector have a similar yet different view of recovery, one that includes both abstinence and harm minimisation perspectives that have evolved over time, allowing consumers (tangata whaiora) a choice to adopt the approach that best represents their worldview. There is a long and generally held view that in the addictions field recovery involves an expectation/hope that people can and will recover from their addiction/unwellness, acceptance that recovery is a process not a state of being, and recognition that the recovery is done by the person addicted/affected, in partnership with the services (in the word's widest sense) providing help. A challenge faced by both the mental health and addiction sectors is the ongoing development of the concept and language of recovery.</p>
Research	<p>An organised and systematic approach to finding answers to questions.</p>
Service user	<p>A person who uses mental health services. This term is often used interchangeably with consumer and/or tangata whaiora.</p>
Specialist mental health	<p>For the purposes of this document specialist mental health refers to all those mental health and addiction services described in the Nationwide Services Framework and funded through the mental health ringfence. This includes NGOs.</p>
Tangata whaiora	<p>People seeking wellness; mental health service users. People that have experienced mental illness who are managing their wellbeing.</p> <p>The concepts of tangata whaiora and tangata whai ora align clearly with the description of recovery as both a destination and a journey. In this document we use tangata whaiora to refer to both.</p>
Tangata whai ora	<p>People that have experienced mental illness and are on the pathway towards wellbeing.</p>
Te Kōkiri	<p>To action; to activate</p>
Whānau	<p>Kuia, koroua, pakeke, rangatahi, tamariki. The use of the term whānau in this document is not limited to traditional definitions, but recognises the wide diversity of families represented within Māori communities. It is up to each whānau and each individual to define for</p>

	themselves who their whānau is.
Whānau ora	Māori families achieving their maximum health and wellbeing. This concept also extends to non-Maori families.
WHO	World Health Organization

Abbreviations

DHB	District Health Board
P&F	Planning and Funding
KPI	Key Performance Indicator
MOH AP	Ministry of Health Action Plan
MSD	Ministry of Social Development
NGO	Non-government organisation
TK	Te Kokiri
WINZ	Work and Income New Zealand

Guiding Principles

Protection of Human Rights: services should respect the autonomy of individuals, empower them to make decisions, and minimise the use of compulsion.

Maori Health: services acknowledge the important relationship that exists between Maori and the Crown under the Treaty of Waitangi, and recognise the needs of whanau.

Accessibility: services should be affordable, available locally, and acceptable to consumers.

Comprehensiveness: services should include all facilities and programmes required to address the needs of the population.

Responsiveness: services are easy to access, timely in their delivery and responsive to consumer needs.

Coordination and continuity: services should work in a coordinated manner to meet a range of social, psychological and medical needs.

Diversity: the diverse needs and expectations of individuals, ethnic groups and sectors of society should be met through a diverse workforce and a varied range of service choices.

Effectiveness: evidence of effectiveness should be used to develop and improve services.

Equity: services should aim to reduce disparities in mental health status through easy access for vulnerable groups.

Efficiency: evidence on cost effectiveness should be taken into account in developing services and allocating resources.

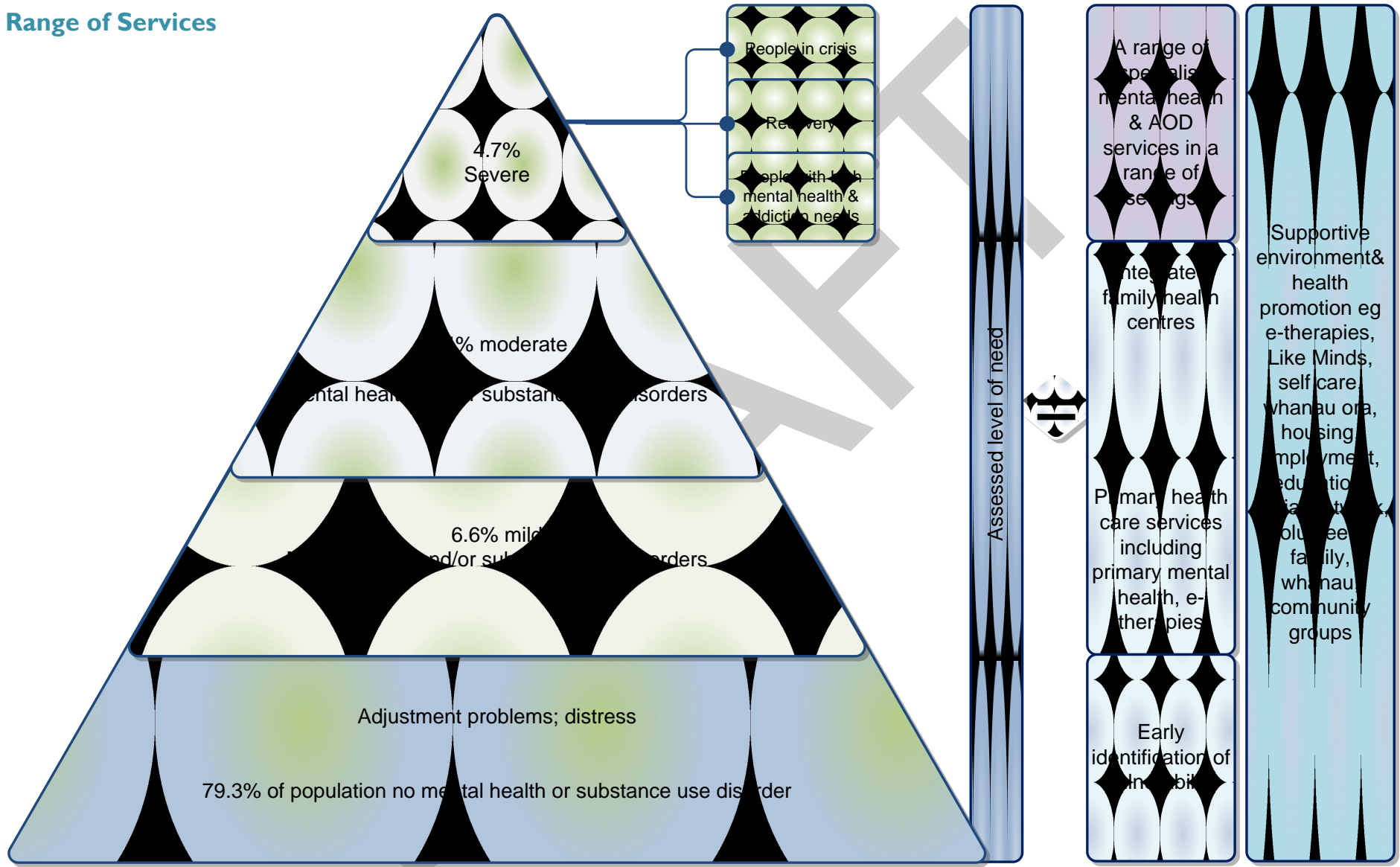
Augmentation: specialist mental health services and primary care services work along side and complement each other.

Recovery: services should aim to support people to live well in the presence or absence of a mental illness.

Community Development: people / whanau should have power over the changes that are taking place around them, the policies which affect them and the services they use.

Holistic approach: mental health and physical health needs should be met in an integrated manner.

Range of Services



Our Partner Agencies

Housing New Zealand

About us - Overview¹²

Housing New Zealand Corporation is a Crown agent that provides housing services for people in need. It is also the New Zealand Government's principal advisor on housing.

Mission:

Housing New Zealand provides access to decent homes, helping New Zealanders to manage their own circumstances and contribute to community life.

Purpose:

Our main role has traditionally been to provide good quality, affordable rental homes for people on low incomes or with special housing needs.

MSD – About Us and our Work¹³

Our responsibility as a government department is to lead social development to achieve better futures for all New Zealanders.

To do this we need strong families, healthy confident kids, safe communities and positive aging. And these results are at the heart of our business - in the research we undertake and the advice we provide to government on social policy, and in the range of services we provide to New Zealanders.

Our Ministry is all about helping to build successful individuals, and in turn building strong, healthy families and communities.

It's a big job - we're tackling some of the big issues in society, like family violence and youth offending.

We're working towards this through providing:

- Treatment, support and protection of vulnerable children and young people
- employment, income support and superannuation services
- funding to community service providers
- social policy and advice to government
- student allowances and loans.

About Work and Income¹⁴

Work and Income provides financial assistance and employment services throughout New Zealand. We offer a single point of contact for New Zealanders needing job search support, financial assistance and in-work support.

Work and Income helps people into work and pays income support on behalf of the Government. This includes New Zealand Superannuation and Veteran's Pension payments along with the administration of residential care and support subsidies.

Work and Income also administers:

- the Community Services Card

¹² Downloaded from HNZ website 2 November 2010.

¹³ Downloaded from <http://www.msd.govt.nz/about-msd-and-our-work/about-msd/index.html> on 2 November 2010.

¹⁴ Downloaded from <http://www.workandincome.govt.nz/about-work-and-income/> on 2 November 2010.

International Services
the Enterprising Communities grants programme.

We work with other government agencies, employers, business and community groups to design and run projects that generate work opportunities. These projects assist people throughout New Zealand to improve their and their family's lives through paid employment.

As part of the Ministry of Social Development we play a major role in supporting the Ministry's vision of an inclusive New Zealand, where all people are able to participate in the social and economic life of their communities.

Rental housing is still a large part of what we do. We own or manage more than 66,000 properties nationwide, including about 1,500 homes for community groups providing residential services.

We also work in many ways to improve access to affordable homes for New Zealanders.

Our Population

C&C DHB is the sixth largest DHB in New Zealand, home to seven percent of the national population. Geographically it is a relatively compact, an urban District, covering three Territorial Authorities (TAs): Wellington City, Porirua City and the Kapiti Coast south of Te Horo.

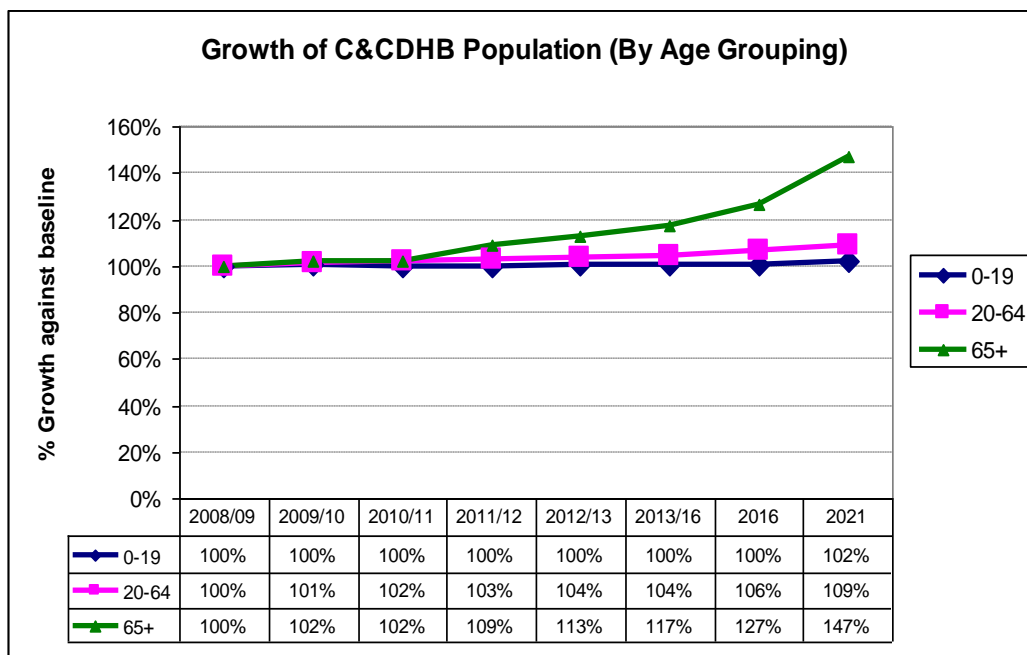
At the last census in 2006, the DHB had a population of 266,658. Two-thirds of the population live in Wellington City, with 18 percent in Porirua and 14 percent on the Kapiti Coast. There are fewer Maori (10%), more Pacific (seven %) and more Asian (nine %) than average.

Overall, the District has fewer elderly and fewer children than the national average and a large proportion of young to middle aged adults. Maori and Pacific populations have a younger age structure in comparison, with a greater percentage of children and fewer people aged over 65. The age composition differs between the three TAs:

- Wellington City has a large proportion of youth and adults aged 25-44
- Porirua City has a large proportion of children aged under 15
- Kapiti Coast has a large population aged over 65.

The graph below shows the projected growth of the C&CDHB population to 2021¹⁵. The 0-19 year group is expected to remain at a similar level, with a 9% growth in the 20-64 year group. There is 47% growth projected in the 65+ year group.

¹⁵ Census population data projections.



References

- Capital & Coast DHB. *Kotahi Tatou: Valued Lives, Full Participation - Implementing the New Zealand Disability Strategy and the UN Convention on the Rights of Persons with Disabilities in our District 2010 – 2015*. Capital & Coast DHB. 2010.
- Chapple A, Rogers A. 1999. *Self-care and its relevance to developing demand management strategies: A review of qualitative research*. *Health and Social Care in the Community* 7: 445-54.
- Disability Rights Promotion International. *Disability Rights in Aotearoa New Zealand 2010. An Easy Read Summary of the Report on the Human Rights in Aotearoa New Zealand*.
- Dowell AC, Garrett S, Collings S, McBain L, McKinlay E, Stanley J. 2009. *Evaluation of the Primary Mental Health Initiatives: Summary report 2008*. Wellington: University of Otago and Ministry of Health.
- Mental Health Commission. *Our Lives in 2014. A recovery vision from people with experience of mental illness for the second mental health plan and the development of the health and social sectors*. Mental Health Commission. June 2004.
- Mental Health Commission. *Blueprint for Mental Health Services in New Zealand. How things need to be*. Mental Health Commission, December 1998
- Ministry of Health. *Te Puawaitanga: Maori Mental Health National Strategic Framework*. Ministry of Health, April 2002.
- Ministry of Health. *The Primary Health Care Strategy*. Ministry of Health, February 2001.
- Ministry of Health. *Primary Health Care Implementation Work Programme 2006 – 2010*. <http://www.moh.govt.nz/moh.nsf/indexmh/phcs-iwp>. December 2010.
- Minister of Health. 2006. *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015*. Wellington: Ministry of Health.
- Ministry of Health. 2008. *Let's get real: Real Skills for people working in mental health and addiction*. Wellington: Ministry of Health. Published in 2008 by the Ministry of Health.
- Ministry of Health. 2010. *Mental Health & Addiction Action Plan 2010*.

Ministry of Health. *Te Tahuhu: Improving Mental Health 2005-2015. The Second New Zealand Mental Health and Addiction Plan 2005.* Ministry of Health, June 2005

Ministry of Health. *Service Coverage Requirements.* June 2010

Ministry of Health. *The New Zealand Disability Strategy—Making a World of Difference, Whakanui Oranga,* Ministry of Health, April 2001

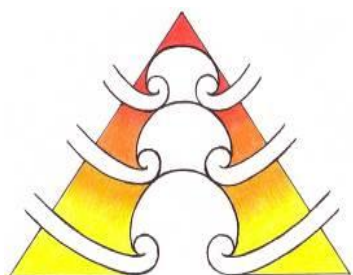
Naylor, Chris & Bell, Andy. *Mental Health and the Productivity Challenge. Improving quality and value for money.* The Kings Fund, London. 2010.

Northern DHB Support Agency. *Key Performance Indicator Framework for New Zealand, Mental Health and Addiction Services , Phase III: Implementation of the Framework. Technical Specifications for participating organisations.* July 2010

Oakley Browne MA, Wells JE, Scott KM (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey.* Wellington: Ministry of Health.

York, Ann, Kingsbury, Steve. *The Choice and Partnership Approach. A guide to CAPA.* Caric Press Ltd, Bournemouth. 2009

The Journey Forward Logo



The Journey Forward logo depicts a journey from illness to recovery and was created by Jim Wiki.

The koru signify the range of services that support the journey. Additionally, they depict reaching out for support.

The central crescents symbolize the stages of the journey as a person gets stronger. They also represent the intrinsic elements of a person; tinana (body), hinengaro (mind) and wairua (spirit). The supportive environment of the whānau (family) completes the balance of a person. This is depicted by the shape of the triangle.

The colours represent the transition from complexity (at the peak of the triangle) to enlightenment (at the base of the triangle).