DISABILITY SERVICES ADVISORY COMMITTEE

PUBLIC
Agenda

3 December 2018, 10.00am to 12.30pm
CSSB Lecture Room, CSSB Building, Wairarapa Hospital, Masterton

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS						
1.1	Karakia				10am	
1.2	Apologies	**RECORD**	F Wilde			
1.3	Continuous Disclosure - Register of Interest	**ACCEPT**	F Wilde			2
1.4	Confirmation of Draft Minutes from 10 September 2018	**APPROVE**	F Wilde			6
1.5	Matters Arising	**NOTE**	F Wilde			
1.6	Action List	**NOTE**	F Wilde			11
2 DECISION						
2.1	Mental Health Strategy 2.1.1 Living Life Well 2019 - 2025		Rachel Haggerty Helene Carbonatto Joy Cooper Nigel Fairley			13
3 DISCUSSION						
3.1	3DHB Mental Health and Addictions Improvement Programme - Acute Demand Response - Investment and Alignment - Patient Acuity and Resources - Safety and Quality - Acute Care Continuum Project - Te Whare Ahuru Reconfiguration 3DHB System Review to Suicide/Suicidal Behaviour - AOD Model of Care Project - Consumer Network Group		Rachel Haggerty Helene Carbonatto Joy Cooper			81
3.2	Whole of Life NASC update		Emma Hickson			89
3.3	Update on the Implementation of the 3DHB Sub-Regional Disability Strategy 3.3.1 Disability Dashboard		Emma Hickson Bob Francis			92
4 INFORMATION						
4.1	Sub-Regional Disability Planning Workshop	Verbal	Emma Hickson Bob Francis			
DATE OF NEXT MEETING 4 FEBRUARY – BOARD ROOM, LEVEL 11, GRACE NEILL BLOCK WELLINGTON REGIONAL HOSPITAL						

3 DHB DISABILITY SUPPORT ADVISORY COMMITTEE

Conflicts & Declarations of Interest Register

UPDATED AS AT NOVEMBER 2018

Name	Interest
Dame Fran Wilde *Chairperson*	• Ambassador Cancer Society Hope Fellowship • Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims • Chair, Kiwi Can do Ltd • Chair National Military Heritage Trust • Chair, Remuneration Authority • Chair Wellington Lifelines Group • Deputy Chair, Capital & Coast District Health Board • Deputy Chair NZ Transport Agency • Director Museum of NZ Te Papa Tongarewa • Director Frequency Projects Ltd
Yvette Grace *Deputy Chair*	• Member, Hutt Valley District Health Board (includes HAC) • Deputy Chair, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Chair, Te Oranga O Te Iwi Kainga Māori Relationship Board to Wairarapa DHB • Trustee, Rangitane Tu Mai Ra Treaty Settlement Trust • Manager, Compass Health Wairarapa • Member, 3DHB Youth SLA (Service Level Alliance) • Member, Te Whiti Ki Te Uru Central Regions Māori Relationship Board • Husband, Family Violence Intervention Coordinator and Child Protection Officer Wairarapa DHB • Husband, Community Council, Compass Health • Husband, Community member of Tihei Wairarapa Alliance Leadership Team • Sister in law, Nurse at Hutt Hospital • Sister in Law, Private Physiotherapist in Upper Hutt • Niece, Nurse at Hutt Hospital
Mr Andrew Blair *Member*	• Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector • Chair, Hutt Valley District Health Board (from 5 December 2016) • Chair, Queenstown Lakes Community Housing Trust • Advisor to the Board Breastscreen Auckland Limited • Advisor to the Board, Forte Health Limited, Christchurch

Name	Interest
	• Advisor to the Board of St Marks Women's Health (Remuera) Limited • Advisor to Southern Cross Hospitals Limited and Central Lakes Trust to establish an independent short stay surgical hospital in the Queenstown Lakes region • Former Chair, Cancer Control (2014-2015) • Former CEO Acurity Health Group Limited • Former Member of the Hawkes Bay District Health Board (2013-2016)
Lisa Bridson *Member*	• Member, Hutt Valley District Health Board (Includes HAC) • Member, 3DHB Combined CPHAC DSAC Committee • Hutt City Councillor • Chair, Kete Foodshare
Ms Eileen Brown *Member*	• Member of Capital & Coast District Health Board • Board member (until Feb. 2017), Newtown Union Health Service Board • Employee of New Zealand Council of Trade Unions • Senior Policy Analyst at the Council of Trade Unions (CTU). CTU affiliated members include NZNO, PSA, E tū, ASMS, MERAS and First Union • Executive Committee Member of Healthcare Aotearoa.
Ms Sue Kedgley *Member*	• Member, Capital & Coast District Health Board • Member, CCDHB CPHAC/DSAC committee • Member, Greater Wellington Regional Council • Member, Consumer New Zealand Board • Deputy Chair, Consumer New Zealand • Environment spokesperson and Chair of Environment committee, Wellington Regional Council • Step son works in middle management of Fletcher Steel
Prue Lamason *Member*	• Member, Hutt Valley District Health Board (Includes HAC) • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees • Deputy Chair, Hutt Mana Charitable Trust • Deputy Chair, Britannia House – residence for the Elderly • Councillor, Greater Wellington Regional Council • Deputy Chair, Greater Wellington Regional Council Holdings Company • Trustee, She Trust • Daughter is a Lead Maternity Carer in the Hutt
Mr Derek Milne *Member*	• Member, Wairarapa District Health Board • Member, WrDHB CPHAC/DSAC (30 March 2016) • Brother-in-law is on the Board of Health Care Ltd • Daughter, GP in Manurewa, Auckland
Jane Hopkirk *Member*	• Member, Wairarapa District Health Board • Member, Wairarapa, Hutt Valley and CCDHB CPHAC DSAC Committee • Member, Wairarapa Te Iwi Kainga Committee • Kaiarahi, Takiri Mai Te Ata, Kokiri Hauora • Member, Occupational Therapy Board of New Zealand (23 February

Name	Interest
	2016)
Mr Alan Shirley *Member*	• Member, Wairarapa District Health Board (includes HAC) • Member, Wairarapa, Hutt Valley and CCDHB CPHAC DSAC Committee • General surgeon at Wairarapa Hospital • Wairarapa Community Health Board Member • Wairarapa Community Health Trust Trustee (15 September 2016)
Kim Smith *Member*	• Employee of Te Puni Kokiri • Trustee for Te Hauora Runanga o Wairarapa • Brother is Chair for Te Hauora Runanga o Wairarapa • Chair, Te Oranga o Te Iwi Kainga • Sister, Member of Parliament
John Terris *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees
Sue Driver *Member*	• Community representative, Australian and NZ College of Anaesthetists • Board Member of Kaibosh • Daughter, Policy Advisor, College of Physicians • Former Chair, Robinson Seismic (Base isolators, Wgtn Hospital) • Advisor to various NGOs
'Ana Coffey *Member*	• Member of Capital & Coast District Health Board • Councillor, Porirua City Council • Director, Dunstan Lake District Limited • Trustee, Whitireia Foundation • Brother is Team Coach for Pathways and Real Youth Counties Manukau District Health Board • Father is Acting Director in the Office for Disability Issues, Ministry of Social Development
Bob Francis *Member*	• None
Fa'amatuainu Tino Pereira *Member*	• Managing Director Niu Vision Group Ltd (NVG) • Chair 3DHB Sub-Regional Pacific Strategic Health Group (SPSHG) • Chair Pacific Business Trust • Chair Pacific Advisory Group (PAG) MSD • Chair Central Pacific Group (CPC) • Chair, Pasefika Healthy Home Trust • Establishment Chair Council of Pacific Collectives • Chair, Pacific Panel for Vulnerable Children • Member, 3DHB CPHAC/DSAC
Dr Tristram Ingham *Member*	• Senior Research Fellow, University of Otago Wellington • Member, Capital & Coast DHB Māori Partnership Board • Clinical Scientific Advisor & Chair Scientific Advisory Board – Asthma Foundation of NZ • Trustee, Wellhealth Trust PHO

Name	Interest
	• Councillor at Large – National Council of the Muscular Dystrophy Association
	• Trustee, Neuromuscular Research Foundation Trust
	• Member, Wellington City Council Accessibility Advisory Group
	• Member, 3DHB Sub-Regional Disability Advisory Group
	• Professional Member – Royal Society of New Zealand
	• Member, Institute of Directors
	• Member, Health Research Council College of Experts
	• Member, European Respiratory Society
	• Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association)
	• Director, Miramar Enterprises Limited (Property Investment Company)
	• Daughter, Employee of Hutt Valley based Māori provider (Tu Kotahi Māori Asthma Trust)
	• Wife, Research Fellow, University of Otago Wellington

DRAFT Minutes of the 3DHB DSAC
Held on Monday 10 September 2018 at 10am
Level 11, Board Room, Grace Neill Block, Capital and Coast District Health Board
PUBLIC SECTION

PRESENT:

BOARD   Dame Fran Wilde (Chair)
                     Ms Lisa Bridson
                     Ms Eileen Brown
                     Mr Derek Milne *via video conference*
                     Mr Alan Shirley *via video conference*
                     Ms Sue Driver
                     Mr Bob Francis
                     Ms Sue Kedgley
                     Ms Yvette Grace *via video conference*

STAFF: Ms Julie Patterson, Interim Chief Executive, Capital and Coast DHB (CCDHB)
                     Ms Dale Oliff, Interim Chief Executive, Hutt Valley DHB (HVDHB)
                     Ms Adri Isbister, Chief Executive, Wairarapa DHB (WrDHB) *via video conference*
                     Ms Helene Carbonatto, General Manager, Strategy Planning and Outcome (HVDHB)
                     Mr Nigel Fairley, General Manager, MHAIDS (3DHBs)
                     Ms Rachel Haggerty, Director, Strategy Innovation and Performance, CCDHB
                     Ms Doris Tuifao (Minute Secretary)

PRESENTERS: Rawinia Mariner, General Manager, Mental Health & Addictions (Items 3.1 and 3.2)
                     Emma Hickson, Acting Director, Disability Responsiveness, (Items 4.1 and 4.2)

GENERAL PUBLIC: No members of public in attendance

1   PROCEDURAL BUSINESS

1.1   PROCEDURAL
The Karakia was led by Yvette Grace. Committee Chair, Dame Fran Wilde, welcomed the members and DHB staff.

1.2   APOLOGIES
Apologies received from Andrew Blair, John Terris, Kim Smith, Tino Pereira, Jane Hopkirk, 'Ana Coffey, Dr Tristram Ingham, Prue Lamason, Roger Blakely

1.3   INTERESTS
1.3.1   REGISTER OF INTERESTS
The Chair noted the amendments to her interests had not been updated.

Actions:
   1. The Chair to provide her updated information to Catherine.

1.4   CONFIRMATION OF PREVIOUS MINUTES: 18 JUNE 2018

Note item 1.4, remove 'Derek – community circles. (8:40)' from minutes, as the Committee was unsure what this related to.

1.5   TERMS OF REFERENCE

The Chair noted there was no representation from the Sub-Regional Pacific Advisory Group (SRPAG) or the Maori Partnership Board (MPB), therefore there was no quorum for the meeting to go ahead formally. The meeting went into 'an informal meeting phase'.

1.6   MATTERS ARISING

No matters arising

1.7   ACTION LIST

Item 3.1 – Report on UK Research Trip: Citizen Led Social Care and NHS Transformation

Actions:

1.   Pauline Boyles' paper to be recirculated to the Committee.

Item 1.7 – Terms of Reference

Actions:

1.   The Chair will recommend to the Board, 2 members from each advisory group be invited to attend this meeting, with a note to revisit the Terms of Reference.

2   UPDATE

2.1   VERBAL UPDATE ON KEY ISSUES:

Memorandum of Understanding **– Update from Julie Patterson, CEO (CCDHB)**

The 3 CEs are working closely at the wrap around support for MHAIDS. There are 10 projects which have been agreed, with a lot of work happening around the programme of improvement. The lead for these pieces of work are the 3 CEs, Nigel Fairley, Rachel Haggerty, Helene Carbonatto who a lot of impetus on supporting MHAIDS.

There is an issue the DHBs have become aware of from the Minister's office with a 'handbrake' type situation, with the work currently being done around integration and the structural changes. While this handbrake is underway the DHBs are still moving forward with work around:

- An agreed Vision and Strategy and how to achieve it
- Strong delivery models
- Alignment of future funding models (service models and funding models)
- Responding to MHAIDS crisis (clinicians and medicals concerns) drive by demand, service delivery model/configuration is still not correct
- Linkages to project steams (and links back)
- Review models of health care service (including integration with Primacy Care)
- Matching resources to patient activity/resource match service model
- The information from Trendcare/Care Capacity demand – learn from experiences. This work will be joined up across the 3DHBs).
- Improving safety and quality with a focus on Health
- Improvement project – held nationally
- Robust accountability project

- Each CE leading a project (so having a hands on approach)

Integration of MHAIDS

SMOs looking forward to getting the work done., There is a need to ensure development recommendations for a clear strategic direction to articulate the messages we want to get out to the community. The 3 CEs have endorsed their commitment for the strategy by taking a hands on approach for their respective DHBs, and look forward to getting this progressed.

The Committee were reassured that the Primary Health Care links are very strong in all DHBs. The work programme looks at the whole system, with a look at whole spectrum. There is work being completed on Primary Care and Mental Health interface.

Actions:

1. The Committee has requested an update report at their next meeting.

3   FOR DISCUSSION

3.1   REGIONAL ALCOHOL AND OTHER DRUGS REQUEST FOR PROPOSAL UPDATE REPORT

The paper was taken as **read**.

The Committee:

a) **Noted** the outcome of the Regional AOD RFP and endorse the recommendation to proceed to contract with Salvation Army.

b) **Endorsed** to the Board that the service proceed through the normal delegations for their DHBs.

Discussion:

1. The Committee discussed the co-design process, and asked about the consultation process. The Committee were reassured that there was a very extensive consultation process and the provider was selected for its patient/family flows and other services they provided which would link in well with the new service.

2. The Committee noted the wording of the report did not indicate the new service would support people who have significant addiction who require assistance with residential treatment. It was reinforced that this is a regional residential programme with strong community links.

Actions:

1. SIP to write a one page report for the Boards to clarify the new service, and explain the new service that will replace the service previously funded.

3.2   SUICIDE PREVENTION PROJECT ACROSS 3DHBS

The paper was taken as **read**.

The Committee:

a) **Noted** that suicide and suicide behaviour is a significant issue for our community but it is our Maori community who carry the greatest burden experiencing suicide at a rate of 18.9 compared to 10.3 per 100,000.

b) **Noted** there is funding to support the development of a suicide prevention work programme in 2018/19.

c) **Recommended** to their respective Boards the development of a whole-of-system approach to suicide prevention that extends beyond the current commitment to community based suicide prevention and postvention activity and focuses on the touch points of health services in the lives of those most at risk.

d) **Recommended** to their respective Boards to endorse the development of a response that has a zero-tolerance for suicide, seeing suicide as a preventable event in people's lives.

Discussion:

1. The CCDHB approach to this piece of work is to analyse where and how people present to our health system and who is experiencing distress, understand the current way of in which our health system responds to people presenting with distress suicidal behaviour. The DHB will also be looking at progress and evidence nationally and internationally that could work to make a difference to people who are at risk of distress and suicidal behaviour. This could include service responses, changes in models of care in how services respond to suicidal behaviour, how we work with other agencies such as Corrections and NZ Police, and how we engage with our communities.

2. The data report from the first phase will inform the scope of the second deliverable, a research document which will analyse the data, seek to understand what the key issues are where these lie within the health system including community, non-government organisations (NGOs), and primary and secondary care and what our overall response should look like.

3.3 ROLLESTON STREET DEVELOPMENT PROJECT

The paper was taken as **read**.

The Committee:

a) **Noted** the cross sectoral project with our partners (MSD, HNZ, WCC) in the development of an intensive supported living service for people with complex health and addiction needs who are homeless.

b) **Recommended** to the Board of CCDHB that they endorse the multi-agency initiative to provide support for vulnerable people with significant need in the Wellington region and become party to the final memorandum of understanding between the key parties.

Discussion:

1. The DHB is working with MSD and HNZ agencies to provide better supported social housing. This is an important initiative for community care models, to support people to be more successful, with a whole of system response. There is a similar service run out of a Naenae with a wrap-around service which is fully supported by their community.

2. It was noted that MSD would provide the wraparound service with 24-7 support. There will be a further series of public consultations in the future for the public.

4   DISCUSSION

4.1 WHOLE OF LIFE NEEDS ASSESSMENT SERVICE COORDINATION APPROACH

The paper was taken as **read**.

The Committee:

4

a) **Noted** progress on the Whole-of-Life Needs Assessment and Service Coordination (NASC) project occurring at CCDHB to develop options to improve whole-of-life approaches.

b) **Noted** the current system of NASC does not deliver the best use of resources, or the best levels of support for those clients who have complex needs over the course of their lives.

c) **Noted** the proposed model of care and investment will be presented to the December DSAC with recommendations.

Discussion:

1. The paper discussed the continuum of development information to enable options, what changes could be proposed and what will work.

2. The Committee discussed whether this assessment would be means tested, whether it was centred on people of needs, how adequate the training for complex care was and whether there were any issues.

3. The Committee was reassured that the DHB had identified the issues around processes/rules and were looking at ways to create a more integrated approach.

4. It was noted that interRAI does help with service delivery, and provides good information/understanding about what is available.

5. It was noted that the Wairarapa DHB has an integrated whole of life NASC model in place which is working well.

4.2 UPDATE ON THE IMPLEMENTATION OF DISABILITY STRATEGY

The paper was taken as **read**.

The Committee:

a) **Noted** the 3DHB Disability, Strategy and Performance Directorate (DSPD) team has reviewed its 2018/2019 work plan, and identified priorities consistent with 3DHB Sub-Regional Disability Strategy.

b) **Noted** progress on the New Zealand Sign Language (NZSL) Plan and use of Disability Alerts.

c) **Endorsed** the disability performance dashboard measures.

Discussion:

1. Bob Francis provided an update on Pauline Boyle's farewell which happened on 30 August and commented it was a fitting farewell for her. Currently going through a transition phase and will need to look at sourcing issues. Appointment to the Manager role will be made in due course.

2. The Disability Sub-Regional Forum scheduled for November will now be postponed until next year. More information to follow once details have been confirmed.

The meeting closed at 11.40pm.

5 DATE OF NEXT MEETING

3 December 2018, 10am, Lecture Room, CSSB Building, Wairarapa Hospital, Masteron.

SCHEDULE OF ACTION POINTS – DISABILITY SERVICES ADVISORY COMMITTEE (DSAC)

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
DSAC Public Meeting 10 September 2018					
1.7	**Action List** **Item 1.7 Terms of Reference**	1. The Chair will recommend to the Board, 2 members from each advisory group be invited to attend this meeting, with a note to revisit the Terms of Reference.	Rachel Haggerty		

Closed since last meeting – 10 September 2018

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
DSAC Public Meeting 10 September 2018					
2.1	**Verbal update on key issues** *Integration of MHAIDS*	The Committee has requested an update report at their next meeting	Rachel Haggerty	The report to be discussed at the December meeting.	Closed
3.1	**Regional Alcohol and Other Drugs Request for Proposal Update Report**	SIP to write a one page report for the Boards to clarify the new service, and explain the new service that will replace the service previously funded.	Rachel Haggerty	The paper was submitted to the Boards in October.	Closed
3.2	**Wairarapa DHB Mental Health & Addiction Services Review**	1. Nigel Broom to confirm what Pasifika individual feedback was received.	Nigel Broom	This is confirmed.	Closed
DSAC Public Meeting 18 March 2018					
2.2	**Mental Health and Addiction: Joint Work Programme Update**	Sharing the Consumer Leadership presentation with the 3DHB Consumer Advisory Groups and Citizens Health Council (CHC) and obtain their feedback on	SIP	On the CHC Agenda October 2018.	Closed

		how it fits with CHC's framework and recommendations.			
3.1	**Report on UK Research Trip: Citizen Led Social Care and NHS Transformation**	The Executive to develop proposals to identify how each DHB can implement the Community Circles approach.	SIP	CCDHB is leading a trial on Community Circles with a specific focus on disability and ageing in 2018/19. The findings will be shared across the DHBs.	Closed

	3DHB DISABILITY SERVICES ADVISORY COMMITTEE DECISION PAPER
	Date: 26 November 2018

Author	Marilyn Hunt, Project Manager, Planning & Funding, Mental Health & Addiction Services, Strategy, Innovation & Performance, CCDHB
Endorsed by	Rachel Haggerty, Director – Strategy, Innovation & Performance Helene Carbonatto, General Manager – Strategy, Planning and Outcomes Joy Cooper, Acting Executive Leader Planning and Performance
Subject	**3DHB Mental Health & Addictions Strategy, *Living Life Well 2019 - 2025***

RECOMMENDATION

It is recommended that the Committee:

a) **NOTES** the strategy has been developed in conjunction with a range of stakeholders including mental health consumers, Māori, Pacific, non-governmental organisations, primary health care, specialist mental health and addictions providers and other DHB staff.

b) **NOTES** the strategy is cognisant of the 2018 Government Inquiry into mental health and addiction. It is expected that the Inquiry will provide valuable insight to further inform the 3DHBs' implementation of this strategy, as well as providing additional context to ensure successful application of its underlying principles and direction.

c) **NOTES** this Strategy will be reviewed against the report from the Inquiry. If there is any malalignment the Strategy will be reviewed and the Chief Executives will provide advice to the Board Chairs if the strategy needs to be revised.

d) **ENDORSES** that the Board of each DHB adopt the 3DHB Mental Health & Addictions Strategy, Living Life Well 2019 – 2025, for release in early 2019 to support the Mental Health and Addiction Improvement Programme.

APPENDICES

1. **3DHB MENTAL HEALTH & ADDICTIONS STRATEGY, *LIVING LIFE WELL 2019 - 2025***

1. INTRODUCTION

1.1 Purpose

The purpose of this paper is to seek the 3DHB Disability Services Advisory Committee's (DSAC) approval of the 3DHB Mental Health & Addictions Strategy *Living Life Well 2019 – 2025*, attached as an appendix.

2. BACKGROUND

At present, mental health and addiction services are largely focused on providing specialist services for those with the highest need. The deinstitutionalisation process of the 1990s created a dramatic shift in how mental health and addiction services were provided, and it is timely now to consider the next shift that is required, supporting people to live their best lives well.

3.   PURPOSE OF THIS STRATEGY

The purpose of this strategy is to provide a platform for developing mental health and addiction initiatives and system change for the sub-region.

The 3DHB Mental Health & Addictions Strategy *Living Life Well 2019 - 2025* supports covering a complete continuum of care: sustaining specialist mental health and addiction, recognising the need to do a better job of providing earlier intervention when things start to go wrong, and focusing our attention on those with inequitable health outcomes.

This strategy sets the direction for mental health and addiction care in the sub-region to improve the experience and outcomes for our people, whānau and our communities and is consistent with other national and regional strategies that have been developed in recent years.

4.   PROCESS OF DEVELOPMENT

The strategy has been developed in conjunction with a range of stakeholders, outlined in the document on page 45. These included representatives from consumer, Māori, Pacific, non-governmental organisations, primary health care, specialist mental health and addictions providers and other DHB staff. Stakeholder contributions took place through a series of workshops used to identify issues and potential solutions, which were then confirmed in further forums and subsequently used to develop this strategy.

5.   TIMING

The strategy been produced with the upcoming report from the 2018 Government Inquiry into mental health and addiction in mind and it is expected that the Inquiry will provide valuable insight to further inform the 3DHBs' implementation of this strategy, as well as providing additional context to ensure successful application of its underlying principles and direction.

An approved strategy will put the 3DHBs in a strong position for responding to Government initiatives, including the mental health and addiction Inquiry recommendations, providing a platform from which to launch substantial transformative work on altering the scope of service.

This strategy will be launched in early 2019 supporting the ongoing Mental Health and Addiction Improvement Programme. The report from the Mental Health Inquiry will be available prior to the end of this year. The Strategy will be reviewed in light of this Report. If there is any malalignment the Strategy will be reviewed and the Chief Executives will provide advice to the Chairs if the strategy needs to be revised.

Wairarapa, Hutt Valley and Capital & Coast District Health Boards

Living Life Well - DRAFT

A strategy for planning and funding mental health and addiction responses

2019–2025

Contents

Foreword

This strategic plan sets the direction for mental health and addiction care in the sub-region to improve the experience and outcomes for our people, whānau and our communities.

The three DHBs seek to shift the model of service delivery, ensuring that people's needs are met over the course of their lives in the communities they live.

The publication of this plan coincides with the national review of mental health and addiction and, as a living document, the directions and proposed actions in this plan may be amended to reflect the outcome of the review.

Many people have been involved in developing this plan over a significant period of time. It is the result of collaborative efforts from a vast variety of people, including consumers, clinicians, support workers, community agencies, government agencies, and the district health board (DHB) planning and funding units across Capital & Coast, Hutt Valley, and Wairarapa districts (sub-region).

This strategy is far broader than specialist mental health and addiction services; it is a foundation for all of us with a goal of living life well: accomplishing this with resilience, a focus on recovery, and the freedom from addiction harm.

At present, mental health and addiction services are largely focused on providing specialist services for those with the highest need. This plan supports covering the complete continuum of care: sustaining specialist mental health and addiction, recognising the need to do a better job of providing earlier intervention when things start to go wrong, and focusing our attention on those with inequitable health outcomes.

There is still a lack of understanding, fear, and stigma towards people in our communities who have mental health and addiction issues. While our mental health and addiction services play an important role, the major changes required to remove the associated stigma needs to take place outside services, at a societal level. DHBs have a role in influencing such changes: striving and contributing to a society whose residents can live life well and free from addiction harm, supported by all, and a society where issues affecting mental wellbeing are recognised and acted upon before they require an intensive health system response.

Adri Isbister	Dale Oliff	Julie Patterson
Chief Executive	Interim Chief Executive	Interim Chief Executive
Wairarapa DHB	Hutt Valley DHB	Capital & Coast DHB

Introduction

Good mental health isn't just the absence of mental illness; it's how we constructively and positively cope with our lives, handle situations, relate to others, and make choices. It's about how we think, act, and feel.

Every year, one in five of us will experience a mental health or addiction problem (HDC, 2018). The experience will be different for each of us, as will the type of support we need. People's needs vary considerably, and the services that are meant to support them don't always work as well as they should.

Just as mental health and addiction (MHA) problems are part of our overall health, MHA care is an issue for the entire health and social care system – including GPs, hospitals, community services, and care homes. The future of a successful approach to MHA lies in developing flexible pathways that enable access to services from anywhere.

All health and care services need to be designed with MHA problems in mind, and all health professionals have a part to play in helping people get access to the right support at the right time.

Key to this is a greater acceptance that healthy mental wellbeing requires more than treatment with medication; it requires a holistic approach based on spiritual, psychological, physical, social, family, whānau, and community needs. This also calls for the health sector to integrate more closely and to work with other sectors as well.

The current MHA system across the Wellington region (Wairarapa, Hutt Valley, and Capital & Coast DHBs – the 3DHBs or sub-region) needs to be transformed, building on previous learnings and developments, if we are to better meet the needs of our populations. Significant progress has been made.

- We have moved from historic institutional care to services closer to the community.
- We lead the way in the health sector with supporting/enabling consumer leadership.
- We have peer-led services and leadership at more levels in the system.
- There is an increased focus on de-stigmatisation.
- A greater number of people can access community based services (non-governmental organisation, NGO; primary health organisation, PHO; and DHB) are available.

Moreover, there are better types of medication to treat people who experience mental illness and addiction problems and more information about the medications for service users. We have a wider range of services available to meet people's different cultural needs, such as marae and community-based services, some access to specialist Māori and Pacific services within the secondary and tertiary clinical services, an increased Māori and Pacific health workforce, and family and whānau mental health services.

Our sub-region is unique in hosting a range of highly specialised regional secondary and tertiary mental health services, such as forensic and eating and personality disorder services, maternal mental health, alcohol and other drug (AOD) residential services, and early intervention for psychosis. Although not a direct component of this strategy, Capital & Coast DHB also holds the

national contract for forensic coordination services for intellectual disability, for both adults and youth.

While there is more open discussion about mental illness and addiction problems, there is still quite a way to go. It can be difficult and, in some cases, life altering, to receive a diagnosis of mental illness or substance-use disorder, and the impact across the life of the person and their family and whānau can be significant.

Historically, our focus has been on supporting the population with the most severe and enduring MHA needs, identified as 3 percent of the total population. There is inequity in access, investment, and outcomes for specific groups of people, and *Living Life Well* identifies priority populations to focus on. Whilst retaining our support for those with the most complex needs, we want to focus on intervening earlier (in the life course and in the course of a condition), by providing deliberate, systematic, joined-up responses and interventions across primary health care, MHA specialists, and NGO providers. Traditionally, the area of MHA has been viewed and has functioned as a speciality, often distinctly separate from the wider health system. This view needs to change, with MHA embedded within, and working as part of, the wider health system.

> *Getting a diagnosis is life altering – it impacts everything, my house, my employment, even my insurance – my entire identity. You can't make it go away, even if it was a mistake.*

(3DHB MHA Consumer Leadership Group, personal communication, 2016)

About *Living Life Well*

Achieving better health outcomes for people with MHA problems requires action by the entire health and social sector. This strategic plan describes how the 3DHBs plan to transform MHA services between now and 2025 to improve the mental health and wellbeing of all people across the Wairarapa, Hutt Valley, and Capital & Coast regions. This plan provides guidance on what is required to meet the future needs and how to make the changes required. It brings together the strategic aims of the 3DHBs, building on previous work, such as The Journey Forward 2005 – 2011 (CCDHB), Whakamahingia (Hutt Valley DHB), and To Be Heard (Wairarapa DHB), into a single document for health and MHA services.

> *...certain individuals and groups in society may be placed at a significantly higher risk of experiencing mental health problems. These vulnerable groups may (but do not necessarily) include members of households living in poverty, people with chronic health conditions, infants and children exposed to maltreatment and neglect, adolescents first exposed to substance use, minority groups, indigenous populations, older people, people experiencing discrimination and human rights violations, lesbian, gay, bisexual, and transgender persons, prisoners, and people exposed to conflict, natural disasters or other humanitarian emergencies.*

(3DHB MHA Consumer Leadership Group, personal communication, 2016)

This strategy aligns the needs of people using mental health and addictions (MHA) services and their families/whānau with the communities they live in and the services and groups that respond to their

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needs. It is based on a people-centred[1] approach in which individuals, families/whānau and communities are served by, and able to participate in, trusted health services that respond to their needs in humane and holistic ways. The strategy has a focus on people's needs and enables individuals, families/whānau and communities to collaborate with health practitioners and health care service providers.

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[1] People-centred care aims are consistent with World Health Organization's definitions (World Health Organization, 2016).

Strategic context

This 2019 to 2025 mental health and addiction (MHA) strategy is consistent with other national and regional strategies. The New Zealand Health Strategy focuses on people achieving health and wellbeing throughout their lives, requiring a health system that knows and connects with people at every touch point, not just when they are ill or disadvantaged.

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 (Ministry of Health, 2012) is the national MHA strategy. It focuses on making better use of resources, improving integration between primary and secondary health services, cementing and building on gains for people with high needs, and delivering increased access. *Rising to the Challenge* expects earlier intervention in the life course to strengthen resilience and avert adverse outcomes.

We expect that the report from the 2018 Government inquiry into MHA will provide an update on *Rising to the Challenge'*s approach, as well as additional context for this strategy document.

The Mental Health Commission's 2012 *Blueprint II* provides a 10-year vision to improve the mental health and wellbeing of all New Zealanders. The *Blueprint II* vision, "mental health and wellbeing is everyone's business", sets the stage for a future where everyone plays their part in protecting and improving mental health and wellbeing. Founded on the understanding that mental health and wellbeing plays a critical role in creating a well-functioning and productive society, *Blueprint II* reinforces and strengthens the recovery principle, alongside the principles of resiliency and a people-centred and directed approach.

While each DHB has their own overarching strategic plans, there is a high level of consistency nationally, with common goals for MHA that include supporting living life well, resilience, and freedom from addiction.

This strategy is also consistent with the 3DHBs' *Sub-regional Disability Strategy 2017–2022*, which defines disability as "including physical, mental health, intellectual, sensory, and other impairments that hinder the full and effective participation of people in society on an equal basis with others" (WDHB, HVDHB, CCDHB, 2017).

Likewise, this strategy aligns with the recommended approach to improving care in the perinatal, maternal and infant mental health areas outlined in the 3DHBs' unpublished Perinatal, Maternal and Infant Mental Health Strategy (presented to the Community and Public Health Advisory Committee-Disability Services Advisory Committee, CPHAC-DSAC, in September 2015) (CCDHB, 2015).

He Korowai Oranga (HKO), the national Māori Health Strategy (Ministry of Health, 2014) has the overarching aim of pae ora, healthy futures, and sets the context and provides direction for this *Living Life Well* strategic plan. It includes three interconnected elements: mauri ora – healthy individuals; whānau ora – health families; and wai ora – healthy environments. The interconnection and mutual reinforcement of those elements is illustrated in Figure 1.

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Figure 1:   He Korowai Oranga framework
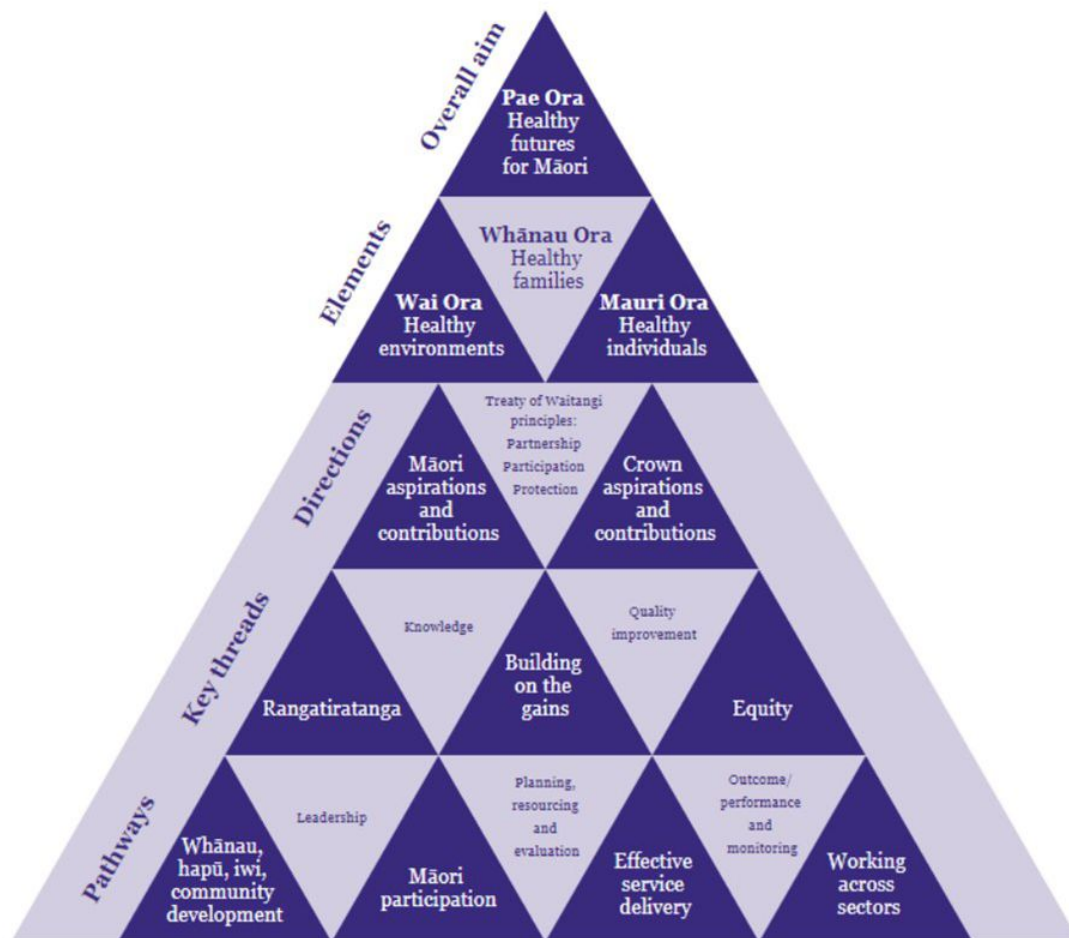
Figure 1 illustrates Māori aspirations on the left and Crown aspirations and obligations on the right. A key thread of HKO is rangatiratanga, enabling whānau, hapū, iwi and all Māori to exercise control over their own health and wellbeing. In alignment with that, this 3DHB strategy recognises that Māori are both a legitimate and an essential part of decision-making in the health and disability sector.

'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018 (Ministry of Health, 2014) is the current health strategy document for Pacific peoples in New Zealand. At the time of publication of this 3DHB mental health & addictions strategy, it is being reviewed in preparation for updating. This 3DHB strategy aligns to its core principles including respecting Pacific culture, and valuing āiga, kāiga, magafaoa, kōpū tangata, vuvale, fāmili (family) and communities as central to the way of life.

In addition, *Nga Vaka o Ka¯iga Tapu*, (Ministry of Social Development, 2012) acknowledges that "while Pacific 'cultures' share some similarities in principles and concepts, they each have specific and independent world views. Culture is reflected in the following terms: akono'ang Māori (Cook Islands), tovo vaka Viti (Fiji), aga fakaNiue (Niue), aganu'u Sāmoa (Samoa), tū ma aganuku o Tokelau (Tokelau), anga fakaTonga (Tonga), tu mo faifaiga faka Tuvalu (Tuvalu)."

There is acknowledgement internationally that health and social care systems are not sustainable in their current form, with increasing demand driving the gap between need and available resources. Many countries are rethinking the way they deliver health and social care and how the health and social care systems support the needs of their populations. Common trends include people- and place-based systems across health and social services (localities), enabling people and their families to take the lead in their own health and wellbeing, focusing on improved outcomes, and shifting away from an emphasis on treatment to prevention and early intervention, thereby avoiding expensive institutional settings (NLGN, 2016).

My issues arise in my community – why am I not looked after in my community?

(3DHB MHA CONSUMER LEADERSHIP GROUP, PERSONAL COMMUNICATION, 2016)

By focusing on localities, immediate links are formed with communities. Evidence from the United Kingdom reveals that services integrated across a geographic area result in better coordinated services and higher-quality care, alongside a reduced need for acute care (NLGN, 2016). Sharing information about the population needs amongst service providers in this locality model is central to achieving change. Such sharing includes enabling funders to shift resourcing so that communities are increasingly able to support their own health and wellbeing over time.

Moving the health system towards locality or place-based care that is more sustainable, effective, and affordable requires:

- shifting from institutions to people and places – leveraging people's capacity and local resources more effectively. This shift began in the 1990s, and requires further conscious evolution to build it up
- shifting from service silos to system outcomes – moving away from vertical silos of 'health' and 'care' to horizontal place-based systems of care
- enabling a change in focus, where possible, from national and regional to local – through policy frameworks that create a long-term environment for placed-based prevention approaches and removing blockages for health practitioners (NLGN, 2016).

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Setting the foundation

Getting the basics right – addressing equity

People using MHA services want to see significant change in the services they receive. They want to receive support before they reach a crisis point, and they want the health professionals they interact with to take a whole-person[2] approach to their treatment and recovery.

Across the New Zealand health sector, there is general agreement to the use of the World Health Organization definition of equity:

> *Equity is the absence of avoidable or remedial differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. Health inequities therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms.*

(World Health Organization, 2018)

Achieving greater equity, and reducing inequities for priority populations is a key focus for this strategy.

This strategy and resultant work to reduce inequities and improve health outcomes for Māori will align with the principles of partnership, participation and protection which underpin the relationship between Government and Māori under the Treaty of Waitangi.

This strategy draws on He Korowai Oranga (HKO), the national Māori Health Strategy, which sets the overarching framework to guide the Government and health and disability sector to achieve the best health outcomes for Māori. (He Korowai Oranga, Ministry of Health, New Zealand, 2014, p. 2)

DHBs need to consider HKO in their planning, funding and delivery of services, and in meeting their statutory objectives and functions for Māori health.

The significance of system deficiencies for achieving equity

As part of working well for everyone, the health system needs to demonstrate that it is achieving as much for its Māori and Pacific population as it is for everyone else. For example, among the responsibilities of DHBs are to reduce the disparities between population groups, improve Māori health and ensure Māori are involved in both decision-making and service delivery. (He Korowai Oranga, Ministry of Health, New Zealand, 2014). This responsibility is enshrined in the New Zealand Public Health and Disability Act 2000 as an objective for DHBs.

"The health system must work well for all New Zealanders, including Māori. As the majority of Māori continue to receive most of their health care from mainstream services, considerable effort is required to ensure that mainstream services make it a key priority to reduce the health inequalities that affect Māori and to work effectively for Māori. Within the health and disability sector, efforts

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[2] Spanning physical, mental, spiritual, cultural, social, family and whānau needs.

need to also focus on reducing risk, strengthening prevention and more effectively managing disease and long-term conditions, as well as improving overall Māori health and disability outcomes." (He Korowai Oranga, Ministry of Health, New Zealand, 2014)

Māori and Pacific should have equitable health outcomes through access to high-quality health and disability services that are responsive to their aspirations and needs. Quality improvement involves simultaneously implementing three quality dimensions:

- Improved quality, safety and experience of care

- Improved health and equity for all populations

- Best value for public health system resources

The Code of Health and Disability Services Consumers' Rights establishes the rights of all consumers, and the obligations and duties of providers to comply with the Code. It is a regulation under the Health and Disability Commissioner Act. In particular the lens of equity should come from Right 4, Right to services of an appropriate standard:

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

The legislative framework for the health and disability system and the national strategies described above underpin the need to address structural barriers to achieving health equity for our populations. These barriers include institutional racism, structural biases and workforce cultural competencies. It is vital that MHA services actively work to eliminate these system and structural barriers if we are to achieve health equity for all.   This 3DHB strategy explicitly recognises the need to address system deficiencies.

Consumer perspectives and responsiveness

Figure 2 shows the consumer perspective of the need for treatment and recovery to take a broad approach to their recovery and maintenance of wellbeing. This includes green prescriptions to support their physical health; assistance with finding meaning and purpose to support their mental and spiritual wellbeing; assistance with social needs, such as housing and employment; and consideration and assistance with family-related problems.

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Figure 2:   The consumer perspective (3DHB MHA Consumer Leadership Group 2016)
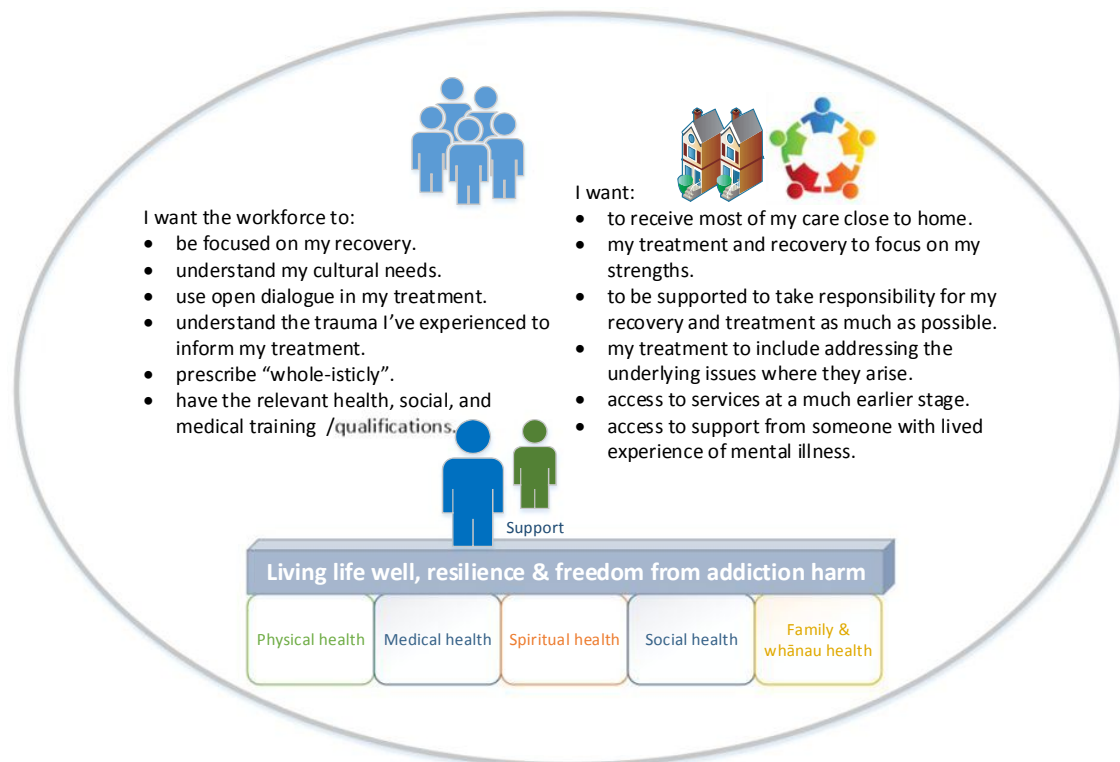
This broad approach to care is often referred to as social prescribing and enables health professionals to refer people to a range of local, non-clinical services and supports. It recognises that people's health is determined primarily by a range of social, economic, and environmental factors and seeks to address people's needs in a holistic way. The approach also aims to support individuals to take greater control of their own health (The King's Fund, 2017).

Such a holistic approach proposed by consumers asks those involved in their care to be aware of the trauma that has lead them to where they are now and to be respectful in ensuring any treatment avoids exposing the consumer to further trauma, while supporting and encouraging them to self-manage wherever possible.

Health needs assessment

The 3DHBs' *2015 Health Needs Assessment* report (WDHB, HVDHB, CCDHB, 2015) highlights the impact of mental and substance-use disorders on population health as an ongoing challenge. Approximately 15 percent of adults in the sub-region experience mental health or addiction issues, with nearly 4 percent experiencing severe mental illness and/or substance-use disorder.

Eight critical points in the development of MHA issues are identified in the *Blueprint II* life-course model. Using *Blueprint II,* we can provide a snapshot of the number of people that utilised primary and secondary mental health services in the sub-region during the 2016/17 year, mapped against the life-course clusters.

Figure 3 shows the number of people provided with MHA responses in 2016/17, mapped against the Blueprint II life course model.

Figure 3:   MHA services in 2016/17, mapped against the *Blueprint II* life-course model
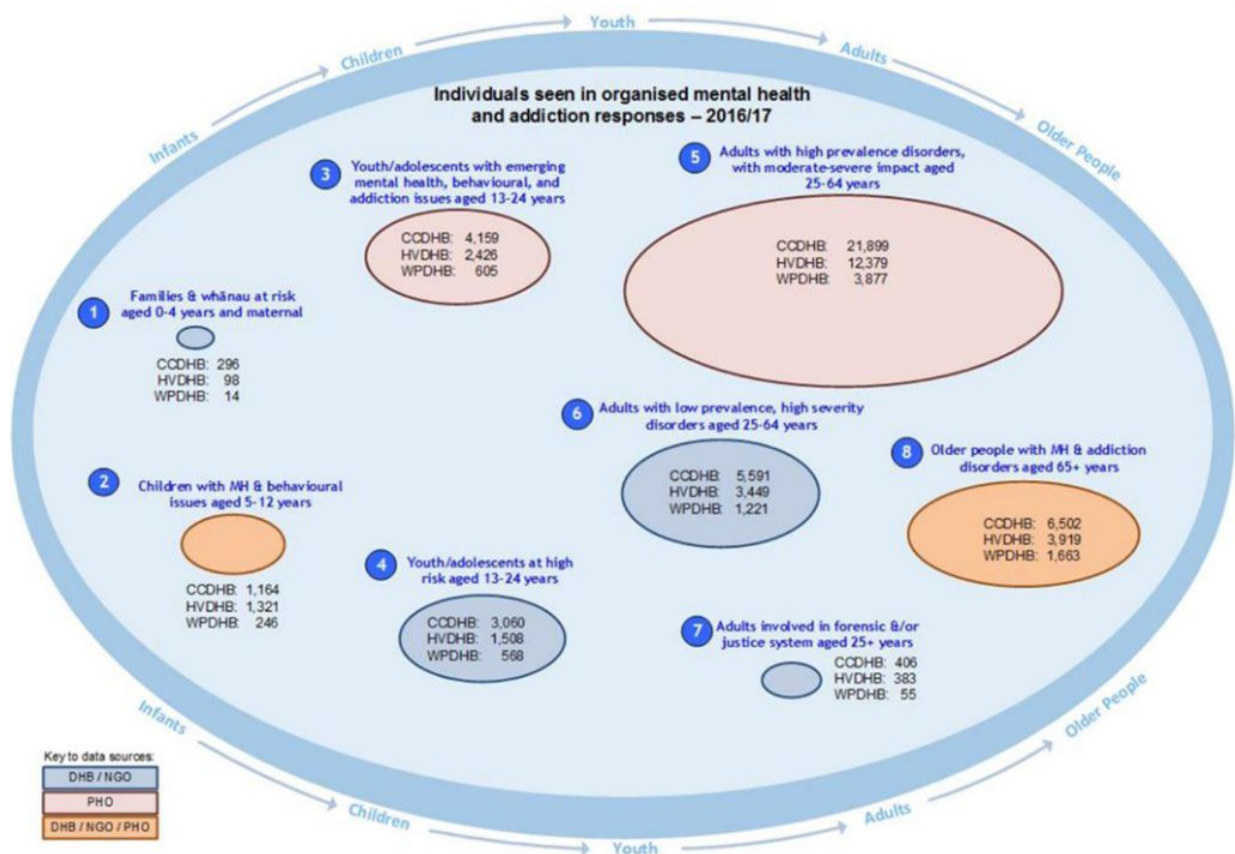
Emerging trends

Of all adults aged 20 years or over accessing MHA services across the 3DHBs in 2015/16, approximately 23 percent were considered to meet the Ministry of Health criteria for a long-term client[3]. In 2006, King and Welsh (King & Welsh, 2006) estimated that long-term users of mental health services accounted for approximately 65 percent of acute bed days and more than 90 percent of social support services provided by NGOs.

Blueprint II (Mental Health Commission, 2012a) and *Rising to the Challenge* (Ministry of Health, 2012) call for DHBs to cement gains made towards recovery and independence for long-term and complex service users. If we can meet needs and reduce demand, this would enable services to focus resources towards improving access for first-time service users and increase efforts towards prevention and early intervention. The charts in Figure 4 below show the proportion of all service users that were new clients and how this measure has been trending for each DHB in recent years.

Investigations from a New Zealand longitudinal research study (Kim-Cohen J, 2003) have found that of those adults now receiving intensive mental health services, around 78% had received a diagnosis prior to 18 years of age and around 60% received one prior to the age of 15 years.

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[3] A long-term client is a person who has had continuous interaction with MHA services for a period of 2 years or more.

Figure 4:   People accessing services for the first time[4]
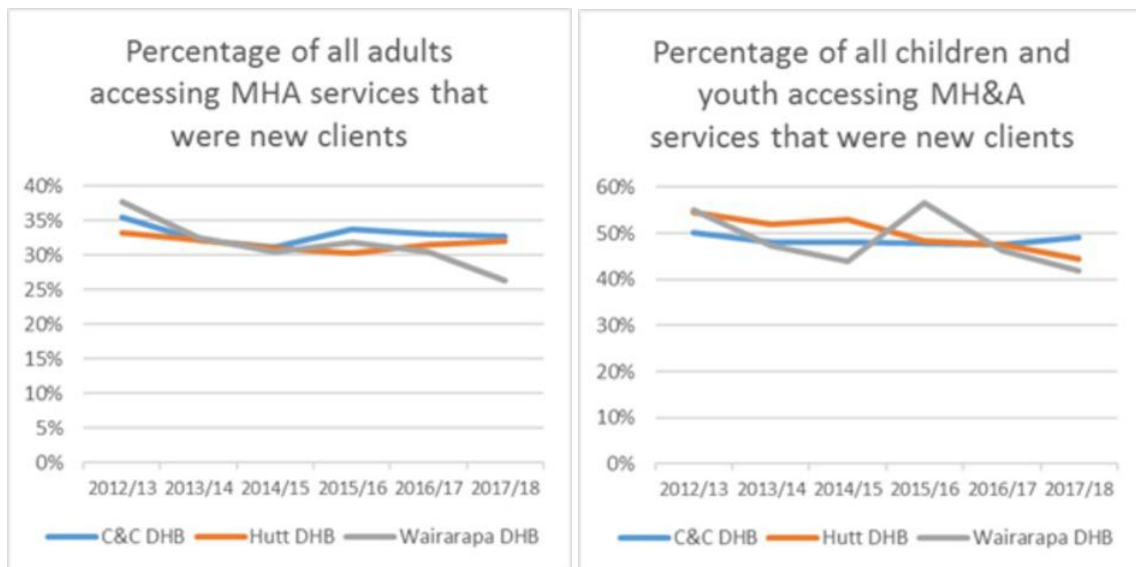
The populations we serve

Population data information is based on the population for which each DHB is funded.

Population in our 3DHBs' area is growing slowly and is projected to increase gradually in all three. The level of population growth is slower than in other parts of the country. Despite this, demand for mental health services is increasing. Our mental health services decline referrals for those people who do not meet the specified threshold, and we adjust our criteria to cope with what is available in our funding pool. We recognise that this does not serve our community completely, as there is significant unmet need.

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[4] Data taken from PRIMHD. A new client is a person who has not had any type of contact with MHA services in the previous 5 years (adults) or 3 years (child and youth).

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Wairarapa: population summary

Wairarapa DHB (WDHB) serves a population of 43,890 people (2016/17 estimate) in Martinborough, Featherston, Greytown, Carterton, Masterton and outlying rural districts.

Figure 5:   Wairarapa projected population (2018 to 2033)
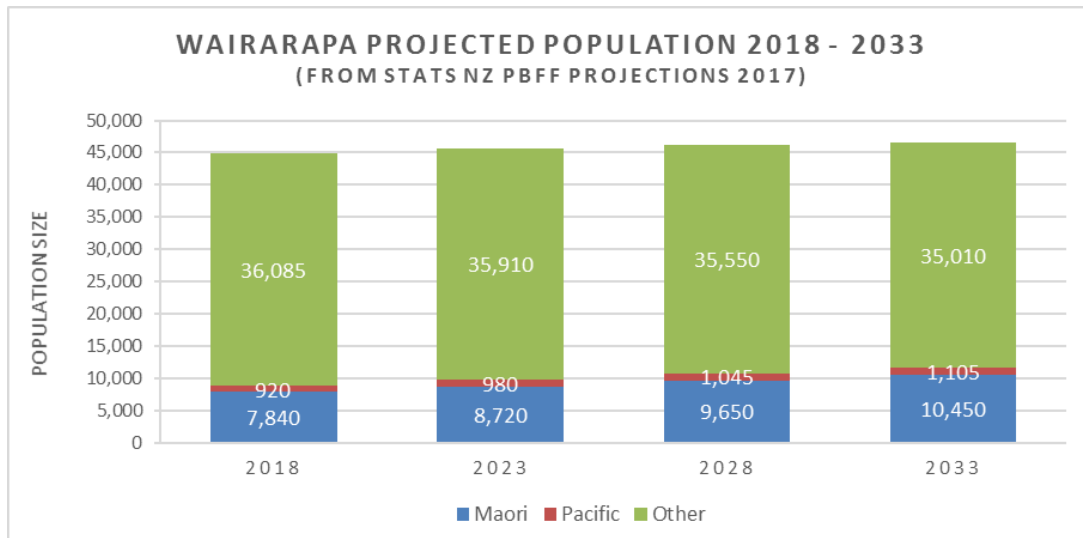
Hutt Valley: population summary

Hutt Valley DHB (HVDHB) meets the needs of roughly 147,000 citizens of Hutt City, Upper Hutt, Petone, Wainuiomata and Eastbourne.

Figure 6:   Hutt Valley projected population (2018 to 2033)
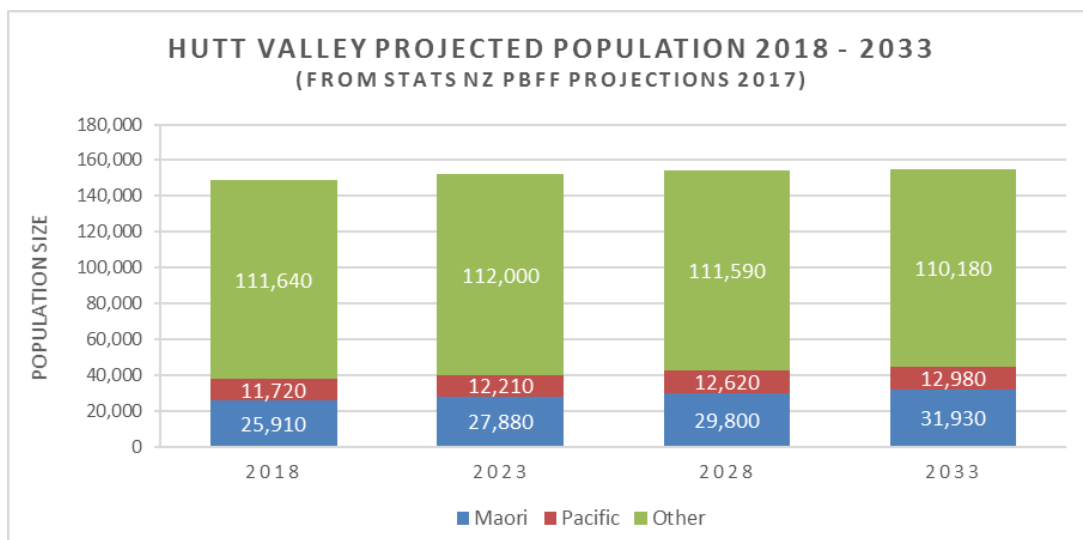
Capital & Coast: population summary

Capital & Coast DHB (CCDHB) receives funding to improve, promote, and protect the health of around 312,000 people in Wellington City and its suburbs, Porirua and along the Kāpiti Coast as far north as Ōtaki.

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Figure 7:   Capital & Coast projected population (2018 to 2033)
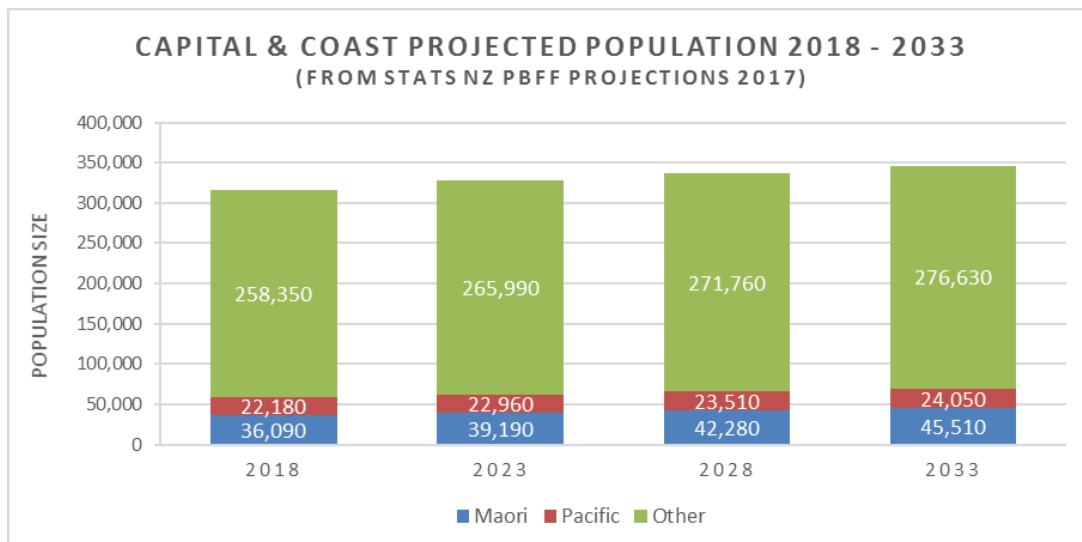
Priority populations

Consumers and their families/whānau should be able to experience the same quality of care, service experience, and outcomes regardless of who they are. Population groups who experience disparity in MHA service provision are Māori and Pacific peoples, and children and youth (HDC, 2018).

Māori

Māori experience the highest levels of mental illness and/or addiction of any ethnic group in New Zealand – almost one in three Māori will experience mental illness and/or addiction in a given year, compared with one in five in the general population. Māori are also more likely than non-Māori to access mental health services later and to experience serious disorders and/or co-existing conditions. They also have the highest rate of suicide of any ethnic group (HDC, 2018).

Māori youth have high rates of self-harm, suicide, addiction, and mental health issues, increasing the likelihood of adverse mental health and psychosocial outcomes that carry on into adulthood if early intervention, prevention, and treatment are ineffective. This is evidenced by disparity in outcomes for adult Māori who accounted for 27% of all mental health and addictions service users in New Zealand (Ministry of Health, 2018). 16% of the total New Zealand population is Māori (Statistics NZ, 2017). The overall population rate for access to mental health and addiction services in New Zealand is 3.6%, with the rate for Māori being almost double that at 6.3% (Ministry of Health, 2018).

Pacific peoples

Pacific peoples also experience mental illness and/or addiction at higher rates than others, with 25 percent experiencing a disorder within the previous 12 months (compared with 21 percent overall). The prevalence of medium to high levels of psychological distress reported over the previous four weeks was significantly higher in young Pacific peoples aged 15 to 24 (38%) and Pacific adults aged 45 to 64 years (35%) (Ataera-Minster, 2018). Pacific peoples have higher rates of

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substance abuse and gambling-related harm, with gambling-related harm four times higher than for the general population.

While the suicide rate for Pacific peoples is lower than the average for the general population, suicide is the leading cause of death amongst young Pacific peoples (aged 12 to 18 years). (HDC, 2018).

Population trends among different ethnic groups

The 3DHB Māori and Pacific populations are younger than the populations for other ethnicity groups, and our Asian population is growing.

Figures 8 and 9: 3DHB Māori population 2018 and 2028 (taken from Stats NZ PBFF projections)
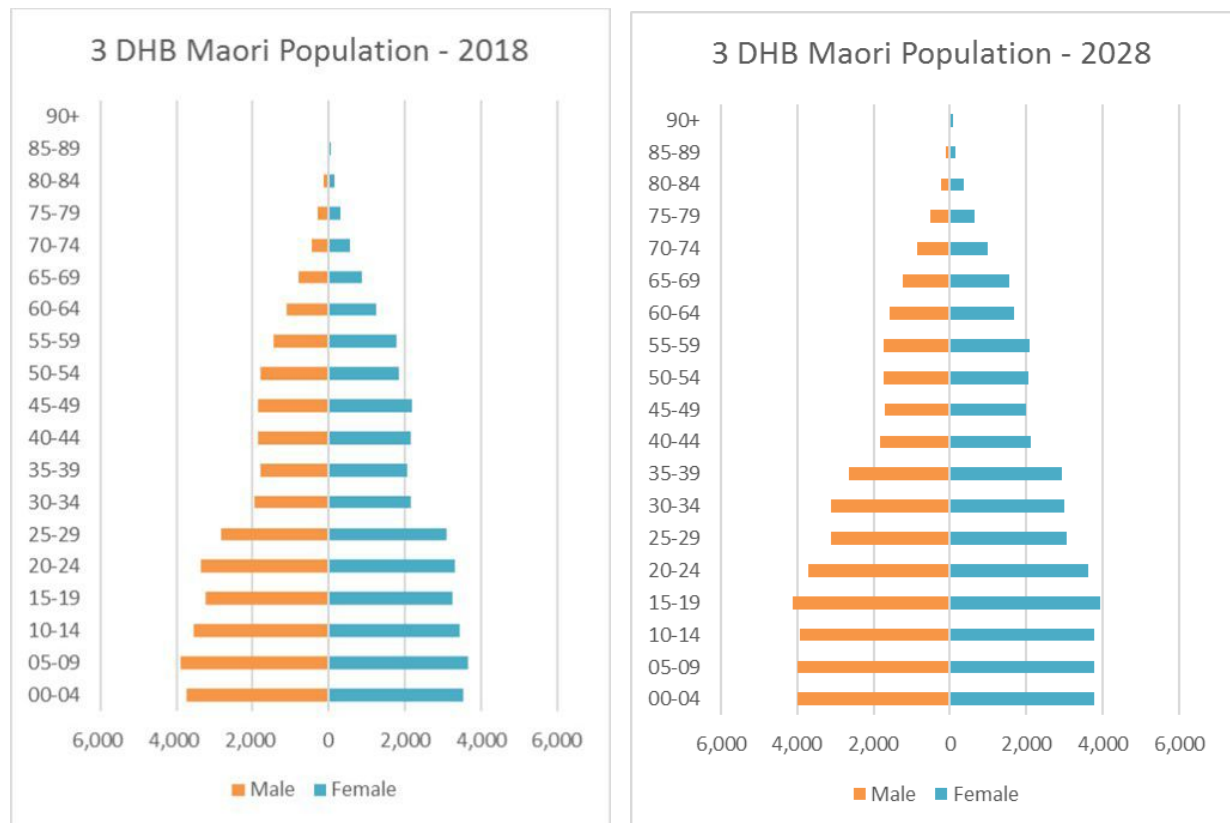
The following graphs illustrate the access rates for Māori and Pacific into 3DHB mental health and addictions services (both provider arm services, Mental Health, Addictions and Intellectual Disability Services / Te Upoko me Te Karu o Te Ika – MHAIDS, and Non-Government Organisations - NGOs), over the last 4 years. Clearly the Māori population are over represented in our service, and we need to we need to ensure equitable health outcomes for Māori through access to high-quality services that are responsive to their aspirations and needs.

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Figures 10 and 11: WDHB, percentage of consumers of Māori and Pacific ethnicity accessing MH&A services (taken from PRIMHD)
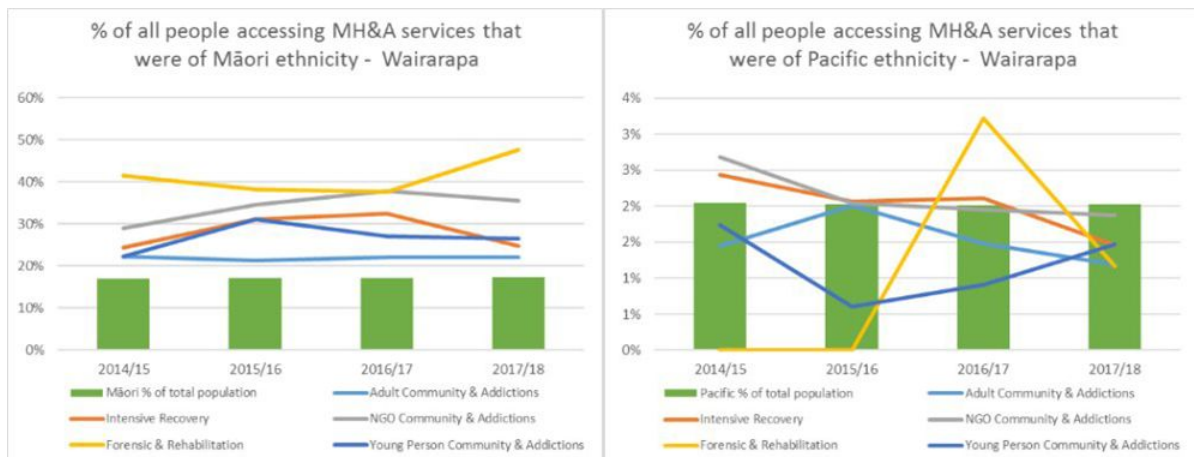
Figures 12 and 13: HVDHB, percentage of consumers of Māori and Pacific ethnicity accessing MH&A services
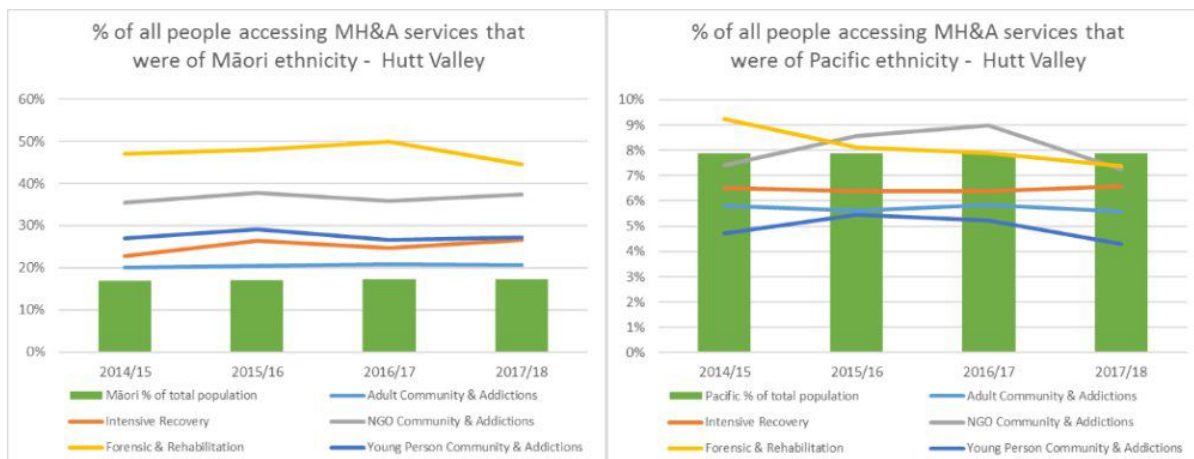
Figures 14 and 15: Capital & Coast, percentage of consumers of Māori and Pacific ethnicity accessing MH&A services
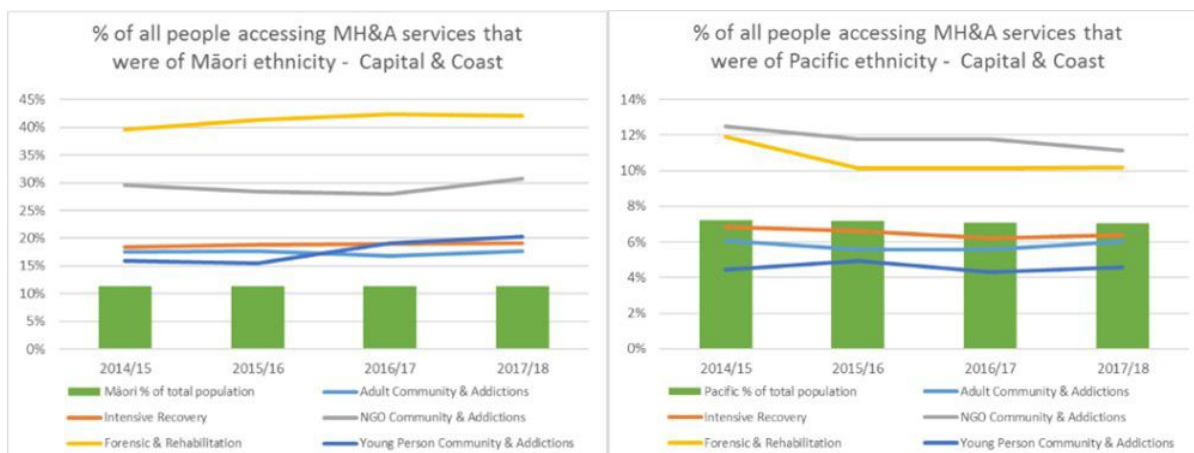
Infants, children, and young people

Childhood events and experiences can have a major impact on a person's future health. Many adult mental health and/or addiction problems have origins from childhood, with 50 percent of those problems becoming apparent by the time a person reaches the age of 18 years.

Depression is the leading risk factor for youth suicide, and New Zealand has the highest youth suicide rate in the Organisation for Economic Co-operation and Development (OECD), with suicide accounting for 35 percent of deaths for the 15- to 19-year-old age group.

Addiction

Issues of dependence and addiction can impact on a broad range of people. In New Zealand, around 12 percent of the population are estimated to experience a substance-use disorder in their lifetime (NCAT, 2016). More than 70 percent of people who attend addiction services are estimated to also have a mental health condition, and over 50 percent who attend mental health services are estimated to have substance-use problems (HDC, 2018).

Addiction intervention, much like mental health intervention, is largely focused on specialist addiction services for those with the most severe needs. There is huge unmet need in this group, with an estimated 50,000 people nationally wanting help with their severe substance-use problems but not receiving it. Services are overextended, and people struggle to find the help they need at the time they need it (New Zealand Drug Foundation, 2017).

Coupled with this, there is a much larger group of people who are not necessarily dependent (or severely addicted) but who are experiencing harm related to their problematic use of substances. For example, one in five (19 percent) New Zealanders aged 15 years or more who drank alcohol in the past year has a potentially hazardous drinking pattern that could result in significant harm to them and their families/whānau (Ministry of Health, 2013). While the harm may be serious, the use of alcohol may not be serious enough to receive a diagnosis of substance-use disorder or to warrant access to specialist addiction services. This group of people is currently underserved and has limited access to services for problematic substance use. The harm is more common for Māori and Pacific peoples and people facing socio-economic disadvantage as these groups have less access to support, are more likely to live in poverty, and are more likely to have co-existing physical or mental health issues (NCAT, 2016).

Prison population

People in prison have the highest prevalence of MHA issues of any sector of our population. Nine out of ten people in prison (91 percent) have a lifetime diagnosis of a mental health or substance-use disorder. Substance-use disorder in the prison population is 13 times bigger than that of the general population, and one in five people in prison had both a mental disorder and a substance-use disorder within the last 12 months.

A focus on the prison population as a priority population achieves more significance when ethnicity is also taken into account. Māori make up the largest proportion of the prison population, in contrast to their proportion of New Zealand's population as a whole. This makes it doubly important

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to ensure that our models of care meet the needs of the prison population, including access to services on release into the community or DHB of domicile.

Figures 16 and 17:   **Department of Corrections, Trends in offender population, 2014 to 2015**

Ethnicity
The number of Maori starting a prison sentence has increased by 105 percent, from 2,095 during 1984/85 to 4,288 during 2014/15. During the same period, the number of NZ Europeans starting a prison sentence increased by 60 percent, from 1,499 in 1984/85 to 2,396 during 2014/15.

Proportionally, prisoners starting a prison sentence who are Maori increased by only very slightly from 56 percent to 57 percent between 1984/85 and 2014/15.

A number of offenders have no recorded ethnicity; these offenders are excluded from this calculation.
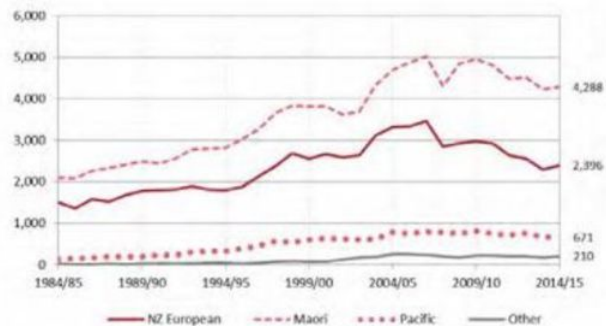
Ethnicity
Maori over-representation has been a feature of the prisoner population for a considerable amount of time.

The proportion of sentenced prisoners in each ethnicity has not changed since 2003. Maori accounted for 50 percent of all sentenced prisoners on 30 June 2015.
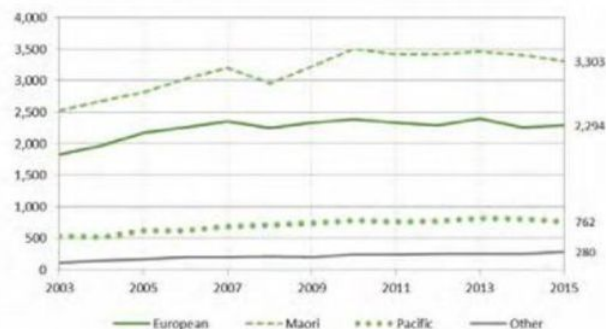
The presentation of more serious conditions is also more prevalent among people in prison, including conditions such as post-traumatic stress disorder and bipolar disorder associated with high levels of distress and disability, especially in acute phases.

People in prison with mild to moderate MHA needs are the responsibility of Department of Corrections' health services, and those with moderate to severe mental health needs are referred to forensic mental health services for assessment and treatment. Such conditions are generally managed within the prison environment, but individuals may also be admitted to secure inpatient forensic facilities if they require a high level of monitoring and care (HDC, 2018).

Determinants of health

Positive mental wellbeing and freedom from addiction rely on many factors at an individual, family and whānau, community, and society level. Socially cohesive societies tend to produce healthier members.

For Māori, He Korowai Oranga provides a framework for supporting the health status of whānau. He Korowai Oranga actively promotes many of the determinants of mental wellbeing, including whānau wellbeing, quality education, employment opportunities, suitable housing, safe working conditions, improvements in income and wealth, and addressing systemic barriers – including institutionalised racism (He Korowai Oranga, Ministry of Health, New Zealand, 2014).

'Ala Mo'ui (Ministry of Health, 2014) provides a similar framework for Pacific peoples, recognising that 'āiga, kāiga, magafaoa, kōpū tangata, vuvale, fāmili (family) is the centre of the community and way of life.

Supporting mental wellbeing and freedom from addiction requires the majority of change to take place outside health services, at a societal level. This calls for a society where wellbeing and freedom from addiction are supported and issues affecting mental health and wellbeing are recognised and acted upon before they require an intensive health system response.

Figure 18:   Health links with the wider environment

(Ministry of Health, 2016b)

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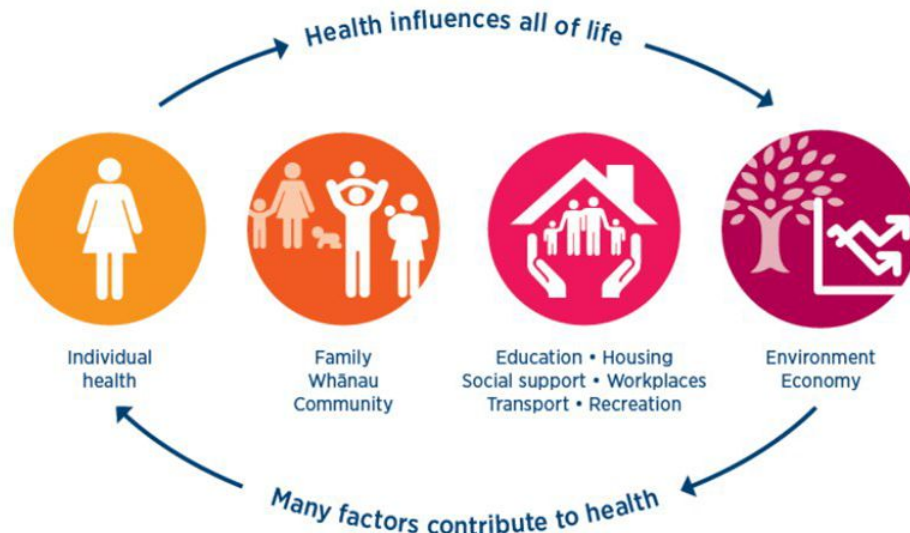
Integration of mental health with other health and social services

Internationally, as well as nationally, there is an increased focus on bringing together physical and mental health through integrated approaches. (Naylor, C., Das, P., Ross, S., Honeyman, M., Thompson, J., Gilburt, H., 2016). The aim of integrating services and MHA responses is to enable people to experience 'seamless' health care.

The separate management of physical and mental health has a high human cost: the life expectancy for people with severe mental illness (such as bipolar disorder or schizophrenia) is up to 25 years below that of the general population, largely due to physical health conditions. Physical health issues are also highly prevalent among people with eating disorders, personality disorders, substance-use disorders, or untreated depression and/or anxiety. These striking and persistent inequalities serve as a powerful reminder that the case for integrated mental and physical health care is an ethical one as much as an economic one (Naylor, C., Das, P., Ross, S., Honeyman, M., Thompson, J., Gilburt, H., 2016).

Mental health, like other aspects of health, can be affected by a range of socio-economic factors (such as relationships with friends, family and whānau, and others; employment; education; welfare; and housing) that need to be addressed through comprehensive strategies for promotion, prevention, treatment, and recovery in a whole-of-government, person-centred approach. People should experience smooth care across all services, with changes and access to different services as their needs dictate.

The situation in New Zealand is very similar to that in other relatively wealthy countries. People who experience serious mental illness and/or addiction die much earlier than their counterparts in the general population (up to 25 years earlier), with a two-to-three times greater risk of premature death. Two-thirds of this premature mortality is due to cardiovascular disease, cancer, and other chronic physical illnesses. Māori who experience mental illness and/or addiction have a one-third higher mortality rate than Māori who do not experience such illness (Te Pou o Te Whakaaro Nui, 2014).

There needs to be a stronger focus on this aspect of integration to address the three related but distinct challenges of:

- rising levels of multi-morbidity
- inequalities in life expectancy
- psychological aspects of physical health.

Equally Well is a New Zealand collective of people and organisations that has formed around the common goal of reducing physical health disparities between people who experience MHA problems and people who do not. Equally Well has five action areas to work towards ensuring that people requiring MHA services have the same opportunities to be physically well as others. These initiatives include metabolic screening, increased dental care, wellness programmes, recovery-focused

guidelines, addressing stigma, and early intervention in psychosis. The Living Life Well strategy includes a commitment to addressing the action areas in Equally Well.

While Equally Well is primarily aimed at those with the greatest need, the intent of increased integration between MHA services and physical health services is applicable for all those with MHA need.

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Workforce capacity and capability

Our workforce is critical and integral to everything we do. The skills, values, morale, and attitudes of the MHA workforce have an enormous impact on the quality, safety, efficacy, and cost of the services.

Our workforce must have the capability and capacity to meet the needs of the population and to adapt to changes in practice across the whole spectrum, from primary health care to specialist mental health. Innovative approaches and training to meet the population's needs will be important in achieving the transformational change required.

Workforce planning

Workforce planning is critical in achieving what we aspire to with our workforce and is necessary to ensure we have the right people with the right skills in the right place at the right time.

At present, the MHA workforce is facing challenges, with staff leaving positions and replacements being difficult to find. This can lead to potentially unsafe staffing levels and undue pressure on those people who remain, causing stress and burn-out.

This strategy will inform our workforce planning, ensuring we can work in with the resources available through organisations such as Te Pou o te Whakaaro Nui to recruit and develop the workforce required to make this strategy's aspirations a reality. Te Pou's recent refresh of *Let's Get Real* (Te Pou o te Whakaaro Nui, 2018)is timely in enabling us to ensure our workforce has the right skills.

Workforce practice

People working in MHA services, including primary and community services, will work closely with individuals and their families/whānau, to centre the person's wellbeing within a wider community context.

Our systems, services, and workforce will take a holistic approach when supporting individuals, ensuring the social determinants and cultural aspects of health are accommodated in treatment and recovery / resiliency plans as well as the medical aspects.

> *It is a medical model; pills first – it should be talk first.*
>
> *There is over reliance on medication. They should be balancing medication with CBT [cognitive behavioural therapy] and other therapies.*
>
> (3DHB MHA Consumer leadership group, personal communication, 2016)

Our workforce extends beyond specialist MHA services in hospitals and NGOs; it includes staff working in primary health care and community services. Individuals do not interact solely with MHA services but also with a multitude of other health and social organisations. We need to shift to an approach that more closely aligns with how people live their lives and provide meaningful support in

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appropriate settings. To do this, we need to bring our workforce along on the journey, making greater use of multidisciplinary teamwork, integrating services, increasing collaboration between services, piloting innovative service delivery arrangements, and eliminating the needless cycles of assessment and referral (Platform Trust & Te Pou o Te Whakaaro Nui, 2015).

People working in MHA services, including primary health care and community services, will work closely with individuals and their families/whānau to provide wellbeing within a wider community context.

Our workforce will be characterised by:
- having compassionate care skills
- fostering recovery and resilience in consumers
- utilising open dialogue and trauma-informed practices
- equipped to improve Māori and Pacific peoples' health
- being a strong Māori and Pacific peoples' health workforce
- being culturally competent
- being pro-equity and anti-racist
- following holistic approaches to assessment, planning, and treatment
- only using chemical sedation and seclusion once all other options have been tried
- understanding the role that culture plays in consumers' wellbeing
- having the right clinical and social skills needed to carry out the work.

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New approaches

Figure 19: **Current and future approach to MHA care of the community (built from information collected at workshops across the 3DHBs)**

Current Approach: Issues and Challenges		New Approach: Addressing Issues and Challenges
Life-course care		
Predominantly adult services	Equity	Increased and earlier access for children & youth, Māori and Pacific, people with addictions, achieving better outcomes
Services available only to those with the highest need	Earlier intervention	Life-course approach with a broad range of services, including widely available self-management, e-therapies and brief interventions
People-based care		
Large DHBs, PHOs, and smaller community services	Service model	Locality based linked services with limited central services
Minimal integration between services & early access difficult	Client journey	Early intervention (including relapse) and exit to services with one plan across all services
Multiple services with evolving linkages to one another, some good IT tools	Linked services	Integrated services, co-located, enabled technology
Information Intelligence		
Siloed, mainly not connected, not visibly shared and ineffective links	Information systems	Big data and linked systems and client records
Disjointed, not well utilised	Smart & innovative technology	Self-help resources readily available, technology well utilised
Siloed, some sector oversight groups, limited accountability, and limited cross-sector collaboration	Governance	System-wide transparency, collaboration & accountability
Quality and safety		
A narrow focus on managing risk	Service ethos	Ethos supports wellbeing, resilience, freedom from addiction, effective intervention, safe journey and exit from service
Reactive, immature quality systems	Quality management	Experience-driven quality improvement, able to identify where health outcomes are improved
Shortages, time poor, focused on managing immediate needs of individuals, some recovery focus	Workforce	Focused on resiliency, recovery, and being supportive
Low trust, differing belief systems, patch protective, competitive	Culture	Family/whānau/person centered, can do, continuous improvement
Commissioning		
Not a shared view of funding, especially outside health	Resources	Integration beyond health
Competitive, reactive, transactional, evolving	Commissioning	Outcomes focused, freedom in implementation, accountable delivery, locality planning with district support

Figure 17 describes our current approach and its associated issues and challenges, alongside the new approach we expect future workforce and services to embrace and implement. We envisage a service-level alliance structure[5] made up of a range of stakeholders with oversight of the needs in the region and how current services and resources deliver the required outcomes.

Utilising cultural partnerships in approaches

New Zealand is uniquely placed to take advantage of our cultural partnerships, bringing together the holistic approaches in a range of Māori, Pacific and Pākehā models, such as *Te Whare Tapa Whā* (Durie, 1985), *Fonofale* (Pulotu-Endemann, 2001), *Nga Vaka o Ka¯iga Tapu*, (Ministry of Social Development, 2012) and trauma-informed care and the recovery approach as outlined in *Blueprint II* (Mental Health Commission, 2012a). For Māori (and indeed for all ethnicities) health and wellbeing, the inclusion of wairua (the spiritual dimension), the role of the whānau (family) and the balance of the hinengaro (mind) are as important as the tinana (physical). Wellbeing is attained when all relational aspects are in balance. A lack of balance between dimensions or within a dimension creates stress and may result in a person becoming unwell.

The Pacific models of health care share common elements with Māori understanding of health, in that they are collective and relational. Six core values have been identified as being common across different Pacific peoples: tapu (sacred bonds), alofa (love and compassion), fa'aaloalo (respect and deference), fa'amaualalo (humility), tautua (reciprocal service), and aiga (family).

Consumers have applied this thinking to the way they wish to experience support for living life well; they wish to see greater emphasis on the things that contribute to their overall wellbeing, with medical prescriptions and treatments being only one component. "

Different cultural belief systems and values shape the way that people and their families/whānau experience mental wellbeing, mental distress, illness, and substance-use harm. Māori have always seen health within a broader context, and cultural identity is fundamental to their wellbeing (Te Rau Matatini, 2015).

Pacific peoples also view mental health as an intrinsic component of overall health. Pacific cultures do not have words that translate easily into 'mental illness', and mental health is considered to be inseparable from the overall wellbeing of the body, soul, and spirit**Invalid source specified.**.

All peoples, including Māori and Pacific, will benefit most from care and support that are provided by health professionals in a way that preserves the person's unique sense of culture, spirituality, and wellbeing (HVDHB, WDHB, 2015).

> *The rediscovery of whakapapa – the connections that make us who we are and where we come from – is the foundation of recovery…*

(Best Practice Advocacy Centre NZ, 2008, p. 31)"

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[5] Person-centred care involves mental health providers, other health providers, and professionals from other sectors working together more proactively to manage people's health, avoid illness, and provide safe and appropriate services.

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Whole-of-system model of care

Given the inequity of access across the sub-region, overstretched specialist resources, and the large unmet demand in the inpatient units and community, we need to move towards a consistent, coordinated, and integrated model in responding to MHA care. The intended future way of working will facilitate a coherent and seamless journey through the health system, linking closely with our strategic partners in housing, police, and the social sectors.

Our model of care will guide us so that people experiencing mental distress and/or substance-use harm, as well as their families/whānau, will be able to access care appropriate to their needs when they require it. Health professionals will recognise when they need to intervene and be able to offer a broader range of MHA responses in a broader range of settings. It means intervening in the least intensive way, such as through self-help and e-therapies, as well as across primary and secondary health, NGO, and specialist services. Knowing where and how people in mental distress and/or experiencing substance-use harm and their families/whānau can access the right support will mean implementing a transparent staged care[6] approach. This will involve health professionals working at the top of their scope, a greater role for primary care, and people receiving most of their care close to home from health specialist and other services.

As illustrated in Figure 18 to follow, the staged-care approach in *Blueprint II* involves integrated responses that are timely and appropriate, matched to people's need, and allowing people to enter and exit the health care services at any point. Using this approach means that people receive responses earlier and closer to home and that the experts involved in their care are adept at identifying early distress, signs of increasing distress, and risk of serious illness. This aligns with the 3DHBs *Perinatal, Maternal and Infant Mental Health Strategy* (CCDHB, 2015)*, which also recommends adopting the staged-care approach.

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[6] Staged care must span primary health, NGO, community, and specialist services and create opportunities for collaboration with other organisations, such as in the education, justice, and social sectors.

Figure 20:   Staged-care approach adapted from *Blueprint II*
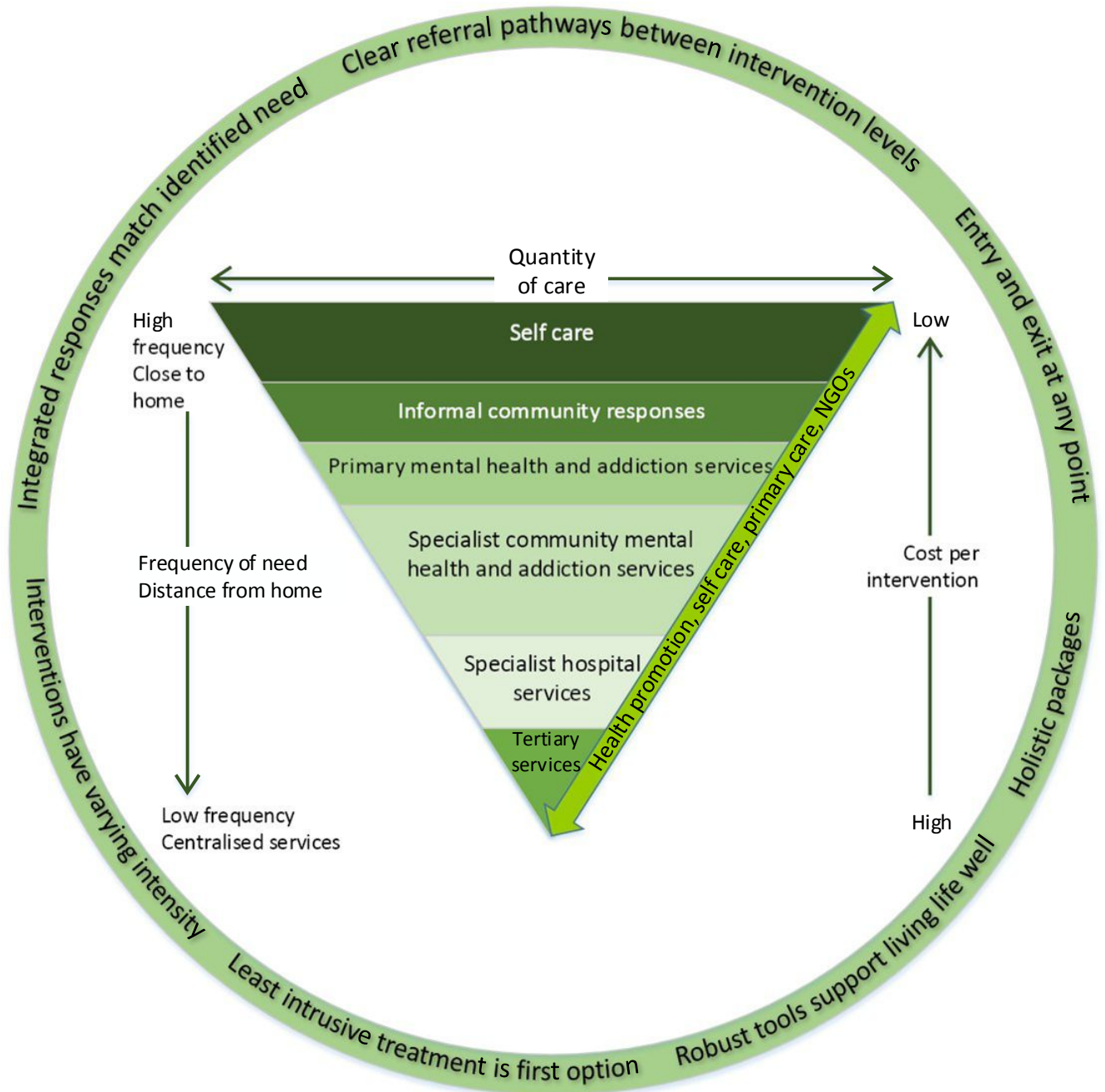
Strategic directions

To move towards the overall goal of living life well with resilience, a recovery focus, and freedom from addiction harm, this strategy has two service directions (life-course care and people-based care), supported by three enabling directions (information intelligence; quality and safety; and commissioning) (Figure 19).

We will focus on equitable outcomes, particularly for our priority groups of Māori, Pacific peoples, children and youth, and people with addictions. In designing and commissioning future services, we will:

- use the principles of integrated and linked services
- work in partnership with Māori
- reduced inequities in access to services, quality of care and health outcomes for Māori
- co-design with our partners and consumers
- intensify services for those with the highest needs
- simplify service delivery
- build on efficient use of resources
- develop culturally appropriate services, working with communities
- focus on person-centred care.

The World Health Organization (WHO) has five interwoven strategies for moving towards integrated, people-centred health care (World Health Organization, 2016). As can be seen in Figure 19, our strategic plan is consistent with these five WHO strategies to:

- empower and engage people and communities
- strengthen governance and accountability
- reorient the model of care
- coordinate services within and across sectors
- create an enabling environment.

Figure 21:   Strategies for integrated, people-centred care

The whole picture

LIFE-COURSE CARE
Treatment and support available throughout life, particularly early in life and illness

In 2025, we expect to see...
1. People will have **early access** to the services they need, with **reduced inequities of service** for Māori and Pacific peoples..
2. Children and youth with developmental and emerging behavioural and addiction issues will have a range of **early responses** available.
3. The **least intrusive services** possible are always the first option, and are used more frequently.
4. All health professionals will be able to **recognise signs of mental illness** and distress and provide an immediate response.

What will we do...
1. Increase the range of **early intervention services and tools** including self management, e-therapies, talking therapies, brief interventions in general practice, with a particular focus on increased services for **priority populations.**
2. Support **health promotion** for mental wellbeing and freedom from addiction harm and destigmatisation of mental illness.
3. Increase **suicide prevention** initiatives.
4. Embed mental health and behavioural health into **Community-based settings,** e.g. primary health care, including:
   a. **specialist** mental health professionals , and
   b. **long-term condition planning** for those with enduring mental illness and/or addiction.
5. Promote health navigator **website** as the basis for information to support patients, families/whānau throughout their journey.
6. Embed **consumer co-design** into all aspects of service design and delivery.

PEOPLE-BASED CARE
Accessible, integrated, and convenient services delivered close to home

In 2025, we expect to see...
1. People will receive most of their mental health and addiction care **close to home** with **specialist services centralised.**
2. **Closer-to-home initiatives** well established in Māori and Pacific communities, and undergoing evaluation.
3. Clients have one plan across all services that focuses on early intervention (including relapse) and safe and early exit from services.
4. People will have access to a range of services (staged care) that are **integrated, and co-located** where possible.

What will we do...
1. Integrate mental health and addiction skills into **interdisciplinary health care teams** across community health networks that work in partnership with communities and our intersectoral partners.
2. Focus on developing options for **priority populations.**
3. Increase **community-based** service delivery and streamline delivery of high-cost secondary and complex care services.
4.. Consolidate current **assessment tools and processes** across multiple providers into an agreed assessment process that allows access to a full complement of services.
5. Implement a **consistent pathway** across all services that supports safe transition and transfer between services.
6. Ensure **individual care plans** are linked across services.

INFORMATION INTELLIGENCE
Smart systems and intelligent use of information

In 2025, we expect to see...
1. **Data integration** informs service design and commissioning.
2. Data analytics **faithful to cultural worldviews**, enabling tailored responses.
3. Consumer **records are linked** between services.
4. **Smart technology** is widely utilised and enables effective use of smart technology.
5. **System-wide governance**, quality framework and monitoring processes with transparency of service delivery and outcomes.

What will we do...
1. Develop and implement **system-wide governance** with quality framework and monitoring including shared dashboards.
2. Implement **integrated data sets** to support system-wide governance, monitoring and service commissioning.
3. Utilise **smart technology** and **social media**.
4. Implement **linked care records** across services.

COMMISSIONING
Services are designed and purchased to match identified need

In 2025, we expect to see...
1. Our **commissioning model** will be focused on living life well and freedom from addiction harm for our priority population groups.
2. **Efficient use of resources** in homes, communities, and hospital.
3. **Integrated** health service responses that meet the needs of people and their whānau.
4. Most people will receive their **care close to home** in community-based settings.
5. Commissioning will be focused on **outcomes.**
6. Collaboration with our **cross-sectoral partners.**

What will we do...
1. Develop an **investment plan** for each DHB that reflects investment in:
   • priority populations and areas of greatest need
   • early intervention
   • services closer to home
2. **Intensify** services for those with the highest need.
3. **Simplify** services.
4. **Monitor outcomes** through robust and transparent governance.
5. Work with our **cross-sectoral partners** to consolidate and simplify services (collective impact).

QUALITY AND SAFETY
Quality systems and sustainable workforce support living life well, resilience, and freedom from addiction harm

In 2025, we expect to see...
1. Consumer and whānau voices drive continuous quality improvement.
2. An embedded measurement framework which monitors the safety of our service delivery, and the timeliness, efficiency and effectiveness of our care.
3. Services are family / person-centred, with a can-do attitude and embrace continuous improvement.
4. Quality systems focus on leading services towards proactive quality development.2. People will be able to access the support they need regardless of where they seek support.
5. The MHA sector will be a more attractive place for people to work, with strong Māori and Pacific peoples' representation..
6. People will access safe and excellent services that are pro-equity and anti-racist.
7. Adequate numbers of a sustainable, culturally competent and skilled workforce focused on resiliency, strengths, and recovery.
8. Service ethos supports living life well, resilience, and freedom from addiction harm.

What will we do...
1. Develop and implement a sub-regional **quality plan** focused on safe and excellent services.
2. Develop and implement a sub-regional **workforce improvement plan,** including identifying gaps and growing the workforce.

Central diagram labels:
- Resilience and recovery
- Co-produce with our partners and consumers
- Intensify services for those with the highest need
- Partnership with Māori
- Person-centred care
- Freedom from addiction harm
- Work with communities
- Culturally appropriate
- Efficient use of resources
- Living life well
- Simplify service delivery
- Integrated, safe and linked services
- Life-course care
- People-based care
- Information intelligence
- Commissioning
- Quality and safety
- Equitable outcomes
- Children & youth
- People with addictions
- Māori
- Pacific

Life-course care

Treatment and support available early in life, while unwell, and before relapse

Current Approach: Issues and Challenges	Life-course care	New Approach: Addressing Issues and Challenges
Predominantly adult services	Equity	Increased and earlier access for children & youth, Māori and Pacific, people with addictions, achieving better outcomes
Services available only to those with the highest need	Earlier intervention	Life-course approach with a broad range of services, including widely available self management, e-therapies, and brief interventions

What does this look like?

Providing life-course care includes early intervention, which is the process of providing MHA support to a person who is experiencing or demonstrating any of the early symptoms of mental illness and/or addiction. Broadening the definition of mental health services to encompass the support of mental distress and trauma provides the opportunity to move beyond a highly medicalised model to reflect more contemporary models of care, including the provision of greater access to talking therapy and other therapies such as e-therapy.

Strengthening prevention and supporting destigmatisation are key factors in healthy communities. There must be safe environments where people in distress feel free to discuss what they are experiencing. Early intervention is particularly important for children and young people, for whom mental illness and addiction can have profound, long-term consequences. We will also intervene earlier for Māori and Pacific people and those with addiction issues.

There is not enough in place to detect trauma and provide early intervention to stop or prevent it becoming deeper. Services are not responding to calls for help from people, their families, or neighbours until things are so bad it becomes a police matter.

Clients are turned away because they are not acute – they then become acute.

(3DHB MHA CONSUMER LEADERSHIP GROUP, PERSONAL COMMUNICATION, 2016)

A range of early and integrated responses will be available, both for children and youth and adults experiencing MHA issues. This will include:

- easy access to self-management tools
- e-therapies, brief interventions in general practice
- primary health care responses
- talking therapies
- early and timely entry to specialist services.

Suicide is the second leading cause of death among 15- to 29-year-olds in New Zealand (World Health Organization, 2017a). Communities can play a critical role in suicide prevention, and facilitating community engagement in suicide prevention is an important task. Furthermore, media reports about suicide can enhance or weaken suicide prevention efforts, thus making responsible reporting essential.

Embedding mental health and behavioural health professionals into primary health care services provides benefits beyond the immediate aim of providing timely support to people with mental distress, illness, and substance-use harm. For example, interdisciplinary teams should address the range of factors (including social and environmental factors) that shape the mental and physical health, wellbeing, and resilience of the people they are serving (Naylor, Taggart, & Charles, 2017).

What will we do?

1: Increase the range of **early intervention services and tools**, including self-management, e-therapies, talking therapies, and brief interventions in general practice, with a focus on increased services for **priority populations**.
2: Support **health promotion** for mental wellbeing, freedom from addiction harm, and destigmatisation of mental illness.
3: Increase **suicide prevention** initiatives.
4: Embed mental health and behavioural health into **community based settings**, for example, primary health care services, including:
    a. **specialist** mental health professionals
    b. **long-term condition planning** for those with enduring mental illness and/or addiction.
5: Promote the health navigator **website** as the basis for information to support patients and their families/whānau throughout their journey.
6: Embed **consumer co-design** into all aspects of service design and delivery.

Why should we do this?

Intervening in childhood, when required, minimises the impact of mental illness across the life course. It has been shown to reduce negative societal impacts and minimises the social and economic costs to individuals and the community later in life, including through the justice system. For this life-course approach to be successful, an integrated approach must be taken with our partners in education, police, justice, and the social sector.

Figure 22:   Proposed intervention time-line
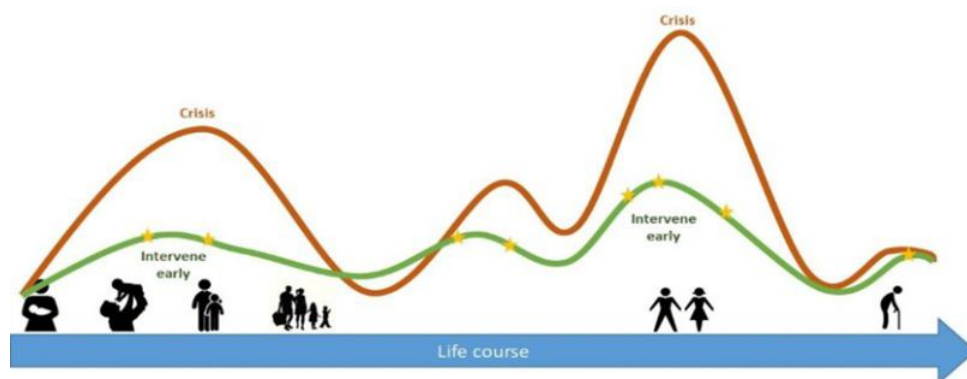
By intervening at key points, when things start to go wrong, we not only provide better care for individuals but also reduce the load on acute crisis services in health and justice.

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Prompt diagnosis and early intervention in the initial stages of a mental illness and/or substance-use harm can have significant and life-changing consequences for a person's wellbeing. Intervening early not only has the potential to reduce the impact of poor mental wellbeing and substance-use harm on a person's life, but it can also improve their mental and physical health, community participation and socio-economic outcomes well into the future. Intervening early in life in the initial stages of an issue means children and adolescents are less likely to develop long term mental illness and/or substance-use disorder, thus reducing the impact on family, whānau and friends.

Intervening when someone starts to show early symptoms of distress or addiction rather than waiting until they reach a crisis can mean a better response to treatment and increased likelihood of recovery. Strong demand for acute specialist mental health services often means that, until someone reaches a crisis point, they are not accepted into these specialist services. "If left untreated, mental health disorders that emerge prior to adulthood impose a ten-fold greater health cost than those that emerge later in life." (Brazier, 2017, p. 24).

Māori and Pacific peoples access specialist support services later than other ethnicities, when they are likely to be nearer to crisis stage, and this late intervention leads to a greater prevalence of adults with enduring mental illness in these ethnicities. Only half of Māori with a serious mental health disorder in the past 12 months had any contact with mental health services nationally, compared with two-thirds of non-Māori.

Untreated mental illness contributes to a significant and tragic burden of suicide for young people, particularly young men. Mental illness remains the biggest risk factor for suicide. In 2009, over three-quarters (76.6 percent) of suicides in New Zealand were males, making suicide the tenth leading cause of death for males and the fourteenth leading cause of death overall in this country. Although death by suicide accounts for a relatively small proportion (2 percent) of the national overall deaths, in 2009, suicide accounted for 22 percent of deaths for males aged 15 to 24 years. New Zealand has one of the highest youth suicide rates in the developed world. Suicide is the leading cause of death amongst young Pacific peoples (aged 12 to 18 years). (HDC, 2018).

In 2025, we expect to see...

1: People will have **easy and early access** to the services they need.
2: **Reduced inequities of access** to services, quality of care and health outcomes **for Māori and Pacific peoples**.
3: Children and youth with developmental and emerging behavioural and addiction issues will have **a range of early responses available**.
4: The **least intrusive services possible** will always be the first option, and will be used more frequently.
5: **All health professionals will be able to recognise signs of mental distress and substance-use harm** and provide an immediate response.
6: There will be **the beginnings of a decrease** in demand for acute services.

People-based care

Accessible and convenient services delivered close to home
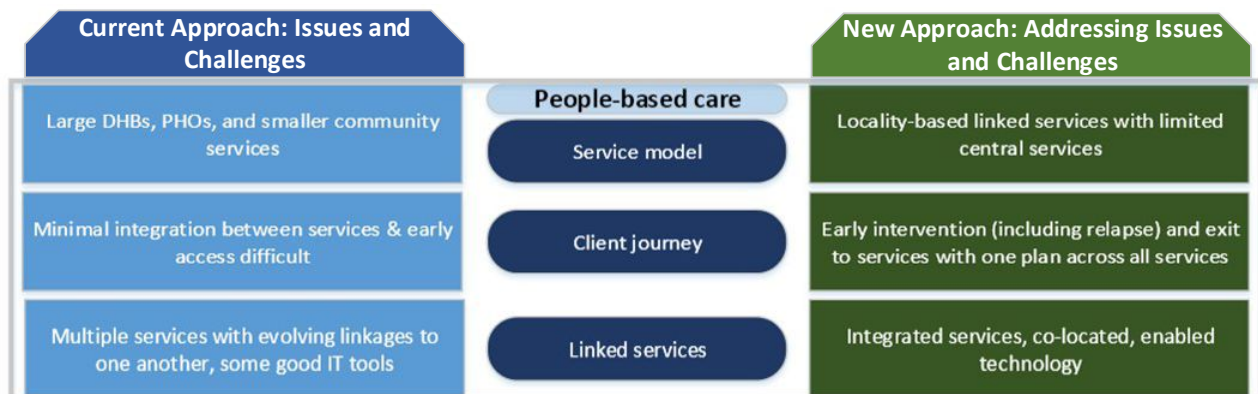
What does this mean?

Improving health and wellbeing requires effort across communities and is not concentrated in single organisations or within the boundaries of traditional health and social services. Addressing local needs and being closer to home will be achieved through a locality approach, with each locality having the skills, tools, and resources required to match the identified needs of the members of their community.

We need care within our home community, with community involvement and support and interventions closer to home.

There is nothing in place to help families to understand and learn what and how they can provide support.

(3DHB MHA Consumer Leadership Group, personal communication, 2016)

Currently, for many people with high and complex needs, the only solution is specialist mental health care in inpatient settings, followed by specialist community care. For people experiencing substance-use harm, there are both residential and in-community treatment options, however, these can be difficult to access, with long waiting lists. We need to create additional capacity for people to access treatment in the community and, alongside this, we need to assist communities to accommodate people without fear and stigma. By working with communities to co-design new programmes, we can inform the wider community about the continuum on which mental distress, substance-use harm, and substance-use disorder sit and how that impacts people's lives in different ways.

The locality-based community hub concept is a shift away from a top-down approach and gives a degree of autonomy to the locality leadership group to shape service response to meet the unique needs of their neighbourhoods. Closer collaboration with primary health providers and other local agencies will mean a more seamless approach for consumers. The majority of the skills, tools, and resources required to meet the needs of consumers will be available within each locality with integrated services, some co-located and others virtually integrated. Some skills, tools, and resources will, however, be available at a district or even regional level, such as forensic services.

However, co-locating different kinds of services does not automatically mean improved care. To make a significant difference in outcomes, the various services must act as a single care team, using shared electronic health records and care plans. Alongside this, they must have access to specialist advice (ModernMedicine Network, 2016).

What will we do?

1: Integrate MHA skills into **interdisciplinary health care teams** across community health networks that work in partnership with communities and our inter-sectoral partners.
2: Focus on developing specific strategies to address inequities in access to services, quality of care and health outcomes for **priority populations**.
3: Increase **community-based** service delivery with a locality focus and streamline delivery of high-cost secondary and complex health care services.
4: Consolidate current **assessment tools and processes** across multiple providers into an agreed assessment process that allows **easy access** to a full complement of services.
5: Implement a **consistent pathway and easy access** across all services that supports safe transition and transfer between services.
6: Ensure **individual care plans** are linked across services.

Why should we do this?

At any one time approximately 30 percent of adult inpatients no longer require acute inpatient care, but they have other unmet needs (accommodation, financial, and social issues) that mean they cannot safely transition out of inpatient services. Similar circumstances apply to those ready to leave substance-abuse treatment.

Person-centred care does not mean giving people whatever they want or just providing information; it means putting people and their families/whānau at the centre of everything we do. When decisions are made, we see consumer and their families/whānau as experts, working alongside professionals to get the best outcome. Person-centred care considers people's desires, values, family situations, social circumstances, and lifestyles. It means we see the person as an individual and work together to develop appropriate solutions. We are compassionate, think about things from the point of view of the person and their family and whānau, and are respectful. This might be shown through sharing decisions with the person and their family and whānau and helping people manage their health. Person-centred care isn't just about what we do, it is also about the way professionals and consumers think about health care and their relationships across the whole of their life course and between services, sectors, and communities (HIN, 2016).

In 2025, we expect to see…

1: People will receive most of their mental health and addiction care **close to home**, with **centralised specialist services**.
2: **Closer-to-home initiatives** well established in Māori and Pacific communities, and undergoing evaluation.
3: Consumers will have **one plan** across all services that focuses on early intervention (including relapse) and safe and early exit from services.

4: People will have access to a range of services (staged care) that are **easy to access, integrated**, and **co-located** where possible.

Information intelligence

Smart systems and intelligent use of information
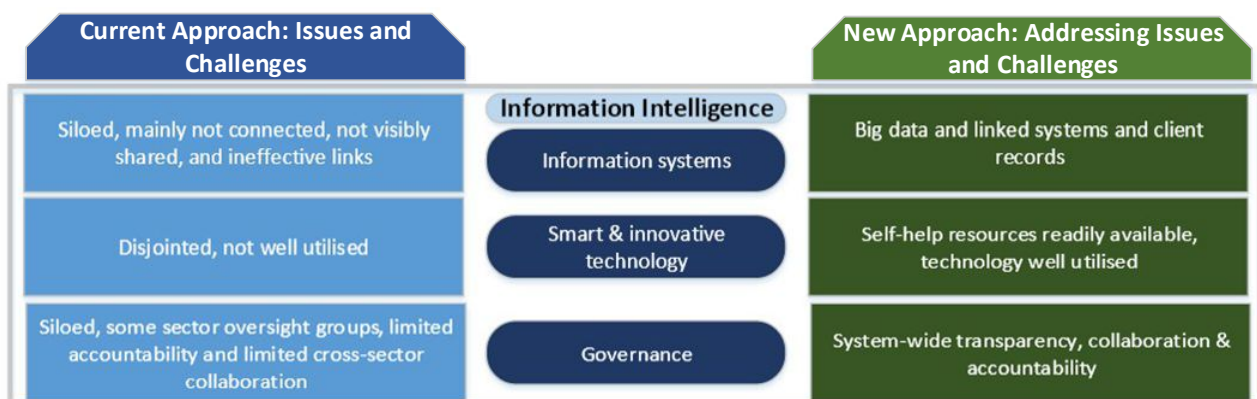
What does this mean?

The information we collect and the insight and intelligence we generate through the knowledge and experience of our people can be used to direct our strategic, tactical, and operational activity. It can be shared with others to unlock benefits for both consumers and their families/whānau and for DHBs and service providers.

It's great being listened to and heard – not having to repeat your story again and again and again…

(3DHB MHA Consumer Leadership Group, personal communication, 2016)

Developing a framework for information collection and analysis will enhance and refine our knowledge of inequalities and inequity in health and system-wide governance, with shared dashboards providing a mechanism for much closer monitoring of progress. A framework will provide consistent reliable information about the health of communities, patterns within those communities, and changes over time.

As we continue to develop comprehensive real-time linked data systems, including data from primary health care as well as other sources, we will improve our ability to provide joined up care for people (Department of Health, 2006).

What will we do?

1: Develop and implement **system-wide governance** with quality framework and monitoring, including shared dashboards.
2: Implement **integrated data sets** to support system-wide governance, monitoring, and service commissioning.

3: Utilise **smart technology** and **social media** (maximise the use of digital technology to improve productivity, reducing the system costs incurred in managing access, waiting lists, and failure demand).

4: Implement **linked care records** across services.

Why should we do this?

Comprehensive and innovative information systems can make a real difference in the planning and delivery of services. The ultimate aim is improvement in mental health and freedom from addiction. However, intelligent information also underpins evidence-based commissioning of services, as well as providing more precise and meaningful monitoring of service performance.

Responsibility for the health of communities will be shared increasingly between DHBs and our partner agencies, along with the communities themselves. Information and knowledge relevant to health is generated on a daily basis and should be made available (contingent on agreements regarding privacy) and used by a wide range of agencies and individuals. Information systems need to work across these settings in an integrated way to provide a fully informed picture of health and its determinants.

Better information on MHA needs and on the effectiveness of interventions will lead to more effective commissioning of services to improve health and care.

In 2025, we expect to see…

1. **Data integration** will inform service design and commissioning.
2. **Data analytics faithful to cultural worldviews** enabling tailored responses for Māori and Pacific peoples, and measuring better outcomes for these groups.
3. Consumer **records will be linked** between services.
4. **Smart technology** will be utilised widely and will enable effective use of smart technology.
5. There will be **system-wide governance**, a quality framework, and monitoring processes with transparent service delivery and outcomes.

Quality and safety

Quality systems and a sustainable workforce support living life well, resilience, and freedom from addiction harm

Current Approach: Issues and Challenges	Quality and safety	New Approach: Addressing Issues and Challenges
A narrow focus on managing risk	Service ethos	Ethos supports wellbeing, resilience, freedom from addiction, effective intervention, safe journey and exit from service
Reactive, immature quality systems	Quality managment	Experience-driven quality improvement, able to identify where health outcomes are improved
Shortages, time poor, focused on managing immediate needs of individuals, some recovery focus	Workforce	Focused on resiliency, recovery, and supportive
Low trust, differing belief systems, patch protective, competitive	Culture	Family/whānau/person-centered, can do, continuous improvement

What does this mean?

Transformational improvements in MHA will require new, less medicalised models focused on working with communities, reducing the pressures on acute care and having a workforce aligned with the new models of care and ways of working. Our quality systems must draw more on utilising experience and quality systems to drive quality improvement. The organisational cultures must move from competitive patch protection to person-centred solutions with a can-do attitude focused on continuous improvement.

We want a workforce that has empathy and compassion.

We want our GPs to understand the mental health system, to know what services are available and how to access them, and to refer us to their nurses for longer times. For example, to a mental health nurse for 1-hour counselling sessions.

(3DHB MHA Consumer Leadership Group, personal communication, 2016)

This involves changing the discourse in the MHA workforce, moving beyond risk management to a focus on the general health and wellbeing of consumers, encouraging safe and effective earlier intervention, helping to develop resilience, supporting freedom from addiction harm, and facilitating recovery and exit from specialist services. This means:

- building a culture and system for continuous improvement and learning
- co-design and co-production driving a system-wide quality culture
- workforce development, particularly for the health care practitioners who are best placed to deliver talking therapies to our population
- all frontline staff receiving appropriate training in MHA, regardless of the setting in which they work. Training should equip staff to recognise and manage common mental health problems at

different stages in the life course and to understand the psychological components of physical illness (Naylor, Taggart, & Charles, 2017)

- workforce training that better prepares and educates our staff so they can learn how to work effectively with children and families/whānau and use kaupapa Māori frameworks and other cultural lenses for viewing mental health and wellbeing
- relevant tertiary education providers delivering training that more closely aligns with the transformed models of care
- increasing the capability of the primary health care workforce
- making the work sufficiently rewarding, thus incentivising staff to work in primary health care and community settings (rather than remaining predominantly in secondary health care specialist services).

What will we do?

1: Develop and implement **a sub-regional quality plan focused on safe and excellent services**.
2: Develop and implement **a sub-regional workforce improvement plan**, including identifying gaps and growing the workforce.

Why should we do this?

Providing services that are person centred and meet the needs of our populations at all stages of their lives requires an embedded continuous quality improvement framework which supports inclusion from consumers, family and whānau.

Consumers and family/ whānau will be aided in their ability to contribute to co-design if they are confident they are being listened to, and they see this reflected in the services provided.

Workforce challenges are also many and varied, with the MHA sector having an aging workforce and a significant gender and cultural imbalance. MHA is an unattractive sector in which to work; staff report that it is hard to recommend to colleagues or students to come and work in the sector.

While most people access support for their mental distress and addiction issues from primary health care and community-based services, the workers in these sectors receive very little MHA training. There are few in the workforce who have strong cultural competencies or who come from Māori, Pacific or Asian cultures. Early intervention is made more difficult for the workforce in our younger people's services, with most foundation-level health workforce trainings including very little about working with children and families/whānau.

Universities and employers have different drivers. Upon graduation, the workforce is therefore mostly not work ready, and the allied health professions (including social work, occupational therapy, and counselling) are not able to access either appropriate post-graduate training or funding.

In 2025, we expect to see…

1. **Consumer and whānau voices** will drive continuous quality improvement.
2. An embedded **measurement framework** which monitors the safety of our service delivery, and the timeliness, efficiency and effectiveness of our care.

3. Services will be **family, whānau and person-centred**, with a can-do attitude, and embracing continuous improvement.
4. The focus will be on **quality systems** leading services towards proactive quality improvement.
5. The MHA sector will be a **more attractive place** for people to work.
6. The mental health workforce will be a strong Māori and Pacific peoples' health workforce;.
7. People will be able to **access** the support they need regardless of where they seek support.
8. People will be able to access **safe and excellent** services that are pro-equity and anti-racist.
9. There will be **adequate numbers** of workers available to meet demand across the continuum of need.
10. There will be a sustainable, culturally competent and skilled **workforce** focused on resiliency, strengths, and recovery.
11. The **service ethos** will support living life well, resilience, and freedom from addiction harm.

Commissioning

Services are co-designed and purchased to match identified need

What does this mean?

There is a call to broaden what MHA services provide to include addressing need across the spectrum from mental distress through to trauma and serious mental illness and addiction.

DHBs are over investing in compulsion, force and restrictive settings. Seclusion is barbaric and punishing.

(3DHB MHA CONSUMER LEADERSHIP GROUP, PERSONAL COMMUNICATION, 2016)

Our patterns of investment will change to support earlier intervention in the life course and when things start to go wrong. This means increasing resourcing in primary and community-based health services and support services to attend to mild to moderate needs – in many cases, using these services to intervene earlier would not only be more efficient and effective but also less intrusive in people's lives.

Our approach will be to work with communities and our partners in other sectors, such as police and housing, using a life-course model, with funding provided where the emphasis is required. New funding models need to be developed and implemented that consistently support a community-focused, life-course approach.

Successful locality-based work across the whole health and social care system requires several elements to come together. Strategic commissioning must focus on the needs of the wider population, as well as

consumers, while taking responsibility for long-term planning and bringing accountability and contestability to place-led decision-making.

Implementing an across-sector and system approach means open and transparent conversations and information sharing about resources and governance with all those involved.

The current available funded services predominantly focus on adults experiencing mental health issues. To achieve transformational change, significant investment is required in services that support:

- Māori and Pacific peoples
- infants, children, and youth
- people at risk of suicide
- people experiencing addiction
- older adults.

These changes will occur alongside closer integration with primary health care services and other sectors, such as police and social services.

What will we do?

1: Develop an **investment plan** for each DHB that reflects investment in:
   a) priority populations and areas of greatest need
   b) early intervention
   c) services closer to home.

2: **Intensify** services for those with the highest need.
3: **Simplify access** to services.
4: **Monitor outcomes** through robust and transparent governance.
5: Work with our **cross-sectoral partners** to consolidate and simplify services (collective impact).

Why should we do this?

In the last 10 years, the 3DHBs have been focused on protecting and providing services in a low funding growth environment for our populations. This results in a focus on (mostly) DHB-provided MHA specialist services for people with high and severe needs to the detriment of what is available to meet low to moderate needs in the wider community.

There is an ever-increasing expectation on MHA services to intervene and support people who do not necessarily meet criteria for serious mental or substance-use disorder but who require urgent attention and support.

Despite *Blueprint II*, we continue to fund from a *Blueprint I* model.

In 2025, we expect to see...

1: Our **commissioning model** will focus on living life well and freedom from addiction harm for our priority population groups, addressing inequities and improving Māori and Pacific health outcomes in doing so.
2: There will be more **efficient use of resources** in homes, communities, and hospitals.
3: **Integrated** health service responses will aim to meet the needs of people and their families/whānau.

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4: Most people will receive their **care close to home** in community-based settings.

5: Commissioning will be focused on **outcomes**.

6: We will collaborate more with our **cross-sectoral partners**.

Investment approach

How you pay for health and social care encourages different behaviours because people respond to incentives and risks. The payment model in use will determine what incentives people have and how risks are shared. For whole-of-system models of care to succeed, DHBs need to provide incentives and share risks so that providers and agencies work together to keep people well.

Approximately 17,488 people accessed the 3DHBs MHA services in 2015/16. As a result, the 3DHBs spent $112.4 million on MHA services in 2016/17.

To enable the implementation of this strategy, the 3DHBs will need to consider how to prioritise current and new spending. We will do this by considering the needs of those who require services, as well as what services they need most and to what extent.

Disinvesting to reinvest remains an unsuccessful approach in funding-constrained environments with competing demands. We will invest in the areas of greatest need, with wellbeing and freedom from addiction harm being our priority areas. Alongside this, we will continue our current approach of utilising increases in population-based funding streams, but this will be slow to achieve the transformational change required.

Principles for investment

The following principles should guide investments in this area.

1: Support intervening earlier in the life course and illness, integrated responses and accessing more services closer to home.
2: Make the client pathway more efficient.
3: Provide value for money.
4: Improve equity of access and outcomes for our priority populations (Māori and Pacific peoples, children and youth, and people with addictions).
5: Connect and collaborate with other agencies and groups.

Enabling this change will require a reallocation of current resources as shown in Figure 21 below. While disinvestment in hospital inpatient services will not be a deliberate strategy, it is likely that, over time, increased availability of community-based services and responses will result in some decrease in demand.

Figure 23:   Patterns of investment
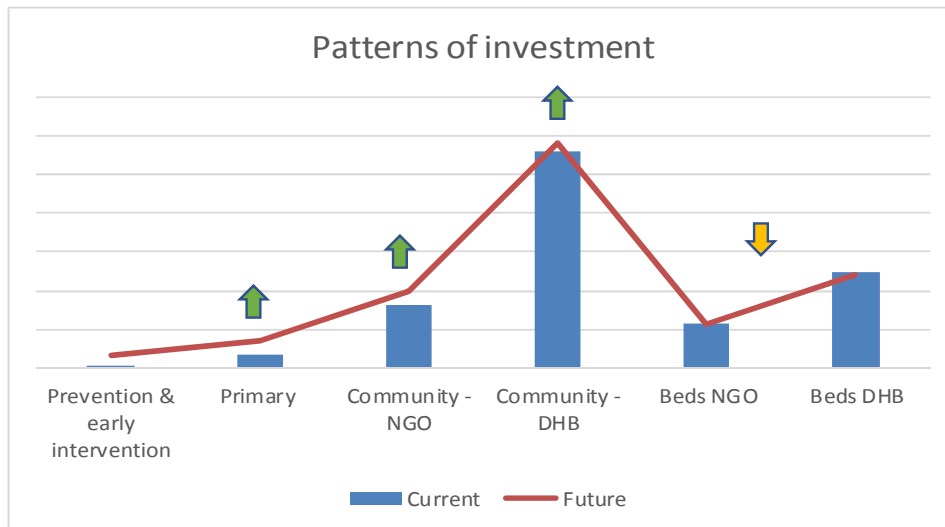
Next steps

Clearly, achieving the future vision for MHA services across the sub-region will involve a period of evolutionary change over the coming years. Despite the gaps and barriers of the current MHA system, there are some pockets of effective integration and partnership working in each district.

We expect the Government Inquiry into mental health and addiction will inform the implementation of this strategy.

Each DHB will develop an implementation plan and expand it across health services to achieve further integration and enhance the coordination of those services.

Implementation will be achieved through local or sub-regional alliancing arrangements, which will be responsible for driving agreed actions to improve the consumer, family and whānau journey. These arrangements will ensure clinically-led service development in conjunction with consumer co-design, and implementation within a 'best for person, best for system' framework. Principles for implementation will be developed and include a principle of collaboration for working with specific localities.

In order to ensure a stable and enduring transition to the future model, it will be important to protect the gains and relationships that have already been made in developing this strategy.

Appendices

Appendix 1: Contributors to the strategic plan

This MHA strategic plan has been developed in conjunction with a range of stakeholders over a number of years. In 2016, a series of workshops was held to identify issues and potential solutions, which were then confirmed in further forums and subsequently used to develop this plan.

The following groups of stakeholders/partners (which may not include all the individuals consulted) have been consulted (either in meetings or by phone/email communications) and provided input to this strategic plan. Some people were involved as members of several different groups over time.

Consumer Leadership Group (CLG) 2016

Waiatamai Tamehana, Aiden Broughton, Sarah Porter, Bronwyn Haines, Debs Craig, Jonathan Beazer, Kim Eruera, Lisa Archibald, Penny Saunders-Francis, Susanne Cummings, ex officio John Tovey, Mike Sukolski

MHA Integrated Leadership Group 2016

Alison Masters, Andrew Curtis-Cody, Carole Koha (Te Waka Whaiora), David Bradley, Frances Hamilton, Hannah Molloy, Helen Rodenberg, Karl Polutu-Endemann, Karla Bergquist, Nigel Fairley, Pauline Boyles, Sandra Williams, Sarah Porter(CLG), Waiatamai Tamehana (CLG)

AOD Leadership Group 2016

Dr Sam McBride (Chair), Peter Critchley, Carole Koha, Tapita (May) Chapman, Carol Devlin, Catherine Milne-Rodrigues, Clarissa Broderick, Fiona Ironside, Penny Francis-Saunders

Wairarapa Consumer Leadership Group

Peter Critchley (AOD), Matt Hall, Aiden Broughton, Kathleen Reid, Penny Francis-Saunders (AOD), Makere Herbert

Māori and Pacific Health

Te Wera Kotua (3D Consumer Consultant – Te Whare Marie, MHAIDS), Pania Ellison, Jim Wiki, Arawhetu Gray, Sipaia Kupa, Taima Fagaloa, Kerry Dougall, Tofa Suafole Gush

Non-governmental organisations

Kimberley Bignel and Moira Jackson (Atareira); Alan Jones, Dan Mustepic, and Tash Lowe (Care NZ); Shirley Cressy (Manager Earthlink Inc); Cherie McKay (Regional Manager Emerge Aotearoa); Stephanie Cairns (Manager Mix); Matey Galloway (Oasis Network); Sandy Finnigan and Sally Pitts-Brown (Pathways); Francesca Faggioli (Refugee Trauma Recovery Services); Catherine Milne-Rodrigues and Wendy Lane (Salvation Army); Allanah Elvy-Arnold, Nicole Smith, and Stephen Scott (Salvation Army Bridge and Oasis); Carole Koha (Te Waka Whaiora); Andrea Bates (Wellbeing Wellington)

Primary health care

Martin Hefford, Chris Kerr, Lynley Byrne, and Loralie Olafson (Compass Health); Frances Hamilton and Bridget Allan, (Te Awaikairangi Health Network); Jane Hopkirk (Kokiri Hauora Whānau Ora collective); Trini Ropata (Ora Toa Mauriora Te Runanga o Toa Rangatira)

MHAIDS (3DHB provider arm)

Helen Mitchell-Shand (Wairarapa); Wakaiti Saba, Faye Jones, John Zonnevylle, Arran Culver, Alison Masters, Sam McBride

Other DHB staff

Jennie Jones (Regional Public Health); Arawhetu Gray, Simon Phillips, Pauline Morrison, Sandra Murray, Marion Thomas, Whetu Campbell, Terry Smith, Jeremy Tumoana, Rawinia Mariner, Anna Nelson, Trish Davis, Noel Hensman, Rod Bartling

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Appendix 3: Other plans informing this strategy

New Zealand Health Strategy

The New Zealand Health Strategy outlines the high-level direction for New Zealand's health system over the 10 years from 2016 to 2026. Its guiding principles for the New Zealand health system are:

1: Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi

2: The best health and wellbeing possible for all New Zealanders throughout their lives

3: An improvement in health status of those currently disadvantaged

4: Collaborative health promotion, rehabilitation, and disease and injury prevention by all sectors

5: Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay

6: A high-performing system in which people have confidence

7: Active partnership with people and communities at all levels

8: Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing.

To achieve health and wellbeing throughout [people's] lives requires a health system that knows and connects with people at every touch point, not just when they are sick or disadvantaged.

(Ministry of Health, 2016b, p. 13)

Figure 22:   New Zealand Health Strategy framework

He Korowai Oranga

As New Zealand's Māori Health Strategy, He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. It was last updated in 2014.

1: It has two key directions: Māori aspirations and contributions, and Government aspirations and contributions.

2: It has three key threads of rangatiratanga, building on the gains, and equity.

3: It is strengthened by six core components:

- Treaty of Waitangi principles
- Quality improvement
- Knowledge
- Leadership
- Planning, resourcing, and evaluation
- Outcome/performance measures and monitoring.

'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018

'Ala Mo'ui has been developed to facilitate the delivery of high-quality health services that meet the needs of Pacific peoples. It sets out the strategic direction to address health needs of Pacific peoples, outlines the Government's priority focus areas for Pacific health and stipulates new actions. At the time of publication of this 3DHB mental health & addictions strategy, 'Ala Mo'ui is being reviewed in preparation for updating.
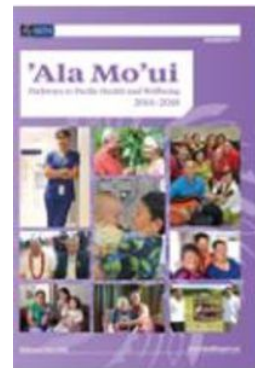
Rising to the Challenge

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 (Ministry of Health, 2012) is the national mental health and addiction strategy. It focuses on the four key areas of:

- making better use of resources
- improving integration between primary and secondary services
- cementing and building on gains for people with high needs
- delivering increased access for all age groups, with a focus on infants, children, and youth; older people; and adults with common mental health and addiction disorders, such as anxiety and depression.

Blueprint II

Blueprint II (Mental Health Commission, 2012a and b) provides a 10-year vision to improve the mental health and wellbeing of all New Zealanders. The *Blueprint II* vision "mental health and wellbeing is everyone's business" sets the stage for a future where everyone plays their part in protecting and improving mental health and wellbeing. It is founded on the understanding that mental health and

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wellbeing plays a critical role in creating a well-functioning and productive society. It reinforces and strengthens the recovery principle alongside the principles of resiliency and a people-centred and directed approach.

Blueprint II identifies eight priorities to achieve this vision.

1: Providing a good start: Respond earlier to mental health and addiction issues in children and young people to reduce lifetime impact.

2: Positively influencing high-risk pathways: Provide earlier and more effective responses for youth and adults who are at risk or involved with social, justice, or forensic mental health and addiction services.

3: Supporting people with episodic needs: Support return to health, functioning, and independence for people with episodic mental health and addiction issues.

4: Supporting people with severe needs: Support return to health, functioning, and independence for people most severely affected by mental health and addiction issues.

5: Supporting people with complex needs: Support people with complex combinations of mental health issues, disabilities, long-term conditions, and/or dementia to achieve the best quality of life.

6: Promoting wellbeing and reducing stigma and discrimination: Promote mental health and wellbeing to individuals, families/whānau, and communities and reduce stigma and discrimination against individuals with mental illness and addictions.

7: Providing a positive experience of care: Strengthen a culture of partnership and engagement in providing a positive experience of care.

8: Improving system performance: Lift system performance and reduce the average cost per person treated while at the same time improving outcomes.

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Appendix 4: Community hub example

Figure 23 shows an example of how a locality-based community wellbeing centre might operate.

Figure 23:   Local community wellbeing hub functional model
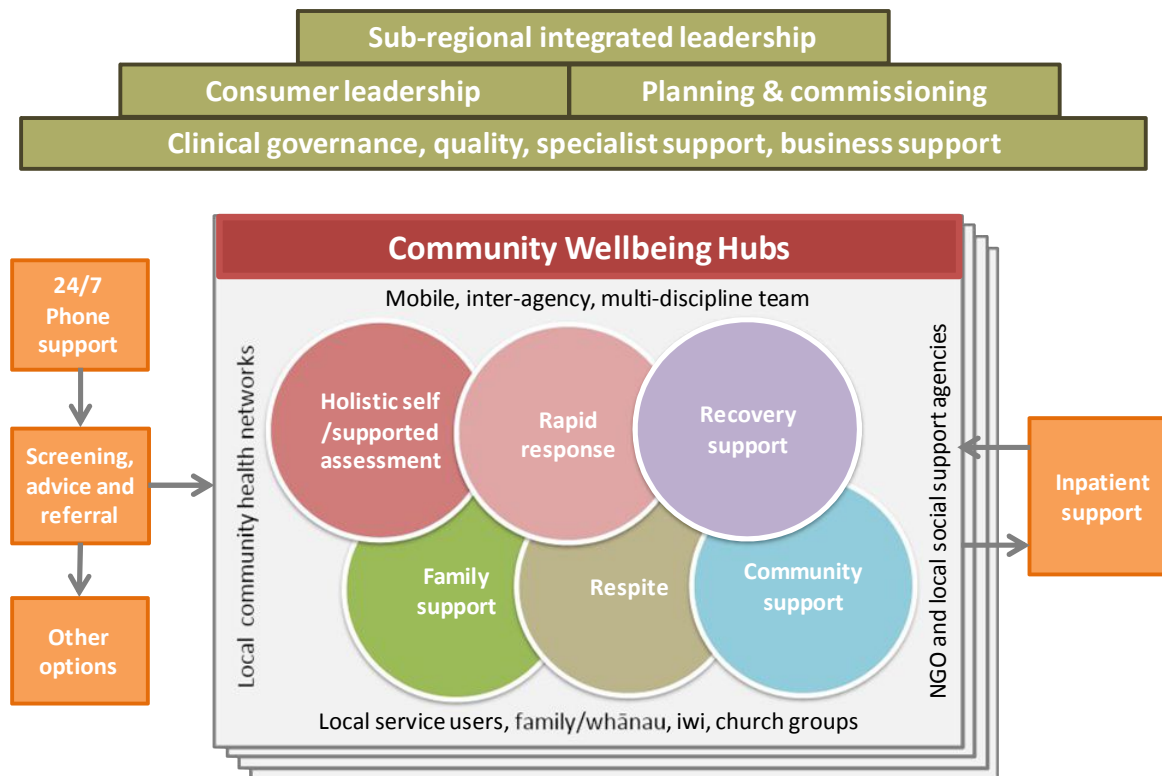
Appendix 5: Glossary of terms

The glossary of terms and abbreviations listed over the following pages is based on information contained in *Blueprint II: Making change happen* (Mental Health Commission, 2012b).

Addiction	The continued use of a mood-altering substance or behaviour despite adverse consequences.
AOD	Alcohol and other drug services.
Behavioural health	Sometimes used interchangeably with the term 'mental health'. It includes not only ways of promoting wellbeing by preventing or intervening in mental illness such as depression or anxiety but also has as an aim of preventing or intervening in substance abuse or other addictions.
Benchmarking	To evaluate or check something by comparing it with the performance of others or with best practices.
CAMHS	Child and adolescent mental health services.
CBT	Cognitive behavioural therapy. A form of psychotherapy in which the therapist and the client work together as a team to identify and solve problems. Therapists use the Cognitive Model to help clients overcome their difficulties by changing their thinking, behaviour, and emotional responses.
Commissioning	A process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers.
Conduct disorder	A childhood and adolescent behavioural disorder characterised by aggressive and destructive activities that cause disruption in the child's environment.
Dementia	Loss of brain function that affects memory, thinking, language, judgement, and behaviour.
Determinants of health	The personal, economic, social, and environmental factors that can influence the health status of an individual or population.
DHB	District health board. The government organisation responsible for providing or funding health and disability services in a defined geographical area.

E-therapy	Electronic therapy programmes aimed at helping people to resolve mental health or addiction issues.
Evaluation	A systematic process for collecting, analysing, and using information to assess change that can be attributed to an intervention. Evaluation involves a judgement about the value, progress, and impact of an intervention.
Family	The service user's whānau, extended family, partner, siblings, friends, or other people who the service user has nominated.
Forensic services	Services delivered in prisons, courts, community- and home-based settings for people with mental health and/or co-existing mental health and addiction needs who are currently in the justice system.
GP	General practitioner. A physician whose practice is not oriented to a specific medical specialty but instead covers a variety of medical problems in patients of all ages.
Health literacy	An individual's ability to read, understand, and use health care information to make decisions and follow instructions for treatment.
Health promotion	A process of enabling people to increase their control over and improve their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.
High-prevalence conditions	Widespread conditions such as anxiety, depression, alcohol and drug issues, and medically unexplained symptoms.
HWNZ	Health Workforce New Zealand. The organisation responsible for the planning and development of the health workforce, ensuring that staffing issues are aligned with planning and delivery of services and that our health workforce is fit for purpose.

Indicators	Measurable characteristics or variables that represent progress and are used to measure changes or trends over a period of time.
Integration	Coordination of services resulting in support that is seamless, smooth, and easy to navigate.
Interventions	An effort/activity to promote good health behaviour and/or prevent/improve or stabilise a medical condition.
IT	Information technology. The use of electronic devices and processes, such as computers, to create, process, store, secure, and exchange electronic data. Sometimes considered part of the broader category information and communications technology (ICT).
Kessler 10-item scale	A 10-item self-report questionnaire intended to obtain a global measure of psychological distress.
Let's Get Real	A workforce development framework that describes the essential knowledge, skills, and attitudes required to deliver effective mental health and addiction services.
Life course	All stages of life, from prenatal to old age.
Mental health and addiction ringfence	Government mechanism to ensure that funding intended for specialist mental health and addiction services is used solely for those purposes.
MHA	Mental health and addiction.
MHAIDS	Mental Health, Addictions and Intellectual Disability Services / Te Upoko me Te Karu o Te Ika. A MHA service for all ethnicities across Wellington, Porirua, Kāpiti, Hutt Valley, and the Wairarapa, as well as some central region and national services.
Ministry of Health	Government agency whose functions are to provide strategic policy advice and ministerial services to the Minister of Health, monitor DHB performance, and administer legislation and regulations.

Morbidity	The incidence of ill health in a population.
Mortality	The incidence of death in a population.
Nationwide Service Framework	A collection of definitions, processes, and guidelines that provides a nationwide, consistent approach to the funding, monitoring, and analysis of services.
New Zealand Triple Aim	An approach designed to simultaneously achieve improved quality, safety, and experience of care; improved health and equity for all populations; and best value from public health system resources.
NGO	Non-governmental organisation. Independent community and iwi/Māori organisation operating on a not-for-profit basis, which brings a value to society that is distinct from both government and the market.
OECD	Organisation for Economic Co-operation and Development. An international intergovernmental organisation, involving 36 member countries, that aims to promote policies to improve the economic and social wellbeing of people around the world.
Peer support services	Services that enable wellbeing, delivered by people who themselves have experienced mental health or addiction issues, and that are based on principles of respect, shared responsibility, and mutual agreement/choice.
Perinatal	Of or relating to the time, usually several weeks, immediately before or after birth.
PHO	Primary health organisation. Funded by DHBs to ensure the provision of essential primary health care services – mostly through general practices – to enrolled clients.
PHU	Public health unit. 12 DHB-owned units providing regional public health services focused on environmental health, communicable disease control, tobacco control, and health promotion programmes.

Prevalence	The total number of cases of a disease in a given population at a specific time.
Primary care	Essential health care that is universally accessible to people in their communities; the first level of contact with the health system.
PRIMHD	Pronounced 'primed'. The Ministry of Health collection of mental health and addition activity and outcome data.
Psychological therapies	A group of therapies designed to improve mental health through talk and other means of communication.
Recovery	Living well in the community with natural supports.
Relapse prevention plan	A plan that identifies early relapse warning signs in clients. The plan identifies what a client can do for themselves and what the service will do to support the client. Ideally, each plan will be developed with involvement from clinicians, clients and their significant others. The plan represents an agreement and ownership between parties. Each plan will have varying degrees of complexity, depending on the client. Each client will know, and ideally have a copy of, their plan.
Resilience	The capacity of individuals to cope well under adversity.
Ringfence	See 'Mental health and addiction ringfence'.
Self-management	Actions and decisions that people take to regain, maintain, and improve their own health and wellbeing.
Serious mental health and/or addictions	People who have serious ongoing and disabling mental illness and addiction issues, who require treatment from specialist mental health, alcohol and drug, or other addiction services.

Service user	A person who uses mental health or addiction services. This term is often used interchangeably with 'consumer' and/or 'tangata whai ora'.
Shared care	Integrated health care delivery in which practitioners from more than one health service work in partnership to provide services to a client and their family and whānau.
Social inclusion	The absence of barriers to full participation within a chosen community by a person or group.
Specialist services	Those mental health and alcohol and other drug services described in the National Service Framework (see above) and funded through the mental health and addiction ringfence (see above). This includes both DHB and NGO services.
Staged care	An approach that uses the least intrusive care to meet presenting needs and enables people to access and/or move to a different level of care to suit their identified needs.
Talking therapies	Various forms of psychotherapy that emphasise the importance of the client speaking to the therapist as the main means of expressing and resolving issues.
Targets	A set of national performance measures specifically designed to improve performance and to provide a focus for action.
Trauma informed therapies	Therapies specifically designed to address the consequences of trauma in an individual and to facilitate healing. This can include physical, sexual, and psychological trauma.
Triple Aim	See 'New Zealand Triple Aim'.
Value for money	A term used to assess if an organisation has obtained the maximum benefit from the goods and services that it both acquires and provides, within the resources available to it.

Well Child	A screening, surveillance, education, and support service offered to all New Zealand children and their family and whānau from birth to 5 years of age.
Whānau	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 individual to define for themselves who comprises their whānau.
Whānau Ora	In this document, the government-funded services or initiatives designed to place whānau at the centre and build on the strengths and capabilities already present within the whānau.
Whole of health	Includes all parts of the health and disability system, including physical health services, disability services, mental health and addiction services, and at all levels, including self-care, primary health care, community health care, specialist health care, and so on.
Whole of person	An approach that looks at all the needs of a person, including mental health and addiction needs, physical health, housing, employment, social supports, and so on. It can also be called a holistic approach.
Whole-of-system model of care	A model for conceptualising and organising services across the health system, including links to cross-sectoral partners, such as housing, education, and justice. It provides client pathways to and through services, including decision rules about what treatments to offer to whom, when, and by whom and a high-level model for allocating service resources at the population level.

	3DHB DISABILITY SERVICES ADVISORY COMMITTEE DISCUSSION PAPER
	Date: 26 November 2018

Author	David Szabo, Programme Manager, MHA Improvement Programme
Endorsed by	Rachel Haggerty, Director – Strategy, Innovation & Performance
	Helene Carbonatto, General Manager – Strategy, Planning and Outcomes
	Joy Cooper, Acting Executive Leader Planning and Performance
Subject	**Mental Health and Addictions Improvement Programme**

RECOMMENDATION

It is recommended that the Committee:

    a) **NOTES** this update on the Mental Health and Addictions improvement programme.

    b) **NOTES** the updates on the AOD Model of Care, Suicide Prevention and Postvention Services, Acute Care Continuum Project and the Te Whare Ahuru (TWA) Reconfiguration.

APPENDICES

    1. **MENTAL HEALTH AND ADDICTION IMPROVEMENT PLAN**

    2. **DSM WORKSTREAM.**

1. INTRODUCTION

1.1 Purpose

The purpose of this paper is to update the 3DHB Disability Services Advisory Committee (DSAC) of the newly formed Mental Health and Addiction Improvement Programme (MHA IP). This programme is a three DHB approach designed to streamline existing Mental Health, Addictions and Intellectual Disability Services (MHAIDS) projects, reviews and improvement work, under a single programme governed by DSAC and sponsored by the three Chief Executives (CEs). It builds on the work commenced under Mental Health Integration, and at CCDHB, the Even Better Health Care Programme.

Alongside providing a high level overview, this paper focuses on highlighting high level progress made since its inception. It provides a detailed summary of the following four projects--AOD Model of Care, Suicide Prevention and Postvention Services, Acute Care Continuum Project and the Te Whare Ahuru (TWA) Reconfiguration project--previously reported to DSAC. These projects are now under the MHA IP programme under the workstream Developing Service Models.

2. BACKGROUND

MHAIDS is the mental health, addictions and intellectual disability service for the Wairarapa, Hutt Valley and Capital & Coast District Health Boards.

The service has two distinct arms—one provides sub regional and local specialist services for the three DHBs, while the other is focused on forensic services and regional rehabilitation, and national services (currently provided through Capital & Coast DHB).

3. **MENTAL HEALTH AND ADDICTION IMPROVEMENT PROGRAMME (MHA IP)**

Improving mental health and wellbeing is a priority for our DHBs. The three DHBs have now drafted the Mental Health and Addictions Strategy *Living Life Well 2019 – 2025* which sets the direction for mental health and addiction care in the sub-region to improve the experience and outcomes for our people, whānau and our communities.

This direction supports the complete continuum of care and recognises that we must have the capability and capacity to meet the needs of our population and adapt to changes in practice across the whole spectrum. It recognises the necessity for service equity and consistent and accessible care for all groups of our population.

We acknowledge that there is increasing demand and pressures on our mental health and addiction services, which impact on the delivery of our services, the workloads of our staff and the care of our clients. To ensure that we are meeting the changing needs of our people and best position ourselves for the future, the MHA IP has been developed to ensure collaboration, oversight and a shared direction across the three DHBs.

The programme brings together a number of short and long-term improvement initiatives and projects from MHAIDS and the three DHBs, and streamlines them by providing shared oversight, responsibility and accountability.

The vision of the programme is that it will address, define and improve the current state of MHAIDS delivery and performance through the creation and enhanced of aligned three DHB processes and practice.

The programme is sponsored by the three CEs and is supported by planning and funding, operations and clinical services teams from across the three DHBs.

The MHA IP is organised to deliver across eight key workstreams, with the associated goals:
(See appendix: MHA IP Plan)

Refining our vision
Agreeing on our vision and how we are going to achieve it. This work stream will complete the Mental Health and Addictions Strategy *Living Life Well 2019 - 2025*.

Service collaboration
Work undertaken across the three DHBs to ensure seamless collaboration as a 3DHB service.

Developing service models
We are refining our service delivery models to ensure that they are in line with current research. This will ensure our models are fit for purpose within our communities and regional service delivery.

Investment alignment
Identify opportunities to use funding levers across the three DHBs to develop and implement preferred models of care.

Acute demand response
Responding swiftly to acute demand pressures and oversee the implementation of short term actions to relieve the current situation across services.

Patient acuity and resources
Matching resource to patient acuity and service need. Enable matching of nursing, medical and allied health workforce resources to service need and acuity.

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Safety and Quality
Continue to improve the safety and quality of service provision. Review the clinical governance framework to ensure that MHAIDS systems, processes and practices are designed to support a patient safety culture and ongoing service improvement.

Accountability framework
Develop a robust 3DHB accountability framework to ensure that reporting on all aspects of MHAIDS performance meets the needs of the three DHBs.

3.1 MHA IP PROGRESS HIGHLIGHTS

3.2 Acute demand response

A series of initiatives have been implemented to respond to significant pressures on MHAIDS acute demand management, and work continues to permanently address the underlying issues and move MHAIDS into a continual service improvement cycle. Key activities that have had a notable impact so far are:

- Daily stand up acute resource flow meetings have been introduced along with the implementation of a facilitated handover meeting to better manage daily capacity and service management challenges.

- A Hutt Valley DHB (HVDHB) MHAIDS Caseload review has been undertaken, with approx. 150 clients reviewed and discharged to date, with an estimated further 200+ expected to be discharged by January 2019.

- Three Mental Health Support Workers have been introduced and the supporting guidelines for their work have been completed. These are deployable resources able to be utilised across the entire MHAIDS 3DHB Service to help relieve pressures as required.

3.3 Investment and Alignment

The programme has started a review of the Capital & Coast DHB (CCDHB) MHAIDS Budget and a plan to manage the re-baselining process is being drafted. The Finance staff and MHAIDS Management Accountants are being consulted over expected timings.

3.4 Patient acuity and resources

Engagement as part of the CCDM Programme has begun to identify the pre-requirements to better enable CCDM delivery across MHAIDS. This work, such as rolling out Trendcare and implementing capacity planning practices, looks set to commence in 2019.

3.5 Safety and Quality

The MHA IP has started preparation work towards rolling out a revised MH clinical governance structure, to be piloted before wider implementation in 2019. This new framework will ensure that MHAIDS systems, processes, protocols and practices are designed to greater support a patient safety culture and encourage ongoing service improvement activity and review.

3.6 DEVELOPING SERVICE MODELS WORKSTREAM UPDATE
The goal of the Developing Service Model Workstream is to ensure that all MHAIDS delivery models are in line with current research, support achieving the vision and are fit for purpose within our communities and regional service delivery. Currently there are four active projects within this workstream.

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3.7   Acute Care Continuum Project

This project's aim is to produce an Acute Care Continuum (ACC) and subsequently procure ACC services (ACCS) to enable that continuum of patient service for both CCDHB and HVDHB by 1 October 2019.

Considerable pressure on existing mental health acute care coupled with future demand growth, requires that we urgently rethink our service configuration within acute care. A project has been initiated to develop an Acute Continuum of Care for the three DHBs.

This project will be led out of HVDHB's Strategy, Planning and Outcomes group on behalf of the three DHBs. A Steering Group has been formed and met for the first time on 21 November 2018. The Project Plan for this work will be presented and finalised at that meeting.

The project will be managed in two stages. The first stage will build on the considerable amount of work completed in 2017 to finalise a preferred continuum of care, including the various services and settings those services should operate within. It is anticipated that this stage will be completed by the end of February 2019.

The second stage is the procurement and/or reconfiguration of services to enable that continuum of care. This procurement may have some joint aspects, but is more likely to be individually managed by each DHB to ensure a strong locality based approach. This stage should culminate with the desired services being in place by 1 October 2019.

We will keep each of the Boards updated as the project progresses.

3.8   Te Whare Ahuru Reconfiguration

The adult acute inpatient service Te Whare Ahuru (TWA) is being reconfigured to ensure that the service is providing the most appropriate care and environment to deliver good long term health outcomes. Phase one of the project is now complete and is set to enter the next phase after having been signed off by the HVDHB's Board.

The second phase will involve finalising the recommendations for the preferred model of care and service delivery approach. This will inform the development of facility refurbishment options and lead to the completion of a single stage business case.

The engagement and consultation work undertaken in the first phase of the project identified several factors including; a strong system perspective, coordinated and seamless care across the system, a commitment to continue to operate in partnership with other MHAIDS acute inpatient services, a facility that caters to variable levels of support, a facility to cater for our diverse populations and cultures, physical disabilities, gender needs and the existence of co-morbidities, and a facility that meets the reflects the specific needs of Māori as our indigenous people. These findings will be incorporated into the model of care and refurbishment options in phase two.

3.9   Preventing Suicide and Suicidal Behaviour in Wairarapa, Hutt Valley and Capital and Coast DHBs

This project will aim to reduce suicide and suicidal behaviour across the three DHBs by creating a more effective whole-of-health system strategy for suicide prevention. The three DHBs wish to develop a more effective strategy for preventing suicide and suicidal behaviour, with a strong focus on improving the health system's response.

The three DHBs are seeking a clearer picture of who is directly affected by suicide and self-harm by analysing the data we hold and using it to inform a review of health services. Based on this analysis, the DHBs will then make recommendations for improvement to the system, process and services.

3.10   Alcohol and other drug (AOD) pathway and model of care project

This project is reviewing current service configuration, identifying gaps, and/or duplication of services, and will develop a new AOD pathway and model of care across the 3DHB region. This project will also identify an agreed implementation approach once the new AOD pathway and model of care is developed.

In 2017, while preparing for the introduction of the new Substance Addiction (Compulsory Assessment and Treatment) Act (SACAAT), it became clear that there was no clearly articulated and agreed, locality based AOD pathway and model of care. As a result of this, it was recognised that there has been no recent or consistent approach to understanding the needs of each DHB population with AOD issues nor associated planning and investment to address these needs when identified.

There are also likely service gaps and access inequities for people who have moderate needs. Including those who would benefit from harm re-reduction, peer support and early interventions.

These observations among other identified in the preparation of SACAAT need to be further explored in order to develop an agreed 3DHB AOD pathway and model of care that better meets the needs of the three populations in a way that is locally obtainable.

3.11   Mental Health and Addiction Consumer Leadership Group (MHACLG)

The mental health and addiction team within Strategy, Innovation and Performance (SIP) (CCDHB) is re-establishing the MHACLG to support the team's programme of work. It is envisaged that the refreshed MHACLG will also support the mental health and addiction work within Hutt Valley and Wairarapa DHBs.

A co-design workshop to re-establish the group, define the terms of reference and the partnership approach, will be held on 6 December 2018. Following this workshop a final decision will be made at 3 DHB governance level about the scope of the consumer leadership group and whether it will take a local or sub-regional focus.

The concept of consumer involvement is best exemplified in the slogan 'nothing about us, without us'. This acknowledges that those who are the recipients of health care, must be involved in its planning, development, delivery and evaluation. This also includes involvement of family and whānau of those who have experienced mental health and/or addiction problems.

We will also continue ongoing discussions with SIP's Disability team, as there may be synergies with their already established disability advisory groups.

Appendix 1

Mental Health & Addictions Improvement Programme

The MHA Improvement Programme will; address, define and improve the current state of MHAIDS service delivery and performance, through the creation and enhanced of aligned 3DHB processes and practice.

3DHB STRATEGY AND RESPONSE WORKSTREAM
- Complete Mental Health Strategy and Consultation
- Review existing initiatives against the MH Strategy
- Plan the MHAIDS IP Programme
- Evaluate the Success of the MHIADS Service Improvement Programme

>> Enhance the Service Delivery Model

ENHANCE THE SERVICE MODELS WORKSTREAM
- Implement and align existing service delivery to the new MH Strategy
- Systematic review of the current delivery model

MHAIDS SERVICE INTERGRATION WORKSTREAM
- Integrate the MHAIDS service across the three DHBs under a single entity
- Review of all the transactional HR policies, systems and practice

>> MHAIDS Service Improvement
>> Enhance the Service Delivery Model

MHAIDS SERVICE IMPROVEMENT
- Assess / Import EBHC MHAIDS work stream
- Te Haika Improvement Project
- MHOC Project
- Digital Client Record 2

ACUTE DEMAND CRISIS RESPONSE WORKSTREAM
- Crisis Response Project
- HVDHB Community MH caseload review implementation

>> MHAIDS Service Improvement
>> Enhance the Service Delivery Model

PATIENT ACUITY AND SERVICE NEED WORKSTREAM
- Rostering Consolidation Project
- Implement Capacity Planning
- Trendcare Implementation Project
- MHAIDS CCDM Adoption

>> Support and enable dependant initiatives

This work stream will define the vision for the programme, oversee the implementation of it and define the planning and evaluation phases

Ensure alignment to all applicable 3DHB strategic directions and continually monitor the progress of the programme

To further the integration of the MHAIDS service across the three DHBs under a single entity

Identify and oversee the implementation of action to relieve the crisis situation across the services caused by the growing demand

Matching of nursing, medical and allied health workforce resources to the service need and acuity

Ensure delivery models are in line with current research, support the 3DHB MHA vision and are fit for purpose within our communities

Ensure that MHAIDS systems, processes, protocols and practices are designed to support a patient safety culture and ongoing service improvement

Identify opportunities to use funding levers to develop and implement preferred models of care

Ensure that reporting on all aspects of MHAIDS performance is meeting the needs of all DHBs

DEVELOPING SERVICE MODELS WORKSTREAM
- Acute Care Continuum Project
- Te Whare Ahuru Reconfiguration
- Suicide Prevention Approach (led by CCDHB)
- Alcohol and other drug (AOD) pathway and model of care project
- Kahukura: Regional Rehabilitation Services
- Nga Tapawae: Forensic Services

>> Enhance the Service Delivery Model

IMPLEMENT MHAIDS QUALITY PLAN WORKSTREAM
- Ensure systems, processes, protocols and practices are designed to support a patient safety

SAFETY AND QUALITY WORKSTREAM
- Clinical partnership and management structure for 2019/20 Project

>> Implementation of the MHAIDS Quality Plan

DEVELOP FUNDING MODELS WORKSTREAM
- Determine Review Framework And Terms Of Reference
- Complete Review/ generate Recommendations
- Seek Approval And Endorsement

INVESTMENT AND ALIGNMENT WORKSTREAM
- Mental Health Budget Rebasline Project
- MHAIDS PVS Review

>> Develop new Funding Models

ACCOUNTABILITY FRAMEWORK WORKSTREAM
- Aligned 3CEs Strategy & Planning Initiative
- Review and engage joint monitoring meetings
- Engage planning, funding and performance to support investment

>> Support and enable dependant initiatives

SUPPORT AND ENABLE DEPENDANT INITIATIVES WORKSTREAM
- Speaking up for safety (cognitive institute)
- Promoting professional accountability programmes
- MHIADS primary and secondary care interface (ICC and Hutt Inc.)
- MHIADS security upgrade project (CCDHB securities)

Central diagram labels
ENHANCE THE SERVICE DELIVERY MODEL · 3DHB STRATEGY AND RESPONSE · DEVELOPING SERVICE MODELS · IMPLEMENT MHAIDS QUALITY PLAN · SAFETY AND QUALITY · INVESTMENT AND ALIGNMENT · DEVELOP NEW FUNDING MODELS · ACCOUNTABILITY FRAMEWORK · SUPPORT AND ENABLE DEPENDANT INITIATIVES · MATCH PATIENT ACUITY AND SERVICE NEED · MHAIDS CRISIS REPONSES · MHAIDS SERVICE IMPROVEMENT · MHAIDS SERVICE INTEGRATION

Inner: SERVICE IMPLEMENTATION PERFORMANCE · MHAIDS (CLINICAL) · PLANNING AND FUNDING · MHAIDS (OPERATIONS) · INDEPENDANT CONSULTANT · WAIDHB · CCDHB · HVDHB

GOVERNANCE TEAM			PROGRAMME MANAGEMENT TEAM	
Chief Executive, WAIDHB — Adri Isbister	Chief Executive, CCDHB — Julie Patterson	Chief Executive, HVDHB — Dale Oliff	Programme Director — Rachel Haggerty	Programme Director / Independent Chair — Warrick Frater
Rachel Haggerty · Alison Masters	Nigel Fairley · Nigel Fairley · Warrick Frater	Helene Carbonatto · Alison Masters · Nigel Fairley	EBHC Advisor — Jenny Langton	MHAIDS Project Manager — Marilyn Hunt	MHA IP Programme Manager — David Szabo
3DHB MHA Strategy · Contemporary Service Models	MHAIDS Acute Demand Crisis Response · Patient Acuity And Service Need · MHAIDS Service Integration	Investment and Alignment · Improve safety and quality of service provision · Develop an accountability framework	Change Manager — To Be Confirmed	MHAIDS Communications — Mel McCool	EBHC Programme Coordinator — Jessica Drysdale

Appendix 2

TE WHARE AHURU RECONFIGURATION

Project objectives
- A reliable insight into our changing long-term mental health needs across the 3DHB system and the Hutt Valley specifically (including demand forecasting).
- An understanding of best practice models of care and facility configurations for mental health inpatient services both nationally and internationally that support improved patient-centered care.
- A description of the future model of care for MHAID Service 3D inpatient services, and its relationship to other mental health services within the sub-region including 'step down', community mental health support services and primary care. This will include a description of patient pathways and workforce skill mix. It will also include an evaluation of the options and trade-offs of various inpatient service delivery approaches and how the preferred options represent best value (patient-centered, clinically and financially).
- A confirmed service delivery approach with associated high level architectural drawings to inform a Board decision on Capex and OPEX investment.

Expected benefit
- Future proof the TWA environment.
- Improve satisfaction of service provision by consumers and their families.
- Provide a fit for purpose environment that staff, consumers and visitors can interact most positively in.
- Reduce average length of stay due to providing an environment more conducive to recovery.
- Clarify the model of care that would clearly describe TWA's role within the sub-region

ANTICIPATED END DATE: OCTOBER 2019

ACUTE CARE CONTINUUM PROJECT

Project Objectives
- Produce the ACC.
- Develop options to address that continuum.
- Procure the preferred service/s.

Workshops will be held with a range of stakeholders including MHAIDS, NGOs, consumer advisors and cultural representatives to identify needs and key features of future services. This information will then be supplemented with benchmarking of service provision elsewhere in the country and data analysis. This will in turn lead to the development of options including a preferred option for consideration by the Steering Group. The respective Boards will then be asked for approval and funding to advance procurement of the preferred option.

Expected benefit
- Increased options available to support the effective management of adult tangata whaiora within CCDHB and HVDHB catchment areas.
- Improved satisfaction of service provision by tangata whaiora and their families.
- Reduction in demand for beds within adult inpatient facilities.
- Reduction in the average length of stay in adult inpatient facilities.

ANTICIPATED END DATE: OCTOBER 2019

DEVELOPING SERVICE MODELS

Today

Start Mon 18/09/17

Oct '17 | Nov '17 | Dec '17 | Jan '18 | Feb '18 | Mar '18 | Apr '18 | May '18 | Jun '18 | Jul '18 | Aug '18 | Sep '18 | Oct '18 | Nov '18 | Dec '18 | Jan '19 | Feb '19 | Mar '19 | Apr '19 | May '19 | Jun '19 | Jul '19 | Aug '19 | Sep '19 | Oct '19 | Nov '19 Finish Fri 8/11/19

Suicide Prevention Approach (led by CCDHB)
Mon 18/09/17 - Tue 19/02/19

Te Whare Ahuru
Wed 1/11/17 - Sat 18/05/19

Acute Continuum Project
Fri 26/10/18 - Tue 1/10/19

AOD Models of Care
Thu 8/11/18 - Fri 8/11/19

SUICIDE PREVENTION APPROACH (LED BY CCDHB)

Project objectives
- Analyse data on deaths by suspected suicide and self-harm to form an overall picture of what is happening and where
- Engage a researcher to use the data identified in stage 1 to inform and undertake a review of key DHB funded health services' and their current responses to suicides and suicide.
- Provide brief update for DSAC Committee and Strategic Advisory Group
- Prepare a final report of review findings and recommendations on what changes (systemic, processes or services) need to be implemented internally within the 3 DHBs as well as the rest of the health system (Align to Ministry of Health's requirements)
- Meet with Strategic Advisory Group
- Develop project brief for any recommended service change as well purchasing brief for any new services.

Expected benefit
- A reduction in Suicide Rates within the 3DHBs (yet to be quantified).

ANTICIPATED END DATE: APRIL 2019

ALCOHOL AND OTHER DRUG (AOD) PATHWAY AND MODEL OF CARE PROJECT

Project Objectives
- Determine what the current AOD pathway and model of care looks like across the 3DHB's
- Analyse current locality based need and demand
- Develop locality based AOD pathways and models of care to meet current and future demand based on best local and international evidence
- develop an implementation approach for the new pathways and model
- Procure the preferred service/s.

Expected benefit
- increased options available to support people with AOD issues and their family and whanau across the 3 DHB's
- local pathways and models of care that meet local needs
- an agreed but locality based pathway and model of care across the 3 DHB's
- reduced waiting times to access AOD services
- service gaps being identified and filled

ANTICIPATED END DATE: TO BE CONFIRMED

PUBLIC

	3DHB DISABILITY SERVICES ADVISORY COMMITTEE **DISCUSSION PAPER**
	DATE: 27 NOVEMBER 2018

From:	Emma Hickson, Acting Manager 3DHB Disability Team, Strategy, Innovation and Performance, Capital and Coast DHB (CCDHB)
Endorsed by:	Rachel Haggerty, Director, Strategy, Innovation and Performance, Capital and Coast DHB (CCDHB)
Subject	Update on the Capital & Coast DHB (CCDHB) Whole of Life NASC Project
It is recommended that the Disability Services Advisory Committee: • **Note** the activity and outcomes of the Whole of Life Needs Assessment Service Co-ordination (NASC) project • **Note** that co-design with the Sub-Regional Disability Advisory Group, Maori Partnership Board, Subregional Pacific Advisory Group and the Integrated Care Collaborative will proceed to enable the development of an implementation plan.	

1. PURPOSE

This paper seeks 3DHB Disability Services Advisory Committee (DSAC) noting of the opportunities identified in the Capital & Coast DHB's (CCDHB) Whole of Life Needs Assessment and Service Coordination (NSAC) Project and endorses its recommendations.

2. BACKGROUND

Capital and Coast District Health Board (CCDHB) is committed to taking a more integrated approach to assessment and organisation of support that takes account of a full range and continuum of a person's needs during their life.

Four separate Needs Assessment and Service Coordination (NASC) agencies operate within the CCDHB region. Each NASC has its own access and eligibility criteria, primarily based on age and or diagnosis as determined by its service agreement. This informs the NASC service and care pathways and processes.

There were several people known to inpatient and NASC services who experience difficulty with access to NASC services. The barriers varied depending on the person's situation and included: their age and diagnosis; not fitting any NASC eligibility criteria; eligibility across multiple NASCs requiring greater coordination for needs to be fully met; and difficulty sourcing service providers who could meet needs. In March 2017, an interim clinical governance group was established to improve access to these people and collect data to quantify the issues and evidence to support informed decision.

In July 2017, a Strategic Group was established with membership across DHB to govern the Whole of Life NASC project work, to develop an integrated model for needs assessment informed by a whole of life approach and recommend the direction that is supportive of organisational priorities including Health Care Home and Capital and Coast Health System Plan implementation. The group held four meetings, considered the current system status supported by data and analytics. The analytics quantified some of the issues raised, highlighted new issues and raise questions on best options that supports a whole of life approach.

Wairarapa, Hutt Valley and Capital & Coast District Health Board

3. SUMMARY

The Strategic Group of Whole of Life NASC project met for the final time in November and discussed the recommendations detailed in a Decision Paper (see Appendix I). The Strategic Group discussion is summarised below:

- Whole of life is a concept that the Strategic Group agreed to as beneficial for all.

- While the concept is beneficial for all, a particular group of people who access multiple NASC or have very complex needs could benefit more from such an approach.

- Integrated NASC was seen as a service model that could implement whole of life NASC approach

- Data analysis quantified the number of people accessing more than one NASC to be much smaller than anticipated. Analysis also showed other opportunities for integration. Gaps in data were similarly identified.

- An integrated NASC service model could be utilised to integrate services or functions or both. This would depend on who the integration is for.

- A number of future opportunities were presented that promoted person centred and whānau centred care. This included opportunities for a person to self-assess, individualised funding and improving equity for Māori and Pacific given current disparities.

- Parallel discussion on service improvement opportunities were also received well. They included opportunities to create a NASC minimum data set, quantifying unmet needs, and standardised pathways.

4. PROJECT RECOMMENDATIONS:

The following opportunities were agreed and recommended by the Strategic Group of Whole of Life NASC project:

- Explore the implementation of e-referrals that could direct referrals to the right NASC agency.

- Investigate referrer pattern from duplicate referrals and provide referrer education and easy to understand access pathways.

- Establish a sharing of knowledge across older persons and disability NASC care managers/service facilitators.

- Allocate key workers (Care Co-ordination Centre Care Managers and Capital Support Service Facilitators) to facilitate smooth transition between NASC.

- Investigate general use of Long Term Support-Chronic Health Conditions funding and potential for disability NASC providing support for babies or children under four to avoid transitioning at age.

- Pathways for identified scenarios of people requiring access to multiple NASC funding is established. The pathways are simple and clearly defined and remove current system constraints.

- Establish shared funding and contracting of service providers for those who are eligible for multiple NASC funding.

- Complete rules analysis – analyse current rules and identify explicit changes required to rules that pose barriers to meet people's needs.

5. OPPORTUNITIES FOR MĀORI AND PACIFIC PEOPLE:

The following opportunities were identified to improve equity of service access and outcomes for Māori and pacific people.

- There is an opportunity for Māori and Pacific people to take a lead in recommending actions that will deliver a culturally responsive service.

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- There is an opportunity for CCDHB to commit to a whānau-centred care approach to NASC and services that NASC has a direct touch with.

- There is an opportunity to integrate services and functions with current Māori and Pacific providers who already take a whānau-centred approach.

- It is recommended that the CCDHB take stock of the 2012 TAS report recommendations (appendix 4 of the decision paper) and develop specific actions to improve the NASC.

6. OTHER OPPORTUNITIES:

The following opportunities were also identified to make an overall improvement in service provision and a more integrated approach to whole of life needs assessment.

- Consolidate NASC intake functions to make easier to navigate, move from eligibility driven referral to request for services.

- Needs assessment processes shared across health care professionals enabling community partnerships, avoiding duplication of assessments.

- Investigate self-assessment supporting independence, person centeredness, person empowerment.

- Enable individualised funding enabling people to influence their care and enabling of whanau-based care.

- Support whānau-based care as best use of natural supports and being more culturally appropriate.

- Develop NASC minimum data set to inform decision making, understand inequities.

- Promote meeting unmet needs and achieving equity.

- Enable NASC's role as part of flexible team in Health Care Homes to support seamless care and build capacity.

7. NATIONAL DEVELOPMENTS

The Government launched a prototype of a transformed disability support system in the MidCentral DHB region, on 1 October 2018. The new system, Mana Whaikaha, has been co-designed over the past 18 months with disabled people and whānau, and others in the disability sector. The new system is based on the Enabling Good Lives principles and aims to provide disabled people and whānau more support options, give disabled people and whānau greater decision making over their support, improve outcomes for disabled people and whānau and create a cost-effective disability support system.

The MidCentral prototype trail will conclude in June 2020 with the expectation that final model will be rolled out across the country in late 2020. MidCentral disability NASC has been restructured, with additional new staff including disabled people being recruited. The new service structure roles include Connectors who act as ally for disabled people and their whānau, People's needs are determined through conversations and not assessed by questions.

8. OUTCOME FROM PROJECT

The Strategic Group endorsed the recommendations to pursue both the integration options and service improvement opportunities.

Implementation planning will now progress including engaging consumers and the Sub-Regional Disability Advisory Group, Maori Partnership Board, Subregional Pacific Advisory Group and the Integrated Care Collaborative in the co-design of identified recommendations.

	3DHB DISABILITY SERVICES ADVISORY COMMITTEE **DISCUSSION PAPER** **DATE: 28 NOVEMBER 2018**
From:	Emma Hickson, Acting Manager Disability Responsiveness Team, 3DHB, Capital and Coast DHB (CCDHB)
Endorsed by:	Rachel Haggerty, Director, Strategy, Innovation and Performance, Capital and Coast DHB (CCDHB) Helene Carbonatto, General Manager, Strategy, Planning and Outcomes, Hutt Valley DHB (HVDHB) Joy Cooper, Acting Executive Leader, Planning and Performance, Wairarapa DHB (WRDHB)
Subject	**Update on the implementation of the 3DHB Sub-Regional Disability Strategy**

It is recommended that the Disability Services Advisory Committee:

- **Note** the outcomes of the Sub-regional Disability Planning Workshop on 2 November 2018, including the identification of priorities consistent with 3DHB Sub-regional Disability Strategy and optimal ways of working together

- **Agree** to take the next available opportunity to ensure that DSAC's membership includes more people with lived experience of disability

- **Note** progress on:
  - Recruiting staff to the vacancies in the 3DHB Disability Responsiveness Team
  - The Disability Dashboard

APPENDIX

1. Disability Dashboard

1. PURPOSE

This paper seeks DSAC's noting of the purpose, recommendations and outcomes from the Sub Regional Disability Advisory groups recent workshop. The paper informs DSAC of the Sub regional Disability Advisory Group (SRDAG) and the other disability groups' view on the importance of people with a lived experience of disability being represented on DSAC and recommends that DSAC take the next available opportunity to ensure that its membership includes more persons with lived experience of disability.

This paper also updates DSAC members on:

- Recruitment to 3DHB Disability Responsiveness Team
- Progress on the Disability Dashboard.

2. SUB-REGIONAL DISABILITY PLANNING WORKSHOP *WEAVING TOGETHER* 2 NOVEMBER 2018

The 3DHB Disability Responsiveness Team convened this facilitated planning workshop on 2 November which was attended by 34 people.

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2.1.   **Attendees** were members of SRDAG, the Māori Sub-regional Disability Rōpū, the Pacific Sub-regional Disability Steering Group and the NZ Sign Language projects Deaf reference group (which advises on the NZ Sign Language project) and the 3DHB Disability Responsiveness Team. Several other DHB staff with relevant roles also attended, including Māori and Pacific managers and a member of the Mental Health team.

2.2.   **Purpose** The half-day workshop had three primary purposes:

- To support the disability advisory groups connecting and exchanging information about their roles and priorities

- To enable the group members to get a better understanding of the environment they are operating within and their roles, and to provide a base for effective working relationships

- To enable the attendees to advise on priorities for the 3DHB Disability team's next work plan (February – June 2019), to support implementing the 3DHB sub-regional disability strategy. Prior to the workshop, Māori and Pacific responsiveness were identified as priority areas.

2.3.   **Key messages and recommendations from attendees at the workshop were:**

- The importance of people with disabilities, in particular Māori and Pacific people, being represented on decision-making and advisory bodies, e.g. DSAC.

- The need for an equity lens to be applied across the whole work programme, as opposed to being solely within particular projects. Continued engagement and working in conjunction with Whāia Te Ao Mārama (2018-2022) and Faiva Ora at all levels.

- The need for baseline data across population groups, and across the 3 DHBs. There also need to be dashboard type information for Māori and Pacific people with disabilities.

- The importance of young disabled people being involved in governance and advisory groups.

- The need to work across the whole populations – Maori; Pacific; the Deaf, and people with mental health and addiction issues. Attendees appreciated the opportunity provided by the workshop to make connections with each other. It was also noted the importance to minimise duplication.

- The need to address diversity across Pacific peoples.

- The need to address low access to and uptake of services, which was believed to be0 in part, a consequence of difficulties in navigating referral pathways.

- The need to review physical access to services. Physical access to health services and facilities was identified as a priority, and accessibility audits need to be done for DHB, Primary and other community providers' facilities.

- The importance of access to health information in accessible formats, including large font, compatible with technology, suitable for people with visual and hearing impairment and easy read for people with learning disabilities.

- The need for continued engagement and co-design. The UN Convention on the Rights of People with Disabilities should guide work in this area. This includes the obligation to "closely consult with and actively involve persons with disabilities" in all decisions and developments for health and disability services.

- The need to extend focus to primary care, the work to date having tended to be hospital-focused. This includes disability responsiveness training and addressing access issues.

- To develop opportunities to use provider contracts to implement the disability strategy and improve performance and accountability

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2.4.   **Sub-regional Disability Forum 3 May 2019**: the workshop attendees proposed Friday 3 May as the best date for the next sub-regional forum. This larger forum will provide the mechanism for engaging with members of the advisory groups and the wider communities on work plan priorities for the year July 2019 – June 2020 and to guide the ongoing implementing the sub-regional disability strategy. Planning towards the forum has already began and will continue early in 2019.

2.5.   **Outcome:** The meeting was reviewed to be well attended with constructive information sharing and agreed priorities. The recommendations were congruent with the Disability Strategy and will be used to develop the Disability Team's next work programmes. The different disability groups valued the opportunity to meet, share their perspectives and plan collaboratively. The proposal was to meet in a similar forum at least annually.

3.   UPDATE ON 3DHB DISABILITY RESPONSIVENESS TEAM

The Disability Responsiveness team continue to work towards attaining a full complement of staff to support the implementation of the Disability Strategy. CCDHB has supported the recruitment of a permanent appointment for project support. The table below sets out progress on recruiting to roles associated with implementing the 3DHB Sub-regional Disability Strategy:

Role	Status	Target / Agreed Start date
Manager	Advertised on 22.11.18	February 2019
Senior Development Leader	Appointment made	December 2018
Committee Secretary/Project support	Appointment made	January 2019
Disability Educator/Advisor CCDHB	In process	January 2019

4.   UPDATE ON DISABILITY DASHBOARD

4.1.   Current Approach

The aim of a disability dashboard of indicators is to synthesise information that support understanding, planning and appreciation of system performance around disability. The prototype dashboard of indicators presented at previous DSAC meetings, was solely based on people with Hospital Disability Alerts. This data set is acknowledged to have limitations and flaws. Iterations of the dashboard have occurred as the data analysts have gathered material from across the system. The ongoing development of the dashboard data requires continued development and collaboration with people with disabilities.

Enquiries with the Ministry of Health has indicated that this sort of development which aims to better understanding the people, services provided and the performance of the system has currently not been started elsewhere in New Zealand.

Further and ongoing collaboration with the Disability Advisory Groups to ascertain what information is most valuable is planned. However, it has already been acknowledged that better understanding of Māori and Pacific people with disability and their outcomes is a priority.

Please see Appendix I for current Dashboard.

DRAFT 3DHB SUB-REGIONAL DISABILITY DASHBOARD

Structural Measures

Population

Number of People with an Impairment by Locality
Localities: Kapiti Coast, Porirua, Wellington, Lower Hutt, Upper Hutt, Masterton, Carterton district, South Wairarapa
Legend: CCDHB, HVDHB, WRDHB

Number of People with an Impairment by Type
Types: Hearing, Physical, Psychological, Vision
Legend: CCDHB, HVDHB, WRDHB

Number of NZ Sign Language Users
2013
Legend: CCDHB, HVDHB, WRDHB

Support Services

Number of Disability Alerts in CCDHB PMS by Ethnicity
Maori, Pacific, Other
Legend: CCDHB, HVDHB, WRDHB

Percentage of CCDHB Population with Disability Alert
Maori, Pacific, Other

Number of Disability Alerts in CCDHB PMS by Type
Intellectual, Physical, Psychiatric, Sensory, Other

Number of Referrals for CCDHB population to Needs Assessment & Coordination Services (NASC)
2014/15, 2015/16, 2016/17, 2017/18
Legend: Maori, Pacific, Other

Engagement

Number of CCDHB staff completing Disability eLearning
Q1 Q2 Q3 Q4 (2016/17), Q1 Q2 Q3 Q4 (2017/18)

System Level Performance

Quality

Percentage of Disability Alerts in CCDHB PMS mentioning a support need
Disability Alert has Support Need

Percentage of inpatient events at CCDHB where Alert was accessed
Jul Sep Nov Jan Mar May — 2017/18

Percentage of Referrals for CCDHB population by Ethnicity to NASC
Referrals, Population
Legend: Maori, Pacific, Other

Percentage of current CCDHB staff who have completed Disability eLearning
2017/18, 2018/19

Effectiveness

ALOS at CCDHB Facilities for General Inpatient and Intended Day Case Events
Jul Sep Nov Jan Mar May (2016/17), Jul Sep Nov Jan Mar May (2017/18)
Legend: No Disability Alert, Disability Alert

System Performance

ED Events for CCDHB Domiciled People with Disability Alerts at WRH
Q1 Q2 Q3 Q4 — 2017/18
Legend: Monthly total, 12 month rolling total

Inpatient Events for CCDHB Domiciled Patients with Disability Alerts at WRH
Q1 Q2 Q3 Q4 — 2017/18
Legend: Monthly total, 12 month rolling total

Percentage of "Did Not Attend" Outpatient Clinics (12 month rolling total)
Jan Mar May Jul Sep Nov — 2018
Legend: Disability Alerts, Total

Impact Measures

System Impact

Under development during 2018/19 – 2019/20

Under development during 2018/19 – 2019/20

Under development during 2018/19 – 2019/20

Patient Experience

HQSC Patient Experience Survey: Communication
Q1 Q2 Q3 Q4 (2016/17), Q1 Q2 Q3 Q4 (2017/18)
Legend: Primary Care, Hospital

HQSC Patient Experience Survey: Partnership
Q1 Q2 Q3 Q4 (2016/17), Q1 Q2 Q3 Q4 (2017/18)
Legend: Primary Care, Hospital

HQSC Patient Experience Survey: Physical & Emotional Needs
Q1 Q2 Q3 Q4 (2016/17), Q1 Q2 Q3 Q4 (2017/18)
Legend: Primary Care, Hospital

HQSC Patient Experience Survey: Coordination
Q1 Q2 Q3 Q4 (2016/17), Q1 Q2 Q3 Q4 (2017/18)
Legend: Primary Care, Hospital

Performance Highlights

Performance Issues

Key
- Achieved
- Partially achieved
- Not achieved

Performance Area	Domain	Indicator	Population	Date	Data Source
Structural Measures	Population	Number of People with a Disability by Locality	Total – Note Kapiti Coast includes Otaki, Otaki Forks & Te Horo (MidCentral DHB)	2013	Statistics New Zealand (Disability Survey 2013; Census 2013)
	Population	Number of People with a Disability by Type	Total – Note Kapiti Coast includes Otaki, Otaki Forks & Te Horo (MidCentral DHB)	2013	Statistics New Zealand (Disability Survey 2013; Census 2013)
	Population	Number of NZ Sign Language Users	Total – Note Kapiti Coast includes Otaki, Otaki Forks & Te Horo (MidCentral DHB)	2013	Statistics New Zealand (Census 2013)
	Support Services	Number of Disability Alerts in CCDHB PMS by Ethnicity	Total Disability Alert population & CCDHB domiciled Disability Alert population		CCDHB (Business, Intelligence & Analytics)
	Support Services	Percentage of Population with Disability Alerts	CCDHB domiciled Disability Alert population		CCDHB (Business, Intelligence & Analytics); Statistics New Zealand (Disability Survey 2013)
	Support Services	Number of Disability Alerts in CCDHB PMS by Type	Total Disability Alert population		CCDHB (Business, Intelligence & Analytics)
	Support Services	Number of Referrals to Needs Assessment & Coordination Services (NASC)	CCDHB domiciled population		NASCs (Care Coordination Centre, Capital Support, FCSID, MHA)
	Engagement	Number of CCDHB staff completing Disability eLearning	Active staff (i.e. currently employed)		CCDHB (People & Capability)
System Level Measures	Quality	Percentage of Disability Alerts mentioning a support need	Total (from sample of 500)		CCDHB (Business, Intelligence & Analytics)
	Quality	Percentage of admissions where Alert page was accessed	Total Disability Alert population		CCDHB (Business, Intelligence & Analytics)
	Quality	Percentage of Referrals by Ethnicity to NASC			NASCs (Care Coordination Centre, Capital Support, FCSID, MHA); Statistics New Zealand (Disability Survey 2013)
	Quality	Percentage of current CCDHB staff completing Disability eLearning	Total	2017/18	CCDHB (People & Capability)
	Effectiveness	ALOS at CCDHB Facilities for General Inpatient and Intended Day Case Events	Total Disability Alert population & Total population		CCDHB (Business, Intelligence & Analytics)
	System Performance	ED Events for CCDHB Domiciled People with Disability Alerts at WRH	Total Disability Alert population		CCDHB (Business, Intelligence & Analytics)
	System Performance	Inpatient Events for CCDHB Domiciled Patients with Disability Alerts at WRH	Total Disability Alert population		CCDHB (Business, Intelligence & Analytics)
	System Performance	Percentage of "Did Not Attend" Outpatient Clinics	Total Disability Alert population		CCDHB (Business, Intelligence & Analytics)
Impact Measures	System Impact	N/A			
	Patient Experience	HQSC Patient Experience Survey – Primary Care	Total population		Health Quality & Safety Commission (HQSC)
	Patient Experience	HQSC Patient Experience Survey – Hospital	Total population		Health Quality & Safety Commission (HQSC)