PUBLIC

Wairarapa DHB · Hutt Valley DHB · Capital & Coast District Health Board	**AGENDA** Held on 24 November 2021 Location: Zoom Time: 1.30pm Zoom meeting ID: 826 6127 3900

3DHB COMBINED DISABILITY SUPPORT ADVISORY COMMITTEE

	ITEM	ACTION	PRESENTER	PG
1	**PROCEDURAL BUSINESS**			
1.1	Karakia		All members	2
1.2	Apologies	**RECORD**	Chair	
1.3	Continuous Disclosure – Interest Register	**ACCEPT**	Chair	3
1.4	Confirmation of Draft Minutes from meeting dated 29 September 2021	**APPROVE**	Chair	6
1.5	Matters Arising • Letter to MOH 20 July 2021 • MOH response 28 October 2021	**NOTE**	Chair	12 13 14
1.6	Draft Work plan	**APPROVE**	Chair	16
2	**PERFORMANCE REPORTING**			
2.1	3DHB Sub Regional Disability Strategy 2017 – 2022 Update	**NOTE**	General Manager – Disability	17
2.2	Review of Sub-Regional Disability Strategy 2017-2022	**NOTE**	General Manager – Disability Grant Cleland – Creative Solutions	21
2.3	MHAIDS Service Performance Update	**NOTE**	Executive Director MHAIDS Executive Clinical Director MHAIDS	27
2.4	3DHB Mental Health and Wellbeing Strategy update	**NOTE**	Director Strategy Planning and Performance Executive Director MHAIDS Executive Clinical Director MHAIDS	48
3	**OTHER**			
3.1	Disability System Transformation https://msd.govt.nz/about-msd-and-our-work/publications-resources/information-releases/cabinet-papers/2021/disability-system-transition.html	**NOTE***	2DHB Director Strategy, Planning and Performance - 2DHB General Manager – Disability	
3.2	Covid-19 update	**NOTE***	2DHB Director Strategy, Planning and Performance	
3.3	General Business		Chair	

DATE OF NEXT DSAC MEETING:
16 March 2022, 1:30pm-4pm, Boardroom, Pilmuir House, Hutt Hospital

**** No paper at the meeting – presentation only***

Karakia

Kia hora te marino

Kia whakapapa pounamu te moana

Hei huarahi mā tātou i te rangi nei

Aroha atu, aroha mai

Tātou i a tātou katoa

Hui e! Tāiki e!

Translation

May peace be wide spread

May the sea be like greenstone

A pathway for us all this day

Let us show respect for each other

For one another

Bind us all together!

3DHB Disability Services Advisory Committee

Interest Register

24/11/2021

Name	Interest
'Ana Coffey *Chair*	• Father, Director of Office for Disabilities • Brother, employee at Pathways, NGO Project Lead Greater Wellington Collaborative • Shareholder, Rolleston Land Developments Ltd
Prue Lamason	• Councillor, Greater Wellington Regional Council • Chair, Greater Wellington Regional Council Holdings Company • Member, Hutt Valley District Health Board • Daughter is a Lead Maternity Carer in the Hutt
Yvette Grace	• Member, Hutt Valley District Health Board • Member, Wairarapa District Health Board • Husband is a Family Violence Intervention Coordinator at Wairarapa District Health Board • Member - Te Hauora Runanga o Wairarapa • Member - Wairarapa Child and Youth Mortally Review Committee Member - He Kahui Wairarapa • Sister-in-law is a Nurse at Hutt Hospital • Sister-in-law is a Private Physiotherapist in Upper Hutt
Dr Tristram Ingham	• Board Member, Health Quality and Safety Commission • Director, Foundation for Equity & Research New Zealand • Director, Miramar Enterprises Limited (Property Investment Company) • Member, Independent Monitoring Mechanism to the United Nations on the United Nations Convention on the Rights of Persons with Disabilities • Chair, Te Ao Mārama Māori Disability Advisory Group • Co-Chair, Wellington City Council Accessibility Advisory Group • Chairperson, Executive Committee Central Region MDA • National Executive Chair, National Council of the Muscular Dystrophy Association • Trustee, Neuromuscular Research Foundation Trust • Professional Member, Royal Society of New Zealand • Member, Disabled Persons Organisation Coalition • Member, Scientific Advisory Board – Asthma Foundation of NZ • Member, 3DHB Sub-Regional Disability Advisory Group • 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) • Senior Research Fellow, University of Otago Wellington • Employee, University of Otago • Wife is a Research Fellow at University of Otago Wellington • Co-Chair, My Life My Voice Charitable Trust • Member, Capital & Coast District Health Board • Member, DSAC • Member, FRAC
Sue Kedgley	• Member, Consumer New Zealand Board
John Ryall	• Member, Social Security Appeal Authority • Member, Hutt Union and Community Health Service Board • Member, E tū Union
Naomi Shaw	• Director, Charisma Rentals • Councillor, Hutt City Council • Member, Hutt Valley Sports Awards • Trustee, Hutt City Communities Facility Trust
Vanessa Simpson	• Director, Kanuka Developments Ltd • Executive Director Relationships & Development, Wellington Free Ambulance • Member, Kapiti Health Advisory Group
Jill Pettis	• Nil
Ryan Soriano	• Clinical Services Manager, Health Care New Zealand • Member, Board Trustee for Saint Patrick School Board, Masterton • Wife Employed as Senior Caregiver at Lansdowne Park Aged Care Facility
Jill Stringer	• Director, Touchwood Services Limited • Husband employed by Rigg-Zschokke Ltd • Trustee on Wellington Welfare Guardianship Trust
Jack Rikihana	• Chair Horo Te Pai Trust • Chair Horo Te Pai health service • Research Advisory Group – Māori • Kaumātua Advisory Group • Noose Monotony Committee • Chairman RGAM • Partner Secretary ICU Wellington • Daughter Managing Director Anaesthetists NZ
Sue Emirali	• Nil
Bernadette Jones	• Director, Foundation for Equity & Research New Zealand • Co-Chair, Tāngata Whakaha Roopu, Subregional Māori Disability Group • Co-Chair, 3DHB Sub-Regional Disability Advisory Group

	• Executive Committee member Muscular Dystrophy Central Region • Board member, My Life My Voice Charitable Trust • Member, Health Research Council NZ, College of Experts • Senior Research Fellow, University of Otago Wellington • Husband, Tristram Ingham, is a board member of CCDHB • Director, Miramar Enterprises Limited
Marama Eddie	• Board member Whaiora Whanui • Sister works for CCDHB • Sister works with the Aged Care at the Kandahar Dementia Unit in Masterton • Trustee of Ngati Kahungunu ki Wairarapa Tamaki Nui a Rua Treaty Settlement Trust • Member of Māori Women's Welfare League

3DHB DSAC MEETING **PUBLIC**

3DHB Disability Support Advisory Committee Meeting - PUBLIC

MINUTES

Held on Wednesday 29 September 2021
Zoom
Zoom link: 826 6127 3900
Time: 1pm-4pm

Due to Covid 19 alert level (level 2) only limited staff attended in person (in person marked with * and all others on zoom).

Members	Attendance	Membership
'Ana Coffey - Chair	Present	CCDHB
Sue Kedgley	Present	CCDHB
Yvette Grace	Present	WrDHB & HVDHB
Prue Lamason	Apology	HVDHB
Tristram Ingham	Present	CCDHB
John Ryall	Present	HVDHB
Naomi Shaw	Present	HVDHB
Vanessa Simpson	Present	CCDHB
Jill Pettis	Present	WrDHB
Jill Stringer	Present	WrDHB
Sue Emirali	Present	Sub Regional Disability Support Advisory Group Rep.
Marama Tuuta	Present	Co-Chair of Kaunihera Whaikaha
Bernadette Jones	Present	Sub Regional Disability Support Advisory Group Rep.
Jack Rikihana	Present	Te Upoko o te Ika a Maui Māori Council

District Health Board Staff Present		
Fionnagh Dougan*	2DHB	Chief Executive
Rachel Haggerty*	2DHB	2DHB Director Strategy, Planning and Performance
Dale Oliff	WrDHB	Chief Executive
Sandra Williams	WrDHB	Executive Leader Planning and Performance
Karla Bergquist	3DHB	Executive Director Mental Health, Addiction and Intellectual Disability Services
Paul Oxnam*	3DHB	Clinical Director Mental Health, Addiction and Intellectual Disability Services
Sally Dossor*	2DHB	Director of Office of the Chief Executive/Board Secretary
Rachel Noble	3DHB	General Manager Disability Strategy, Innovation and Performance
Christopher Nolan*	3DHB	3DHB General Manager - Commissioning Mental Health & Addictions
Matt Fribbens	WrDHB	Service Development Manager - Planning & Performance
Meila Wilkins*	2DHB	Board Liaison Officer

1 PROCEDURAL BUSINESS

1.1 KARAKIA

The Committee opened the meeting with a karakia.

1.2 APOLOGIES

As noted above and noted apologies from Prue Lamason (member) and David Smol (not a member)

1.3 CONTINUOUS DISCLOSURE

The interest register was **noted** as current and any changes would to be sent to the Board Liaison Officer via email.

1.4 MINUTES OF PREVIOUS CONCURRENT MEETING

The Committee **approved** the minutes of the previous 3DHB DSAC Meeting held on 21 July 2021, and corrected the error that recorded Vanessa Simpson as not being a member of the Committee

Moved	**Seconded**	
'Ana Coffey	Yvette Grace	**CARRIED**

1.5 MATTERS ARISING FROM PREVIOUS MEETINGS

Noted that the Committee had not yet received a response to the letter it wrote to the Ministry of Health in regarding access to funding under He Ara Oranga.

1.6 WORK PLAN

The Committee noted that the workplan reflects the now limited number of meetings remaining before the transition to Health New Zealand.

Reordered the agenda to take item 4.1 first in order to accommodate the availability of presenters.

4 OTHER

4.1 COVID-19 RESPONSE

The 2DHB Chief Executive, WDHB Chief Executive, Director Strategy Planning and Performance (2DHB) and Executive Leader, Planning and Performance (WrDHB) presented.

Notes:

- 2DHB Covid response falls into 4 categories:
    - Regional public health
    - Managed isolation - managed 22,000 overnight stays along with comprehensive health care. Have a positive relationship with Defense.
    - Testing – community based and agile, and able to stand up utilising commissioned community model (so does not draw on the provider arm). Testing rates are equitable – Māori and pacific population have a higher testing rate and reflects availability and free. Reflects that community providers are responsive.

  - Vaccination – very strong network of community providers. Vaccinations rate 1st in the country for Maori (64%– noting this still too low). 70% for Pacific population and 73% for disability population.
- Mental health – data matching mental health services with vaccination rates to see where can increase provision.
- Equity approach working across Māori, Pacific and Disability sector. Disabled specific personnel on all major sites.
- Expect to complete vaccination programme by the end of the year. Focus on hesitancy and those that are hard to reach.
- Welfare is a significant issue in lockdowns – including mask supply and WREMO support as well.
- Moving community responses into a BAU approach with surge capacity and ability to maintain readiness.
- Waiting for the Government to make decisions on the national approach.
- Work being done on how we can use the learnings and capacity in other programmes – e.g other vaccination programmes.
- Looking at options for community based isolation.
- National approach being developed and Regional approach (ICU and negative room capacity). Biggest barrier and challenge is workforce. Have been lobbying for an approach that is consistent regarding immigration that aligns with key workforce groups that we are lacking in the country.
- WrDHB presented an update on its programme for testing and vaccination – have had specific responses for disability and mental health – including outreach programmes (involving vaccination in homes). Mobile clinics are also being established
- Concerns expressed at the lack of disability reporting and noted that the reporting is essential to identify if there are pockets of inequities- have to pull the information from other reports.
- 1st dose for disabled people in Wairarapa is at 69% and 73% for 2nd dose.
- Committee asked if possible to identify disabled persons from the health care workforce – but noted that there may be privacy issues in obtaining this information.

2.0 STRATEGIC PRIORITIES

2.1 LOCALITY COMMUNITY MENTAL HEALTH DEVELOPMENT (STRATEGIC PRIORITY: COMMUNITY MENTAL HEALTH NETWORKS)

The Director, Strategy, Planning and Performance, Executive Director MHAIDS and Executive Clinical Director MHAIDS presented.

The Committee noted:

(a) the purpose of the Community Mental Health and Addiction (MHA) Change Programme (the Programme) is to design, and implement integrated, place-based, MHA services for the Hutt Valley, Wellington, Kāpiti and Porirua that are operational by 30 June 2022.

(b) the Programme is part-funded by Ministry of Health investment and is one of three MHA strategic priorities for delivery in the 2021/2022 financial year, as our DHBs transition to a new health and disability system.

(c) the first stage of the Programme is the MHAIDs-led 3-month Te Haika/Crisis Response project to address immediate pressures in our 24 hour call centre and intake/triage services and will consider our community mental health teams' structure.

(d) Te Rangapū Ahikaaroa, our memorandum of understanding with Ngāti Toa Rangatira and Te Āti Awa ki te Upoko o te Ika a Māui, is our platform for partnering to design and develop community MHA services for Māori.

(e) the Mental Health and Addiction Commissioning Forum will provide Programme governance and the design process will implement the Pro-Equity, People-based Commissioning Policy to understand and address inequities for our priority populations.

(f) the enablers for the Programme design and implementation – our evolving partner, provider and stakeholder MHA networks, including the Lived Experience Advisory Group.

Moved	**Seconded**	
Jack Rikihana	'Ana Coffey	**CARRIED**

Notes:

- Members of the Lived Experience Advisory Group were introduced and the Committee thanked them for their contributions to the work.
- The work will start with the 2DHB environment and then sharing learnings about the process with WrDHB. WrDHB has its own model which it will build up.
- This is locality based work.
- WrDHB engagement with MHAIDS service so that it gets integrated in the locality approach in the Wairarapa
- Concern expressed about the MOU referenced in (d). It was raised that the consultation with iwi needs to also ensure that the same connections are made with other iwi in the subregion.
- Lived experience a crucial part to the design and the success for the future.

3.0 PERFORMANCE REPORTING

3.1 MHAIDS SERVICE PERFORMANCE UPDATE

The Executive Director MHAIDS and Executive Clinical Director MHAIDS presented and responded to questions.

The Committee noted:

a) the report from MHAIDS

b) that given the stress on the system identified in the report that it would be appropriate that staff report on actions being taken and mitigation measures being put in place to alleviate the issues identified, and this is to be to be included on the agenda for the meeting on 24 November 2021.

3.1.1 Attachment 1
MHAIDS Service Perf

Moved	**Seconded**	
Tristram Ingham	'Ana Coffey	**CARRIED**

Notes:

- Wait time to service, demand for inpatient beds and workforce issues.
- There was concern the report notes widening gap and the inequities but does not say how the issues in the report will be addressed or suggest any mitigating actions/
- Discussion held on the adequacy of the response and the linkages to the report in item in 2.1.
- The transformational change is a medium – long term solution but there are immediate actions in terms of recruitment and also addressing inpatient beds in Hutt Valley. In addition the improved intake and crisis response with Te Haika and more appropriate response when people present at ED.
- Te Haika response can be shifted into a different model – including its day to day location in Porirua.
- Our facilities and working conditions impact on the workforce issues.
- This emphasizes the importance of the locality framework, lived experience employees and peer support.
- Committee wanted to make sure that there are conscious action points and follow up to record what is being done in response.

Procedural note:

In response to a request for additional information on the management approaches that are being implemented to alleviate stress on the system, the Chair accepted the motion (in the underlined text) for a report on mitigation measures to be provided at the next meeting on 24 November 2021. This was accepted by leave of the meeting.

3.2 3DHB SUB REGIONAL DISABILITY STRATEGY 2017 – 2022 UPDATE

General Manager - Commissioning Disability Responsiveness presented and responded to questions.

The Committee notes:

(a) This report provides DSAC with an update on the implementation of the Sub Regional Disability Strategy 2017 – 2022.

Moved	**Seconded**	
'Ana Coffey	Yvette Grace	**CARRIED**

Notes:

- Noted that the Mayoral Forum was postponed until next week so the Accessibility Charter has not been progressed.
- Noted that the WrDHB has now signed the Accessibility Charter.

4. OTHER *(continued)*

4.1 GENERAL BUSINESS

There was no general business to discuss.

NEXT MEETING

Wednesday 24 November 2021, 1:30pm-4pm, Level 11, Grace Neill Block, Wellington Regional Hospital.

CONFIRMED that these minutes constitute a true and correct record of the proceedings of the meeting.

DATED this day of 2021

'Ana Coffey
DSAC CHAIR

DSAC ACTION LOG - as at 21/11/2021

Action Number	Date of meeting	Due Date	Status	Assigned	Agenda Item #	Agenda Item title	Description of Action to be taken	How Action to be completed
DSAC2021-01	28-Apr-21		Complete	Director Strategy, Planning and Performance	3.1	3DHB alcohol and Other drugs (AOD) Model of care and priority investment	The Committee, through the Chair, will write to the Ministry of Health raising funding delays and the impact the delays are having on the 3DHB's contribution to the transformation outlined in He Ara Oranga.	Completed. The letter and MOH's response are attached.
DSAC2021-02	21-Jul-21		In progress	Committee members	1.5	Action items	Continue to raise the adoption of the Accessibility Charter (and more important- actions under it) with our local government partners. Important in the design work on new projects, for example the LGWM project and consideration of the impact on disabled persons if car parking is removed	Rachel Noble to provide a verbal update at the meeting on 24/11/2021.
DSAC2021-03	21-Jul-21		In progress	General Manager - Disability	2	Engagement with SRDAG	SRDAG invited DSAC Chair (and members) to attend a future SRDAG meeting.	Rachel Noble to provide a verbal update at the meeting on 24/11/2021.

20 July 2021

Toni Gutschlag
Ministry of Health
133 Molesworth Street
Thorndon
WELLINGTON 6011

Email: Toni.Gutschlag@health.govt.nz

Tēnā koe Toni

Re: Implementation of He Ara Oranga – access to funding

At a recent meeting of the 3DHB Disability Support Advisory Committee concern was raised by members about delays in the release of Ministry funding following a request for proposals to Māori and Pacific community providers.

Māori and Pacific providers are committed to achieving equity for their communities and the release of funding to these providers is essential to enable our 3DHBs to deliver transformation through the implementation of He Ara Oranga.

It is the Committee's understanding that Māori and Pacific providers in our region have submitted expressions of interest and that there have been long delays in the application and funding process.

The delays being experienced by Māori and Pacific providers contrasts with the release of funding to more mainstream services, such as Access and Choice. While our Committee acknowledges the importance of such services, our Committee is concerned that the experience of Māori and Pacific providers (in contrast to the experience of others) is a reflection of institutional racism in the system.

Our 3DHB Committee would appreciate detailed advice regarding the delay in the expressions of interest process, and a timeline for the completion of it, and plans to allocate funding.

I look forward to receiving your response.

Ngā mihi

'Ana Coffey
Chair, Disability Support Advisory Committee

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

28 October 2021

‘Ana Coffey
anamcoffey@gmail.com
Disability Support Advisory Committee

Tēnā koe ‘Ana,

Re: Implementation of He Ara Oranga – access to funding

Thank you for your letter of 20 July 2021 which raises concerns about the delays in the release of Ministry funding following the request for proposals (RFPs) for kaupapa Māori and Pacific community providers.

The funding being referred to here is part of the Budget 2019 initiative "Expanding access to and choice of primary mental health and addiction support" (Access and Choice programme), which has multiple work streams. This is a five-year national programme of work with funding increasing annually over that time. Through the Access and Choice programme, four types of services are being rolled out nationally. These are:

- Integrated Primary Mental Health and Addiction (IPMHA) services located in general practices.
- Kaupapa Māori primary mental health and addiction services.
- Pacific primary mental health and addiction services.
- Youth specific primary mental health and addiction services.

I can assure you that the Ministry has prioritised Māori and Pacific peoples within this work programme. The roll out of IPMHA services commenced ahead of the other three streams because this service model had previously been co-designed and evaluated. DHBs are funded to coordinate the roll out of IPMHA services in their area and the Ministry requires DHBs to prioritise general practices with high numbers of Māori, Pacific and youth in the roll out of these services. Funding for the IPMHA services has been allocated to DHBs using the mental health population-based funding formula, which is weighted to reflect high needs populations.

The national procurement of kaupapa Māori, Pacific and youth specific services has happened simultaneously over the past 18-months. As noted above, the funding for the roll out of these services is over a five-year period which has required a phased approach to service implementation nationally. Furthermore, the timing of service implementation has varied across areas for a range of reasons including service readiness, extensive co-design processes, and the challenges presented across the health sector by the COVID-19 Delta outbreak.

With regard to services in the 3DHB regions of Wairarapa, Hutt Valley and Capital and Coast:

- Contracts have been in place for Pacific specific services since late 2020 with service delivery commencing earlier this year. These contracts are with Vaka Tautua in the

Capital and Coast DHB area and two Pacific providers in the Hutt Valley DHB area, Pacific Health Services Hutt Valley and Naku Enei Tamariki Trust. These services were publicly announced in April 2021: www.beehive.govt.nz/release/pacific-mental-wellbeing-supported-across-auckland-and-wellington

- A contract with Wairarapa DHB for youth specific services has been in place since September 2020 and a contract with Kapiti Youth Support One Stop Shop Trust in both Capital and Coast and Hutt Valley DHB areas has been in place since December 2020. These services commenced delivery in early 2021.
- With regard to Kaupapa Māori services the procurement process is still progressing. The Ministry is in negotiations with a preferred provider for delivery of services across all 3DHB areas. Because these negotiations are not yet finalised, we are unable to comment on the process further. Of note, this has been a national procurement process and to date we have 16 kaupapa Māori primary mental health and addiction services contracted across 12 DHB areas. Contracting of services in the 3DHB areas has been slower than in some other areas for a range of reasons, with proposals that were most ready for service delivery prioritised over those that required further development. The kaupapa Māori service provider across the 3DHBs will be announced in the coming weeks.

Again, I thank you for your letter and hope this response has addressed your concerns. We look forward to working further with the DHB, Māori, Pacific and youth services providers in your area, to ensure increased access to and choice of primary mental health and addiction services.

Ngā mihi nui

Philip Grady
Acting Deputy Director-General
Mental Health and Addiction Directorate

DSAC DRAFT WORK PLAN 2021/22 as at 24/11/2021		
	16 March 2022 Hutt Valley 1pm-4pm	**Placeholder meeting (TBC) 8 June 2022 Capital & Coast 1pm-4pm**
Strategic Priorities		
Mental Health and Addiction Services	Kaupapa Māori Mental Health Service Development	
	Child and Adolescent Mental Health	
Strategy		
Sub Regional Disability Strategy 2017 - 2022	Sub Regional Disability Strategy 2017 – 2022 Update	
3DHB Mental Health and Wellbeing Strategy • Sub Regional Living Life Well - a strategy for mental health and addiction 2019 – 2025 • 3DHB Suicide Prevention Postvention Annual Action Plan 2021/2022	3DHB Mental Health and Wellbeing Strategy Update	
Performance Reporting		
3DHB MHAIDS Service Performance Report	3DHB MHAIDS Service Performance report	
System and Service Planning		
Draft Annual Plans 2022/23 (Mental Health, Addiction and Disability Sections)	Planning process for 2022/2023 – subject to confirmation of process required for Health New Zealand.	
Other		
Disability System Transformation	As applicable	

Disability Support Advisory Committee

24 November 2021

3DHB Sub Regional Disability Strategy 2017 – 2022

Action Required

3DHB Disability Support Advisory Committee notes:

(a) the update on implementation of the Sub Regional Disability Strategy 2017 – 2022.

Strategic Alignment	Health System Plan 2030 Living Life Well A strategy for mental health and addiction 2019-2025 (Living Life Well) Taurite Ora Māori Health Strategy 2019-2030 Te Pae Amorangi Maori Health Strategy 2018 -2027 Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025
Authors	Rachel Noble, General Manager Disability
Endorsed by	Rachel Haggerty, Executive Director Strategy, Planning & Performance
Presented by	Rachel Noble, General Manager Disability
Purpose	This paper provides brief updates on the implementation of our Sub Regional Disability Strategy 2017 – 2022.
Contributors	The Disability Team
Consultation	N/A

Background

The Disability Strategy and Performance team supports 3DHB initiatives to provide accessible and inclusive healthcare services to disabled people and their whanau by identifying and addressing inequalities within the DHBs.

The team provides advice across the 3DHBs on policies, strategies and initiatives. It also promotes quality accessible services, reasonable accommodation measures, and co-design while also raising awareness through a range of education initiatives. The team also promotes accountability through data and monitoring initiatives.

The key areas of activity are outlined the in the Sub Regional Disability Strategy 2017 – 2022 and includes our responses to the recommendations from the Sub Regional Disability Forum.

Focus Area One: Leadership

Disability Team

While the COVID response continues create a major pull for members of our team we have taken steps to create two distinct work streams while maintaining our overall aim to Promote Rights Based Inclusive and Accessible Health Care Services. One work stream will focus on the COVID Response and the other on DHB priority areas.

Both streams focus on

1. Implementing the Accessibility Charter
2. Applying the Enabling Good Lives Principles
3. Delivering training and education programmes

To achieve this, new roles are currently being filled while some roles are being seconded to the COVID Programme. We are confident that this will allow us to move ahead on areas that have not been progressed and it will also enable us to translate some of the resources developed for the COVID programme so they are accessible to those providing generic health services.

The Prime Minister, Jacinda Adern visited the High St, Lower Hutt, Vaccination Clinic at the end of October 2021, where we were able to demonstrate the inclusive and accessible features present. The Prime Minister extended her visit by requesting time to talk with members of the Disability Team and Dr Tristram Ingham.

With the Pro-Equity Commissioning Policy in place, alongside the 'evidence' from the COVID vaccination experience we are finding ourselves engaging in a lot of discussions about how to consider disability when planning initiatives. Where we are able to engage early, the promise of good outcomes are better.

Focus Area Two: Inclusion and Support

Enabling Good Lives

In December we will welcome Daniel Barr as the Enabling Good Lives (EGL) Lead. Daniel's role will be to assist teams across the DHBs with implementing the EGL Principles across our priority projects and in focus areas. This is timely with the establishment of the new Ministry for Disabled People sending expectations that more services will be expected to adopt the EGL Principles. Daniel Barr is currently the EGL Transformation Manager in NZ Care so is well positioned to work within the DHB environment.

The Kapiti Health Network is actively working to adopt the Principles in their work. Imagine Better has now delivered three 'Introduction to EGL Principles' workshop to staff members with two more to take place soon. Early in 2022 we will deliver two similar workshops with the local disability community in Kapiti. The third part of the process is to bring staff members from the network and the disability community together to identify ways to amend practice to adhere with the EGL Principles thus creating an accessible and inclusive service. This work is pioneering work and hopefully can be replicated across other networks.

SPP staff members participated in some EGL workshops, and we could see staff members becoming aware of issues disabled people have when accessing health services that they had not considered before. There has been a positive shift in how our input is utilized, which we believe is consistent with, an assisted by, the adoption by our DHBs of its Pro-Equity approach and principles.

We have also met with the Child Development team and created a plan to look into applying the EGL Principles in this space, this includes a plan to co-design with families. In the meantime, the disability team will provide some training for their call centre on the appropriate language framing when engaging with families to align with the Principles.

Focus Area Three: Access

Accessible Information

We continue to produce accessible resources where we can. We will have a designated Accessibility Lead person in place in December.

Easy Read Photo Project

This project continues to progress well, we are thrilled with the positive response we received from clinicians who saw the benefit of this work and told us that they saw this work benefiting a wide range of patients. We have photos from the Wairarapa, Hutt Valley and Capital & Coast DHBs. We also had people from the disability community offering to be models as they want to have access to the resources themselves.

This week we have two people being trained to create Easy Read resources with these photos for use across our DHBS.

Screening Programme

Our COVID work is essentially a public health campaign like the Bowel Screening Programme. Leo Goldie-Anderson is now in the national Bowel Screening Programme committee. Due to this the new campaign will have a disability/accessibility lens applied throughout. This is a major first for New Zealand.

Focus Area Four: Health

Maternity Project

As one of the Priority Projects we were very pleased to have our report on 'Creating enabling maternity care: dismantling disability barriers' available to inform the development of the Maternity Project. We have two staff members involved in the design process plus the author of the research project as a consumer voice. Carey-Ann Morrison is the parent of a baby born with impairments.

Planned Specialist Care and Localities Services Research

Imagine Better is undertaking a research project to understand more about disabled people's experiences of accessing local healthcare services within the 3DHB region. A 'localities' approach to the delivery of healthcare services is being implemented across some of the 3DHB region. This type of approach enables DHBs to partner with local providers to improve health outcomes of communities, address the social determinants of health, and support the work of local networks to meet health and wellbeing needs. Internationally and locally there is a move towards place-based health delivery, that is, integrated healthcare that serves the needs of local communities. Place-based health provision is shown to reduce health inequities and improve health outcomes.

Research consistently shows that disabled people have poorer health outcomes than non-disabled people and do not receive appropriate care. Barriers to access, including limited availability of services and transport options, inaccessible environments and communication, discriminatory attitudes, and inadequate skills and knowledge of healthcare workers, prevent disabled people from accessing health care across the spectrum of health services – promotion, prevention, and treatment. Any attempts to improve the coordination and provision of health care services within 3DHB localities needs to include the experiences of disabled people. Finding out from disabled people what types of barriers prevent them from accessing local healthcare as well as what enables their access will help address health disparities experienced by disabled people in the 3DHB region.

Imagine Better has also been asked to create a research brief for a project on disabled people's experiences of accessing specialist services. Rather than conducting two separate projects, we propose a project that addresses access to specialist services as part of a focus on localities. As described in more detail below, focusing on different sites of healthcare – home, community, hospital – means disabled people's experiences of accessing specialist services can be captured. Combining the two projects helps mitigate the impacts of research fatigue by the disability community within the 3DHB region.

Disability Support Advisory Committee

24 November 2021

Review of progress with the 3DHB Sub Regional Disability Strategy 2017-2022

Action Required

The Committee notes:

(a) Grant Cleland, Director of Creative Solutions, will present the preliminary findings of his review on progress with the Disability Strategy.

(b) The review was based on the recommendations made at the 3DHB Disability Forum in Silverstream 2019.

Strategic Alignment	3DHB Disability Strategy
Author	Rachel Noble, GM Disability
Endorsed by	Rachel Haggerty, Director Strategy, Planning and Performance
Presented by	Grant Cleland, Director Creative Solutions
Purpose	The preliminary findings of the review on the Disability Strategy will be presented
Contributors	3DHB Disability Team, Co-Chairs Sub Regional Disability Advisory Group, Rachel Haggerty, SPP Leaders
Consultation	3DHB Disability Team, Co-Chairs Sub Regional Disability Advisory Group, Rachel Haggerty, SPP Leaders

Executive Summary

The Sub-Regional Disability Strategy 2017-2022 was agreed by the 3DHB Boards in April 2017.

At the Sub-Regional Disability Forum in June 2019, the DHBs' progress against the Strategy was considered and a number of recommendations were made (included as Attachment 1). To improve communication and information access, the Forum recommended that the DHBs "review all departments the current systems for communicating with and providing information to disabled people and their families against these guidelines."

Grant Cleland has been contracted to undertake this review. This required understanding the perspective of the disabled people and clinical people present who articulated priority actions and made recommendations for the 3DHBs to focus on going forward.

The Review will enable the DHBs to report back to the community and to the Board on progress to date. It will also identify gaps and opportunities for further development. The findings will contribute to the development of the next 3DHB Disability Strategy which can be rolled over to the new Health NZ model.

Grant will present a summary of the review at the DSAC meeting on 24 November 2021.

Strategic Considerations

Service	N/A

People	N/A
Financial	N/A
Governance	N/A

Engagement/Consultation

Patient/Family	N/A
Clinician/Staff	N/A
Community	N/A

Attachment/s

1. Independent Review of the Progress with the Sub Regional 2017-2022 Disability Strategy Forum Recommendations.

Independent Review of the Progress with the Sub Regional 2017-2022 Disability Strategy Forum Recommendations

Recommendation
1. The 3 DHBs sign, promote and implement the Accessibility Charter, including: a. Gaining approval from each DHB for the Chief Executive; and the HR, IT and Communications General Managers to sign and resource the Accessibility Charter. b. Identifying an Accessibility Charter Programme Sponsor from the Leadership Team in each DHB. c. Identifying Accessibility Charter Champions within the Human Resources, IT and Communication departments across the 3 DHBs. d. Establishing an Accessibility Charter Programme Team/s with staff and disabled people from across the 3 DHBs. e. Promoting the implications of the Charter for the 3 DHBs. f. Prioritising new and existing projects to be included in the Accessibility Charter Programme, which address historic and new access issues. g. Those involved in the programme attending training and receiving support from Anne Hawker and other MSD/DIA staff, to learn from the journey that other state sector organisations have already gone on who have signed the Accessibility Charter. h. Reporting progress quarterly and annually, both internally and externally.
2. To improve Communication and Information Access, the DHBs: a. Develop staff guidelines and mandatory staff training for all departments for improving communication and information access for the Disability and Deaf community. b. Review across all departments the current systems for communicating with and providing information to disabled people and their families against these guidelines.

This should ensure:

- Written information has simple language and identifies the service on the outside of hospital envelopes.
- There is a contact point for clinics and other services to allow a disabled person, family member and/or support person to contact someone either by phone, text, face-to-face or through an interpreter, to ask questions.
- Like neurology, there is a clinical nurse to interface between the disabled person, their family and/or support person and the clinicians.
- Health Passports that are electronic and include a person's communication and information access needs and preferences; and this is used by all DHB staff.
- Staff know how to arrange and use interpreters and video interpreters.

c. There are monitoring systems to review progress with these strategies.

3. To improve Access to Health Services, the 3 DHBs:
   a. Provide accessible transport for disabled people to access health services.
   b. Review hospital parking so this is easier for disabled people and families.
   c. Have environmental audits with monitored follow up actions.
   d. Investigate whether it is possible to have more staff who are mobile, who can visit disabled people in their homes and local community, and provide these services outside of normal work hours.
   e. Explore options to address the cost of and getting to health services.

4. Building Stronger Links Between Groups in the Community:
   a. Align the work of the:
      - SRDAG
      - Maori & Pacific Disability Groups
   b. Build stronger links across the 3 DHBs, MoH, Councils & Government; from a disability health perspective.

   People want the 'Pockets of brilliance consistent across all 3 DHBs'.

5. An Action Plan for Maori and Pacific people with disabilities is developed that includes:
   a. Better Navigation and Access: Where to go for help, who to ask, how to self-manage health needs, more culturally appropriate Disability Alerts/Health Passports, more services, traditional health practices, face-to-face services.
   b. Simplifying processes to raise their issues and have complaints addressed.
   c. The hosting of forums specifically for Maori and Pacific people in the disability community to raise issues, co-design health services and report progress.
   d. Better outcomes from home support providers – more consistency and resourcing of support and improved training for home support workers/carers.
   e. A housing forum for Maori and Pacific people with disabilities.

   It is important when implementing these recommendations to recognise that for Maori the treaty partnership must be at the forefront, and that while Workshop 5 identified mostly general themes for both Maori and Pacific people where their needs are aligned, it will also be important to identify specific issues for each group.

6. In terms of systems change, explore how to**:**
    a. Implement different levels of co-design across the 3 DHBs:
        - Small focus groups with disabled people and their families giving feedback about specific health services from a user perspective.
        - Using the SRDAG, Maori and Pacific Groups and regular forums to involve disabled people and their families at the strategic level.
        - Having community-based forums for specific groups (eg. Maori, Pacific people, younger people and their families, older people, etc).
        - SRDAG building an ongoing working relationship with the DHB staff on key projects and being included in developing the Disability SIP work programme.
        - More targeted discussions throughout the year on key initiatives eg. Children, youth and older people, etc.
    b. Increase the voice of disabled people at all DHB levels:
        - Governance (eg. DHB) and local community advisory groups (eg. DSAC).
        - Increasing disabled staff employed at management and operational levels.
        - Creating short, long-term and graduate internships/scholarships for disabled people to increase disabled people gaining employment with the 3 DHBs.
        - Discuss how disabled people can add value within DHBs teams.
    c. Build more trust between the disability community and staff of the 3 DHB at all levels, so co-design of health services can be effective. Lived experience of disability needs to be valued and respected as a skill set.
    d. Ensure the ‘pockets of brilliance’ become consistent across all 3 DHBs’.
    e. Further develop Disability Data Collection to provide the evidence that the changes that are being made are making a difference across the 3 DHBs.

Disability Support Advisory Committee

24 November 2021

MHAIDS Service Performance Update

Action Required

The Committee notes:

(a) The MHAIDS Service Performance update – November 2021, included as Attachment 1.

(b) MHAIDS is currently implementing a range of improvement strategies to mitigate immediate demand and access pressures.

Strategic Alignment	Service Access
Presented by	Karla Bergquist, Executive Director MHAIDS Paul Oxnam, Executive Clinical Director, MHAIDS
Purpose	Provide information to DSAC on the mitigation strategies to address MHAIDS service performance challenges
Contributors	Karla Bergquist, Executive Director Paul Oxnam, Executive Clinical Director
Consultation	N/A

Executive Summary

The Mental Health, Addiction & Intellectual Disability Service (MHAIDS) tabled a performance report at the 29 September 2021 DSAC meeting. In reviewing the report, Committee members acknowledged that the mental health and addiction change programme is underway and is expected to deliver over the medium to long term. However, it was noted that MHAIDS is experiencing a number of immediate demand and access pressures that require short-term mitigation. This report describes a range of improvement strategies MHAIDS is currently implementing.

In addition, the MHAIDS service performance report dated November 2021 is included as Attachment 1. There have not been significant changes since the last report was tabled.

Strategic Considerations

Service	All 2DHB services are committed to delivering safe, quality care to patients and whānau, and ensuring staff safety.
People	Increase understanding of patient safety, quality improvement patient / whānau experience and recognising opportunities for learning.
Financial	Poor patient outcomes and harm can have a direct financial impact on the performance of our DHBs.
Governance	We will strengthen quality and safety at every level through effective leadership, integrated governance and defined accountabilities across the health and disability system of the 2DHBs.

Attachment/s

1. MHAIDS Service Performance Update – November 2021

Access

- To support our commitment to integrated care and locality based services, we are working on changes to the Te Haika model to build an enhanced local intake and assessment response within our community mental health teams. This model involves placing intake and assessment roles into our community mental health teams. These positions are designed to triage and manage community team referrals, supporting access to local responses. Initially, the roles will focus on non-urgent referrals. The positions will come from existing resources from within the Te Haika team. Te Haika will continue to function as our 24/7 MHAIDS telephone call centre.
- The role of the Primary Care Liaison Service (PCLS) is to provide flexible and easily accessible education and support to General Practise assisting people presenting with acute and chronic mental health needs. The PCLS helps to reduce the risk of further mental health deterioration, lessen the likelihood of transfer of care to secondary mental health services, and ease transfer of care from secondary services back to primary care. The PCLS has been well received by the General Practice community and we are planning to expand the existing service of a Consultant Psychiatrist and two nurses by adding two nurse practitioner roles to the team

Recruitment and Retention

- We are working with central recruitment (CCDHB) to implement a comprehensive recruitment strategy that includes improving advertisements, widening recruitment channels, social media campaigns, and making efficiencies in the RBC process.
- The MHAIDS New Entrant to Specialist Practice (NESP) nursing programme has been a critical pipeline for our nursing workforce. In 2020, 20 of the 24 NESPS went on to take up permanent contracts. We have employed 24 NESPS during 2021 and will take on 30 in 2022. We continue to get strong interest in the programme.
- MHAIDS recently appointed a NESP Māori Coordinator who supports equitable employment within the service by developing the new nursing workforce, liaising with tertiary education providers (TEPs), and supporting Māori nurses as they adjust to their new work environment.
- The NESP programme is complimented by the MHAIDS Bachelor of Nursing Scholarship Programme. Scholarships are offered to all existing MHAIDS staff including Mental Health Support Workers and Administrators who are on a pathway to become a registered nurse. Scholarships are also offered to Whitireia students who are in Year 2 or above.
- A number of our teams are now employing enrolled nurses (ENs) and supporting them into practise. The CCDM programme has also identified opportunities for more ENs to be employed into our inpatient services, with recruitment to those positions already underway.
- In addition to existing vacancies, the Intellectual Disability Service is recruiting for nurses to work in the new Individual Service Unit (ISU), which opens in February 2022. Directors within MHAIDS are meeting with other DHBs that deliver intellectual disability services to develop a combined recruitment strategy targeting nurses with the specialist training needed to work effectively with this client group. We are exploring other specialist roles to supplement the nursing workforce.
- The MHAIDS Director of Allied Health is implementing strategies to improve the range of support available to Allied Health NESPs and Clinical Psychology Interns. Opportunities to connect with peers and receive mentoring from senior colleagues is helping these staff to begin their careers with an improved degree of confidence.
- MHAIDS has been comprehensively engaged in the TrendCare programme. Our inpatient units have completed a full year of data collection and an additional 118 FTEs have been allocated to meet acuity and demand. Recruitment is underway to fill these positions.

The High Performance High Engagement (HPHE) pilot

- The HPHE pilot is sponsored by ACC and is being implemented in partnership with CTU. The focus is on improving health and safety outcomes. Working closely with NZNO & PSA, there are three improvement projects to address critical service risks that were identified by employees. These are: *Vicarious Trauma*, *Lone and Isolated Workers* and *Building a Health and Safety Culture*. It is anticipated that the outcomes from these MHAIDS-wide projects will improve the experience, health, safety and wellbeing of staff.

Addressing health and safety concerns in MHAIDS acute inpatient units

- Plans have been completed in all inpatient teams that outline the actions each service should take when it experiences a care capacity deficit.
- Earlier this year, a 'bow tie' analysis was conducted to assess the risks for staff and clients at Te Whare o Matairangi. An improvement group made up of directors, managers, staff, health and safety representatives and unions has been established to facilitate or escalate plans for improvement across MHAIDS' acute services. The areas that this group will address include, but is not limited to:
    - Staffing shortages
    - Recruitment
    - Alternatives to hospitalisation
    - Over occupancy and the related delays for access
    - Patient flow
    - Pathways for admission
    - The impacts on wider services including NGOs, ED and the general hospital

Partnerships with other providers

- The Co-Response Team (CRT) is a partnership between MHAIDS, the Police and Wellington Free Ambulance. The trial has been completed and an evaluation carried out by the University of Otago. The CRT is made up of a mental health clinician, a police officer, and an ambulance officer. They travel together as first responders to assist people in the community who call 111 to report an acute mental health concern. The CRT helps to resolve mental health challenges for people in their communities and expedites contact with specialist services. The evaluation report is due for release in December 2021. The draft report indicates a number of positive outcomes from the pilot.
- Workwise (NGO employment service) staff have been allocated space in Community Mental Health Teams to assist clients into employment. Having employment specialists work alongside MHAIDS staff has improved our clinicians' ability to support clients to access meaningful roles that contribute to sustained health and wellbeing.
- MHAIDS is working closely with NGO partners to foster the provision of alternatives to hospitalisation. In the Covid climate, these relationships have assisted vaccine uptake and allowed us to provide more community, rather than inpatient, responses. Further upcoming work in this area will offer an enhanced service model between MHAIDS and Pathways Trust so that people can receive intensive support in a flexible manner in a location that best meets their needs. This approach can be used to interrupt an inpatient admission pathway or shorten a length of stay in an inpatient unit.

Improving mental health service provision in emergency departments

- In response to delays for people with mental health issues presenting to emergency departments (EDs), registered nurse educator roles have recently been established to work alongside ED

clinicians. These staff will provide rapid assessments, deliver training and mentoring to improve the confidence and capability of ED doctors and nurses, and help to expedite access to specialist mental health teams.

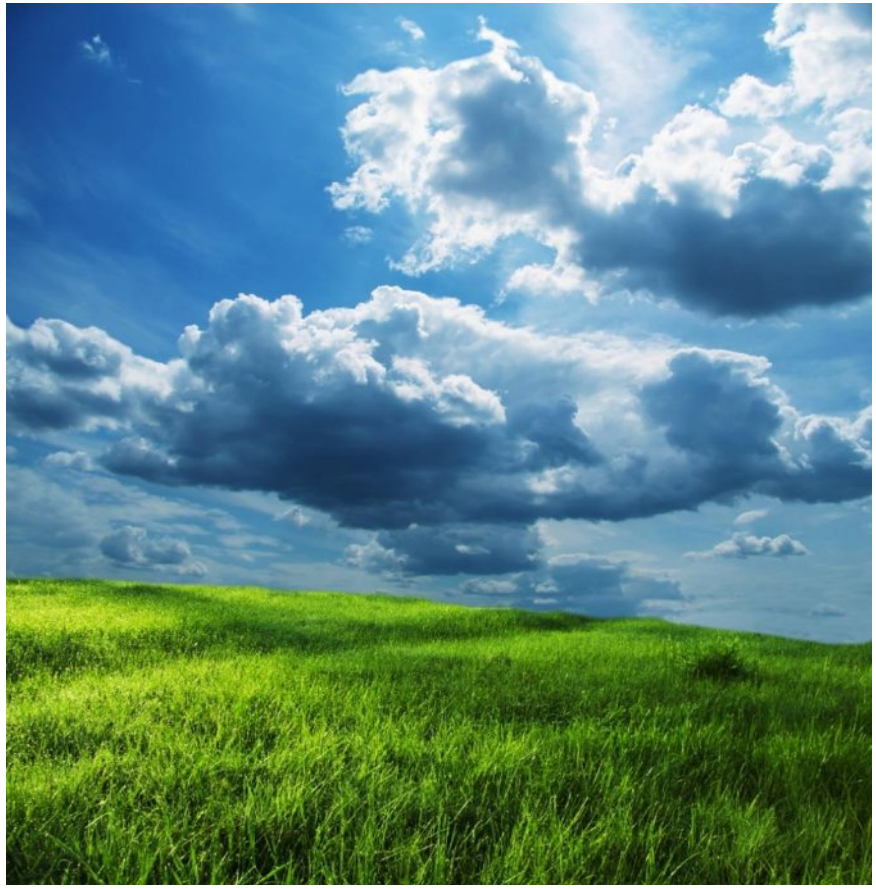
- MHAIDS is actively engaged with the Front of Whare project for the Wellington ED.
- Plans are being finalised to find an alternative more suitable space for mental health clients adjacent to ED.

ICT

- We are in the process of securing more mobile devices to enable an increased number of staff to work in the community and digitally.
- We are in the process of implementing AIMS, the electronic outpatient appointments reminder system to assist with reducing number of did not attends (DNAs).

Mental Health, Addiction and Intellectual Disability Service

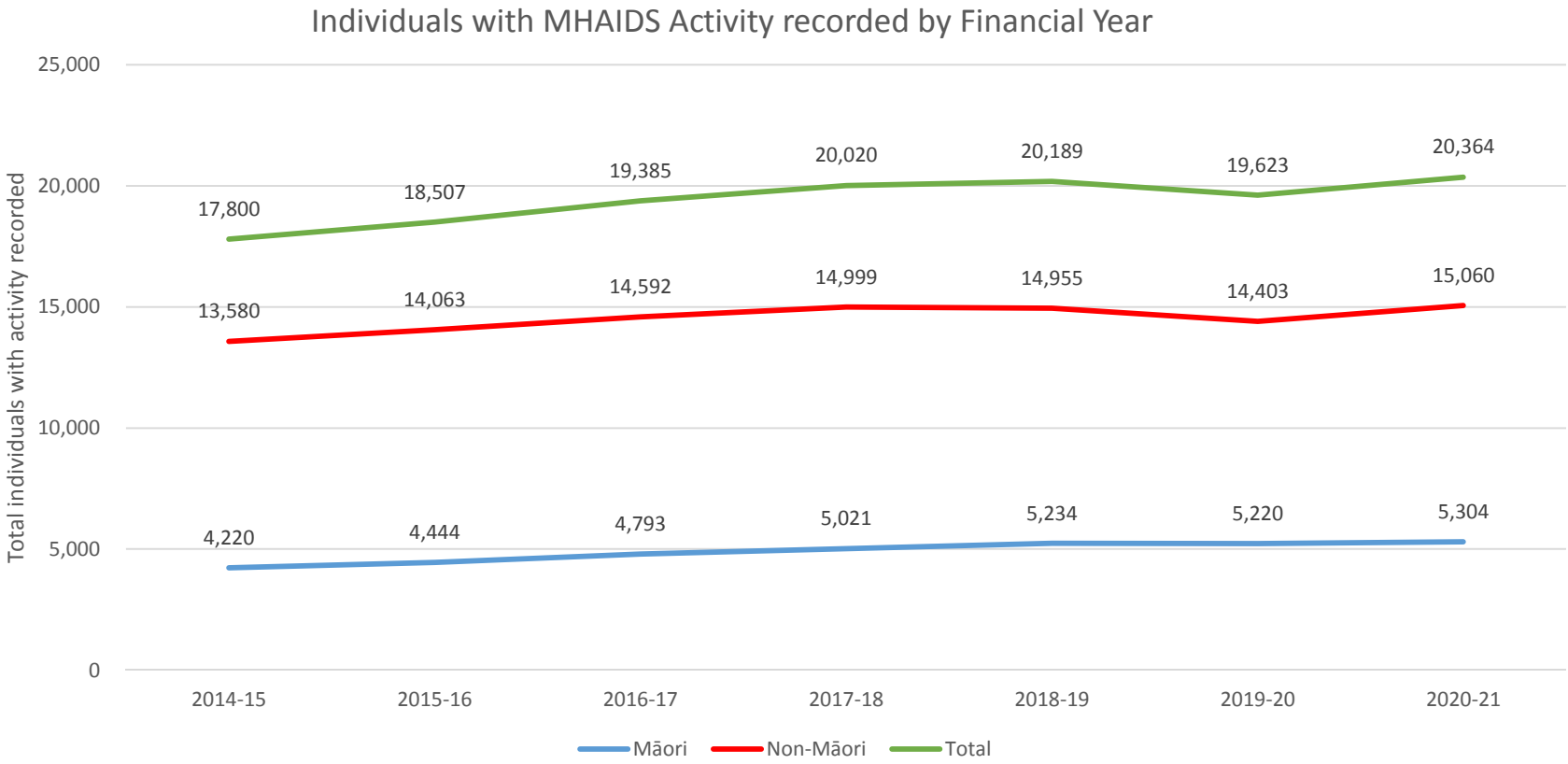
Service Performance Update – November 2021



Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

People accessing MHAIDS services

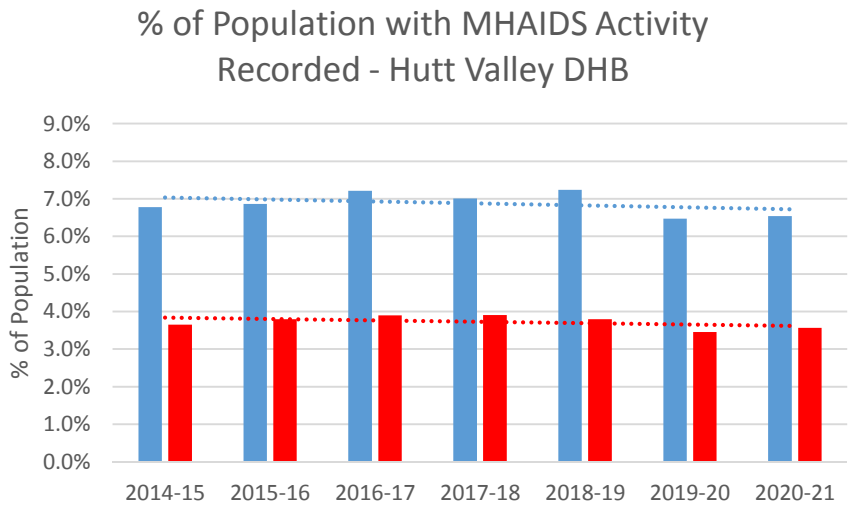
The increase represents an additional 1,480 people in 2020/21 than 2014/15. Māori made up 1,084 (42%) of that number.

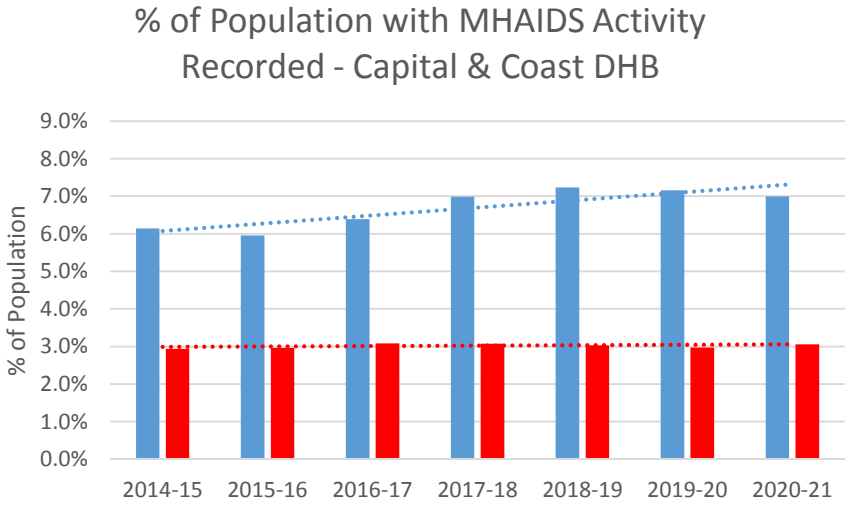


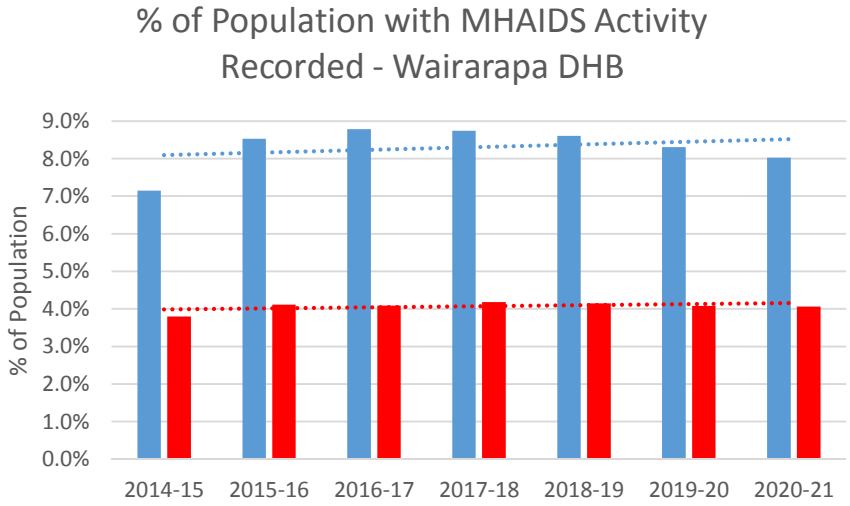
Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

People accessing MHAIDS services

The patterns are similar across DHBs although the rate of Māori accessing services in Hutt has dropped slightly in recent years (7.2 to 6.5%)



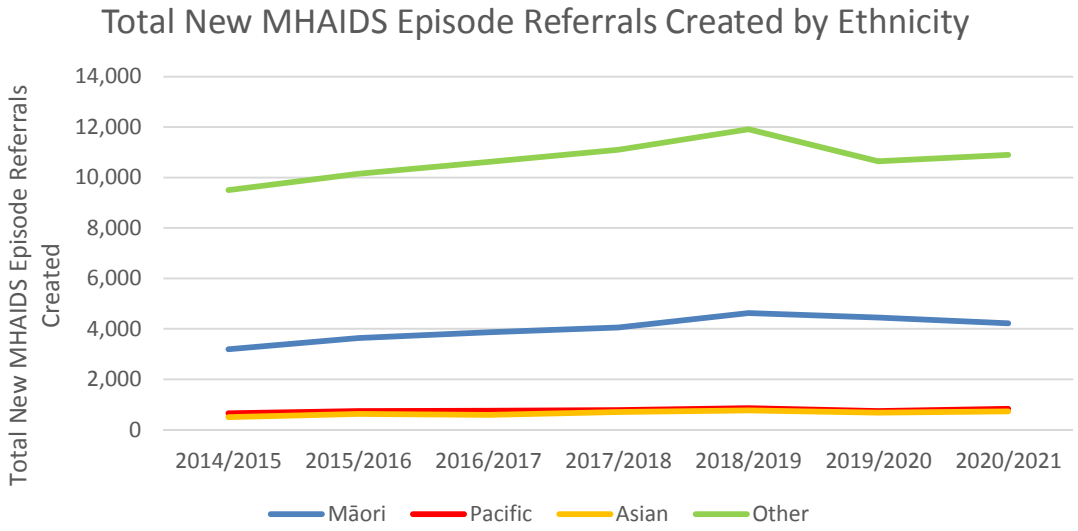


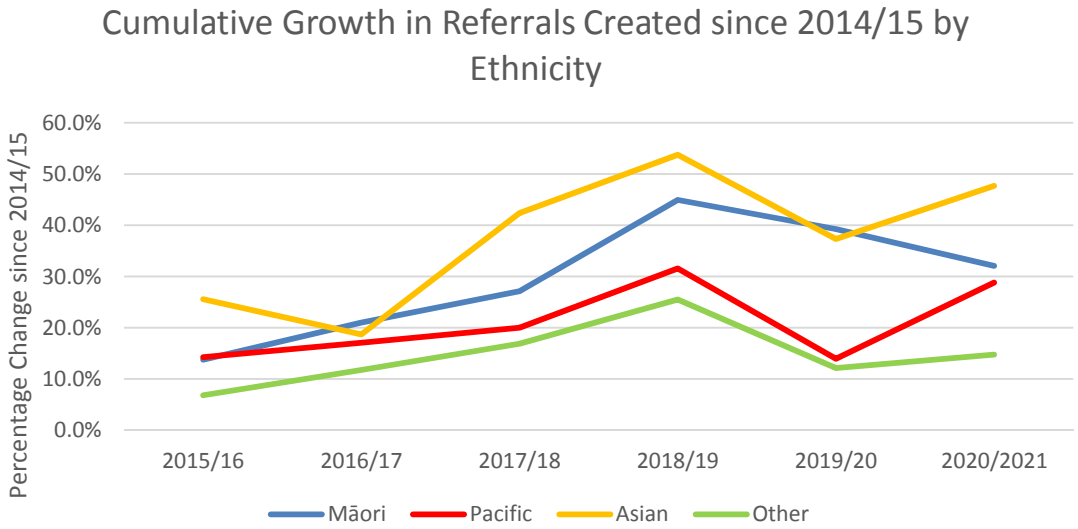


Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

New Referrals to MHAIDS

Referral numbers increased across ethnicity with COVID-related dips in 2019/20. The biggest percentage increase this year has been in referrals for Pacific peoples, and cumulatively since 2014/15 baseline the biggest increases are for Asian and Māori.





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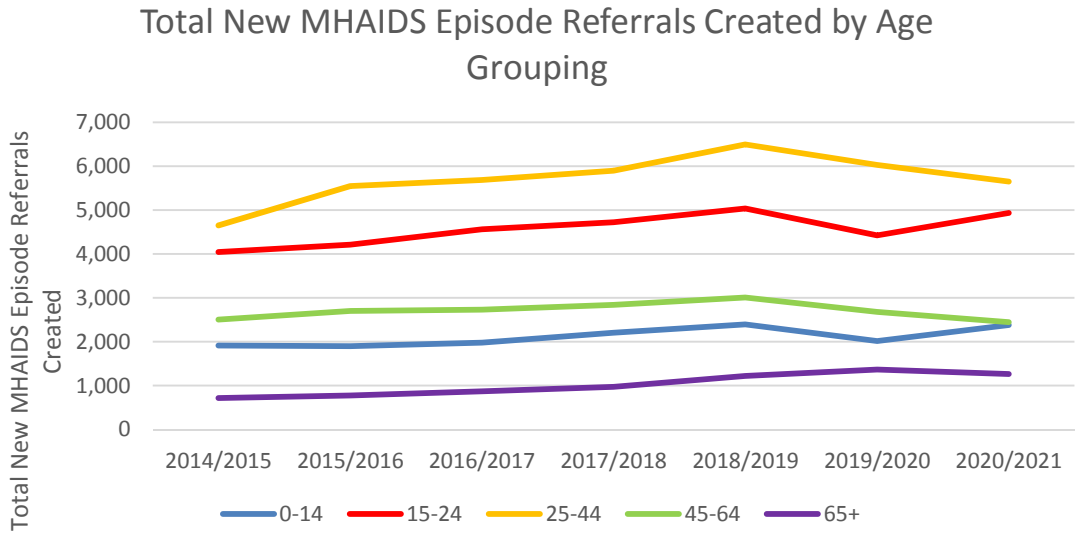
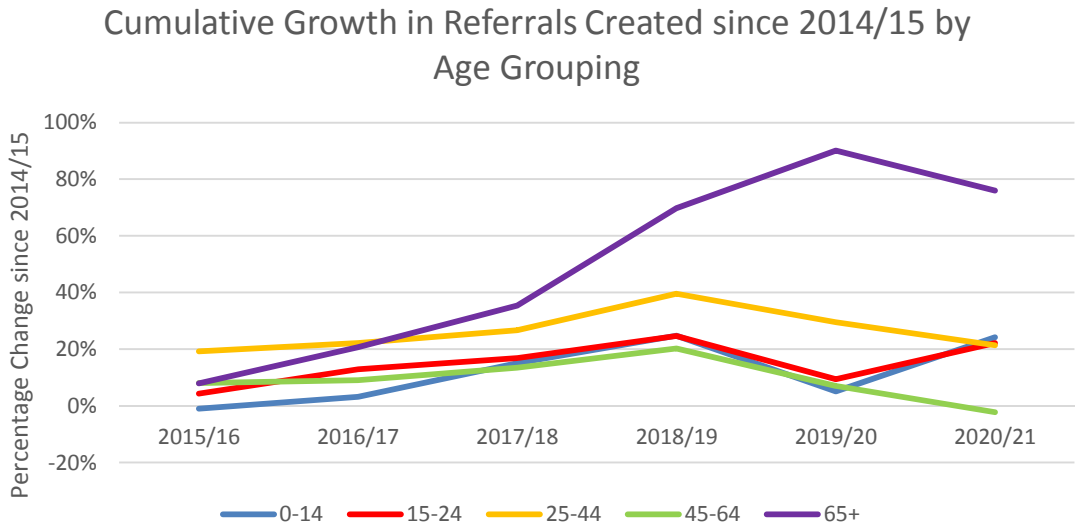
Mental Health, Addictions and Intellectual Disability Service

New Referrals to MHAIDS

Similarly referral numbers increased across age groups until 2018/19 and decreased in 2019/20. This year referrals for young people aged under 24 have increased while other categories have decreased.





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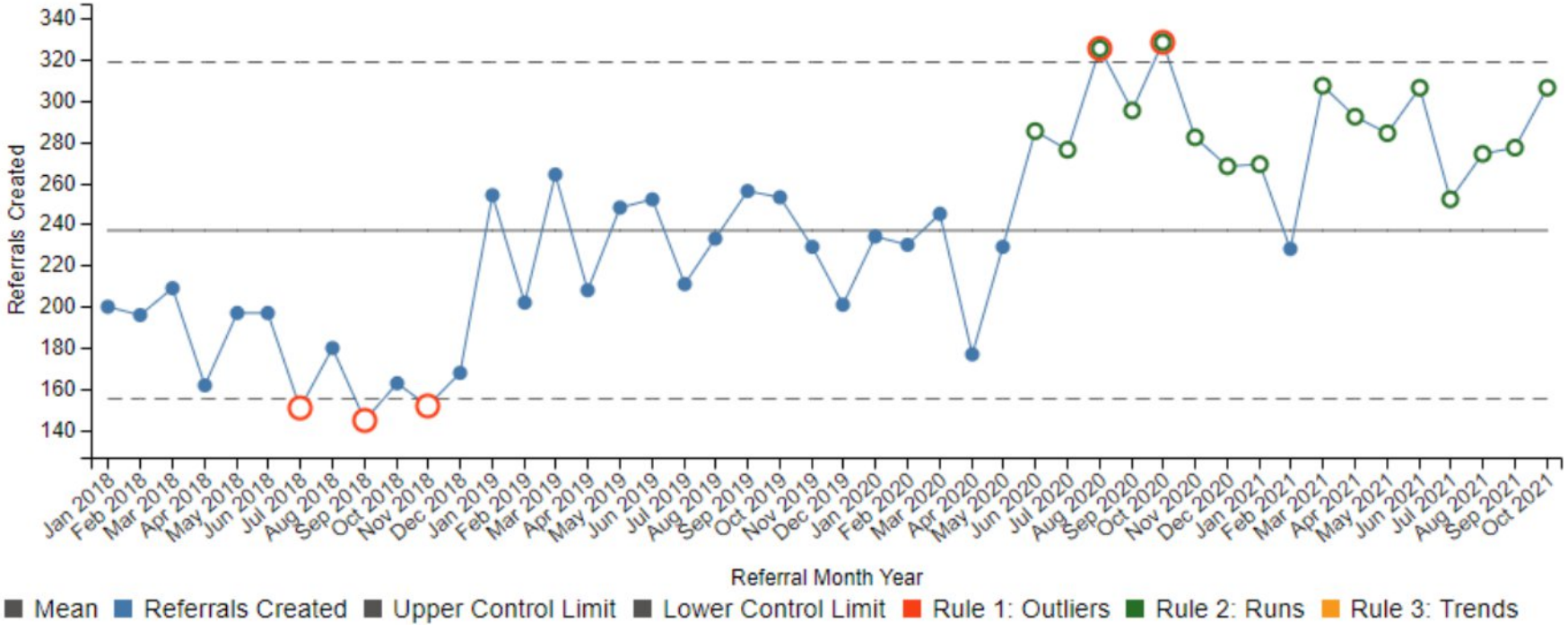
Mental Health, Addictions and Intellectual Disability Service

Urgent Referrals to MHAIDS

While overall referral numbers have returned to levels similar to previous years, there has been a marked increase in urgent referrals received since the end of the initial COVID-19 lockdown in April/May 2020. This pattern has continued over the last 12 months.

Control Chart (I Chart) Showing Urgent Referrals Created

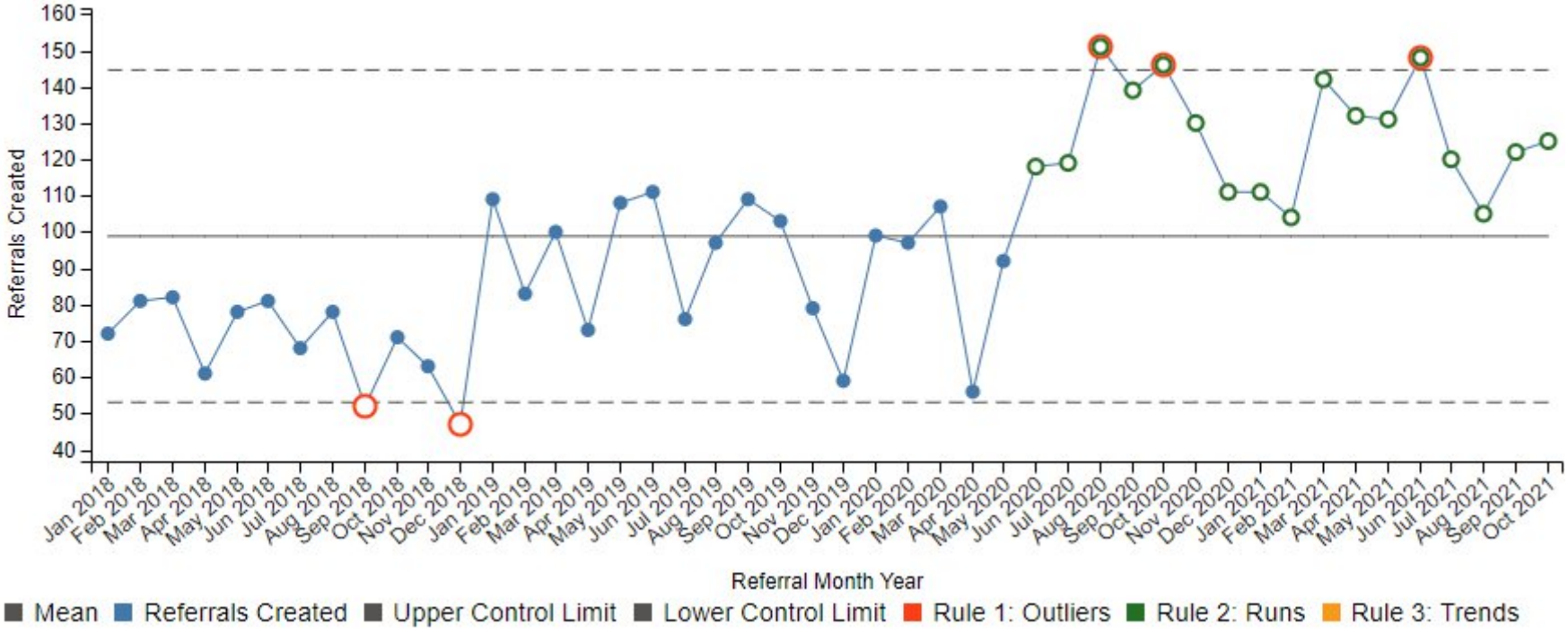


Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Urgent Referrals to MHAIDS

The most significant demographic group for this increase in urgent referrals has been young people aged 24 and under.

Control Chart (I Chart) Showing Urgent Referrals Created – Age 0-24 Years

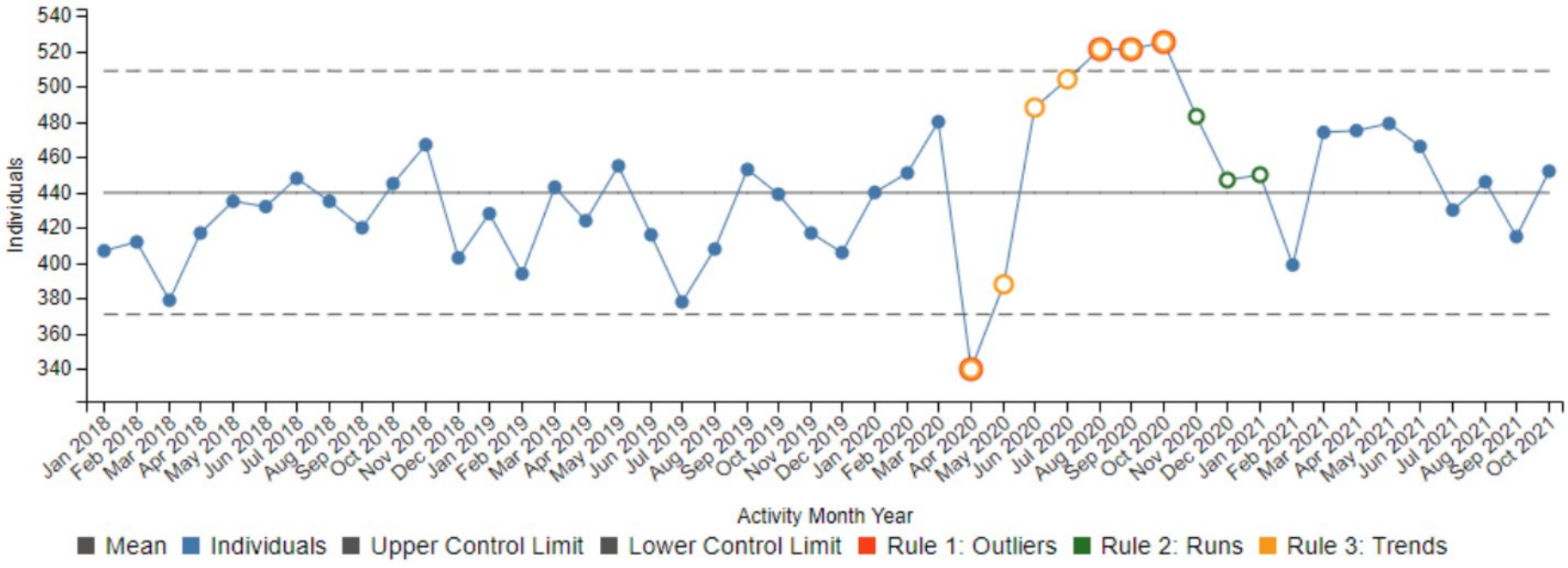


Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Crisis Resolution Service

The Crisis Resolution Service saw a significantly higher number of people in the months post COVID-19 lockdown last year than in previous years. The number of people presenting in crisis this year has remained above the average from previous years.

Control Chart (I Chart) Showing Individuals seen by Crisis Resolution Service



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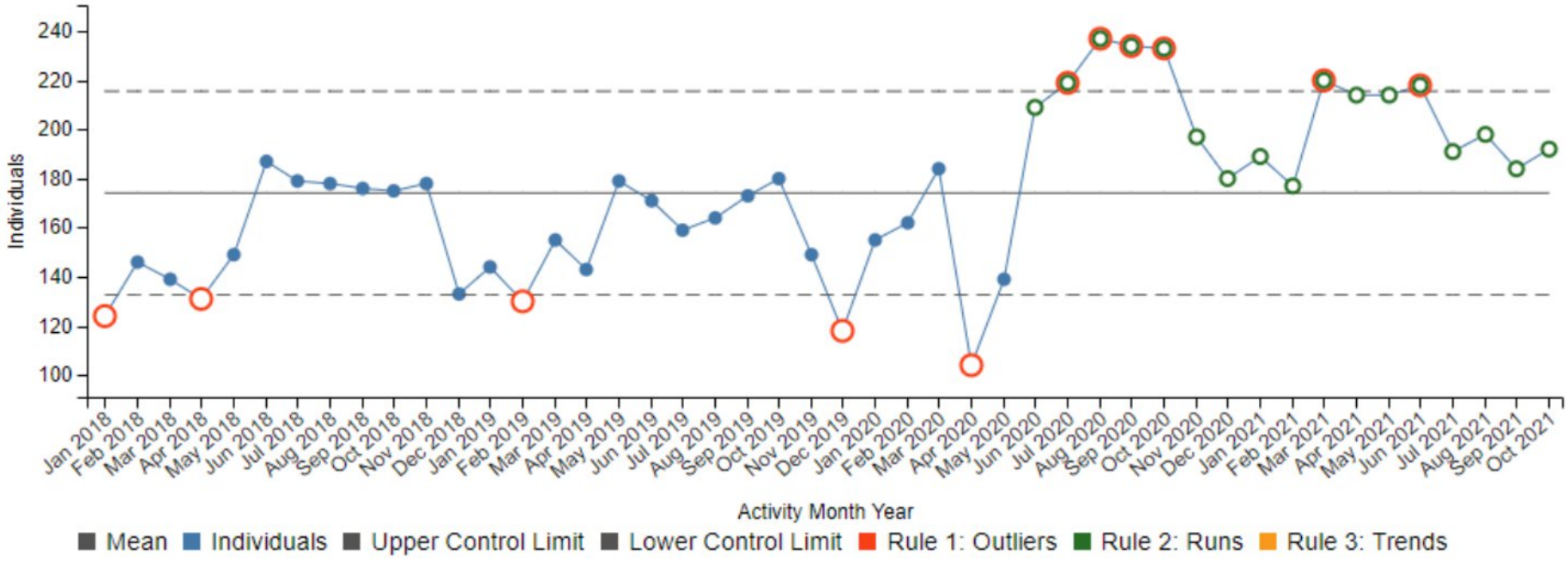
Mental Health, Addictions and Intellectual Disability Service

Crisis Resolution Service

Again the biggest increase has been in presentations by young people (aged 24 years and under) and the monthly total has remained at a higher level than pre-COVID.

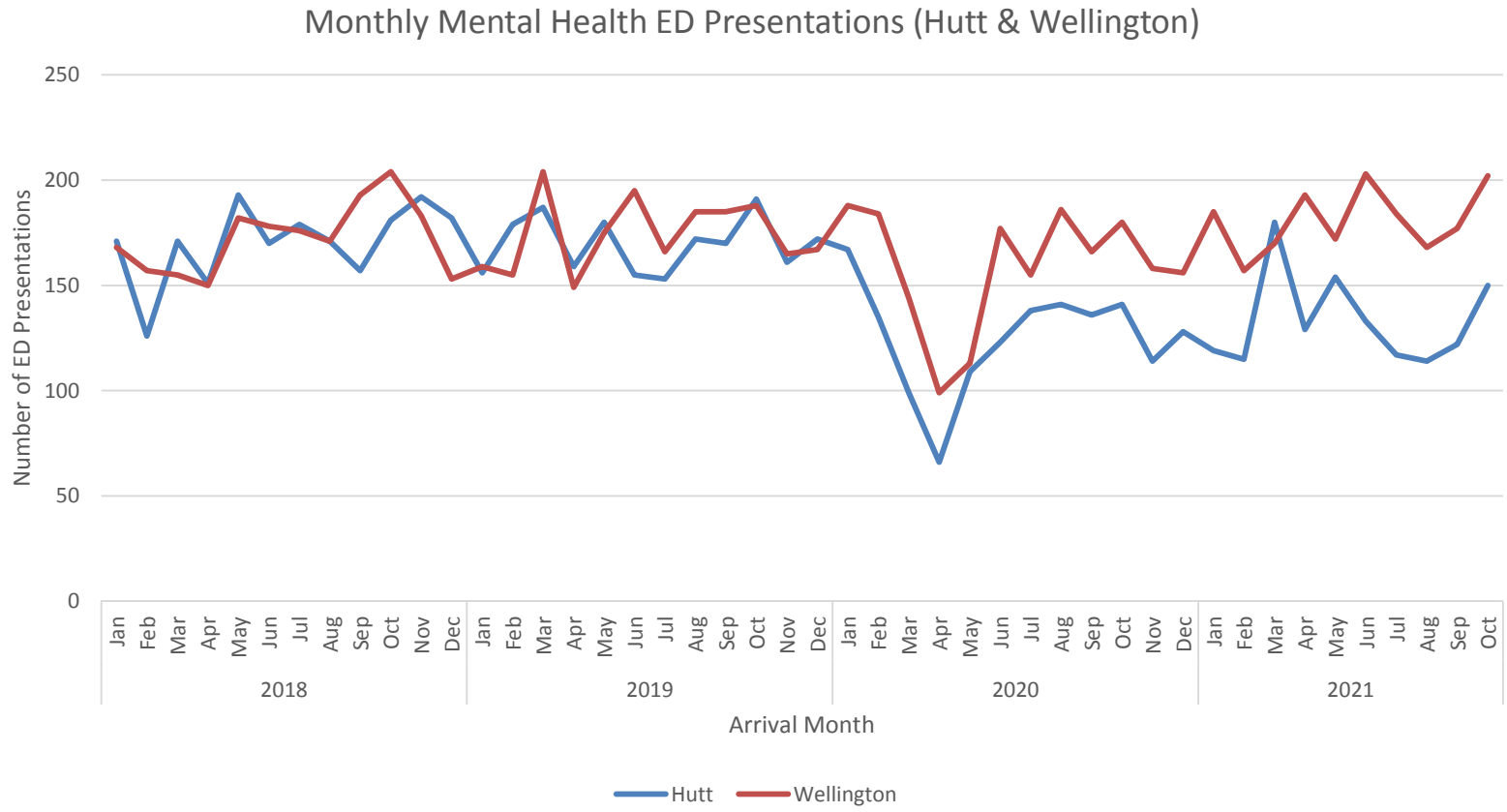
Control Chart (I Chart) Showing Individuals seen by Crisis Resolution Service – Age 0-24 Years



Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Presentations at ED

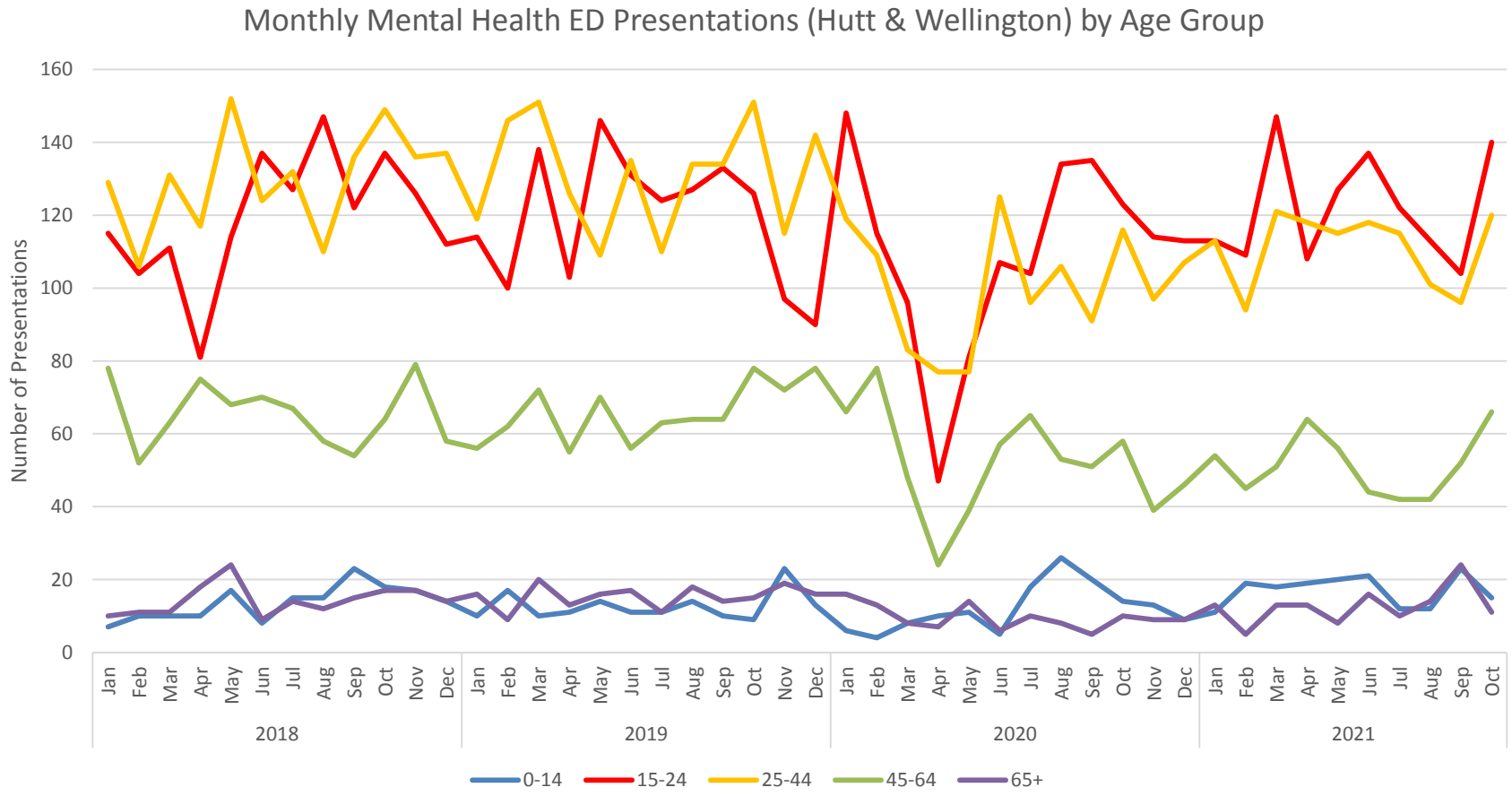
Post- COVID lockdown the number of presentations to ED for mental health reasons has largely returned to the previous volumes at Wellington, with less presentations in the last 12 months at Hutt ED.



Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Presentations at ED

People in the age categories 15-24 and 25-44 are the most likely to present at ED for mental health reasons.



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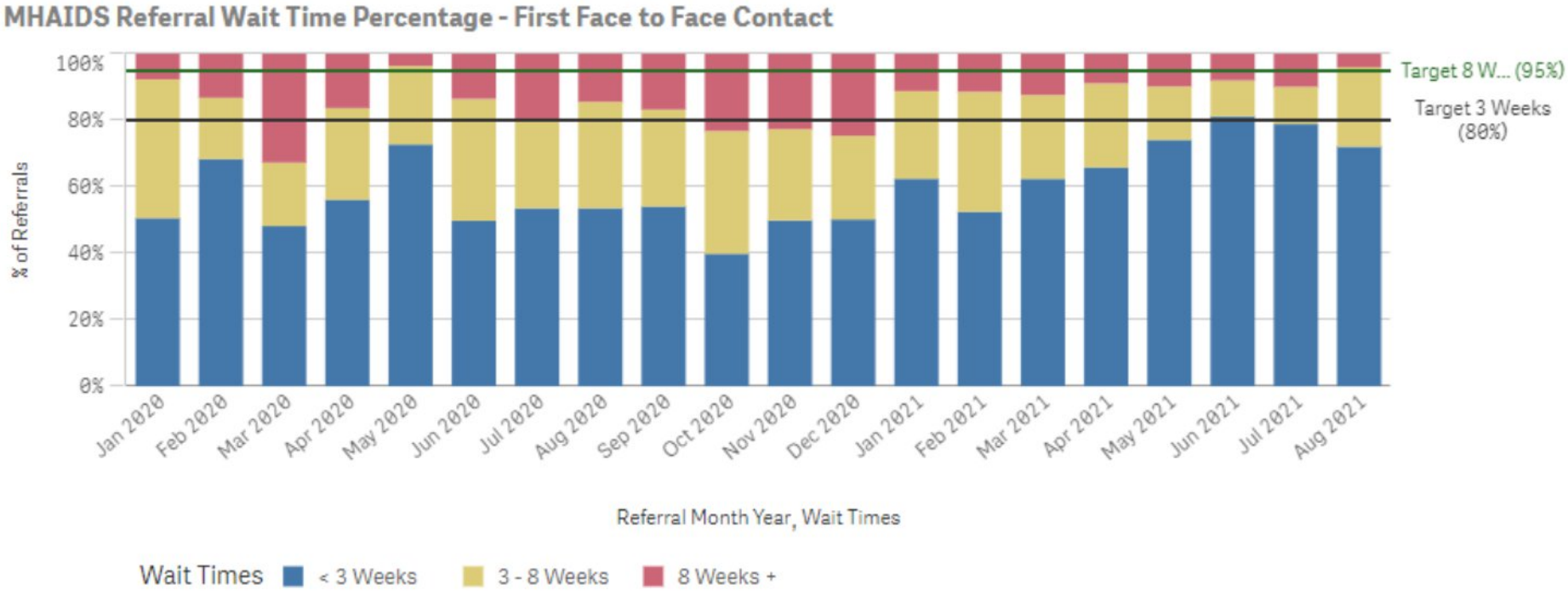
Mental Health, Addictions and Intellectual Disability Service

Wait Times – Younger Persons Community & Addictions Sector

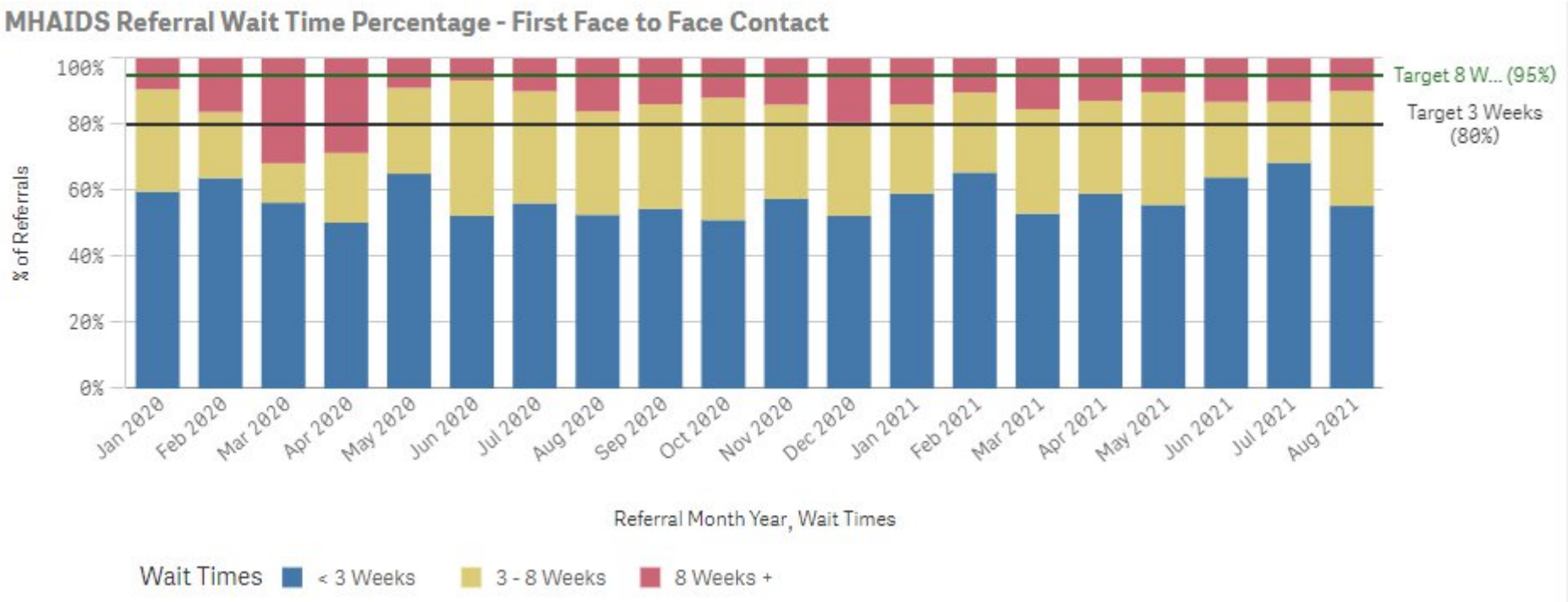
The Ministry of Health targets for wait times are 80% of people to be seen within 3 weeks of referral and 95% of people to be seen within 8 weeks. The Younger Persons sector has struggled to meet these targets – the mean since Jan 2020 is 57% seen within 3 weeks and 83% seen within 8 weeks.



Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Wait Times – Adult Community & Addictions Sector

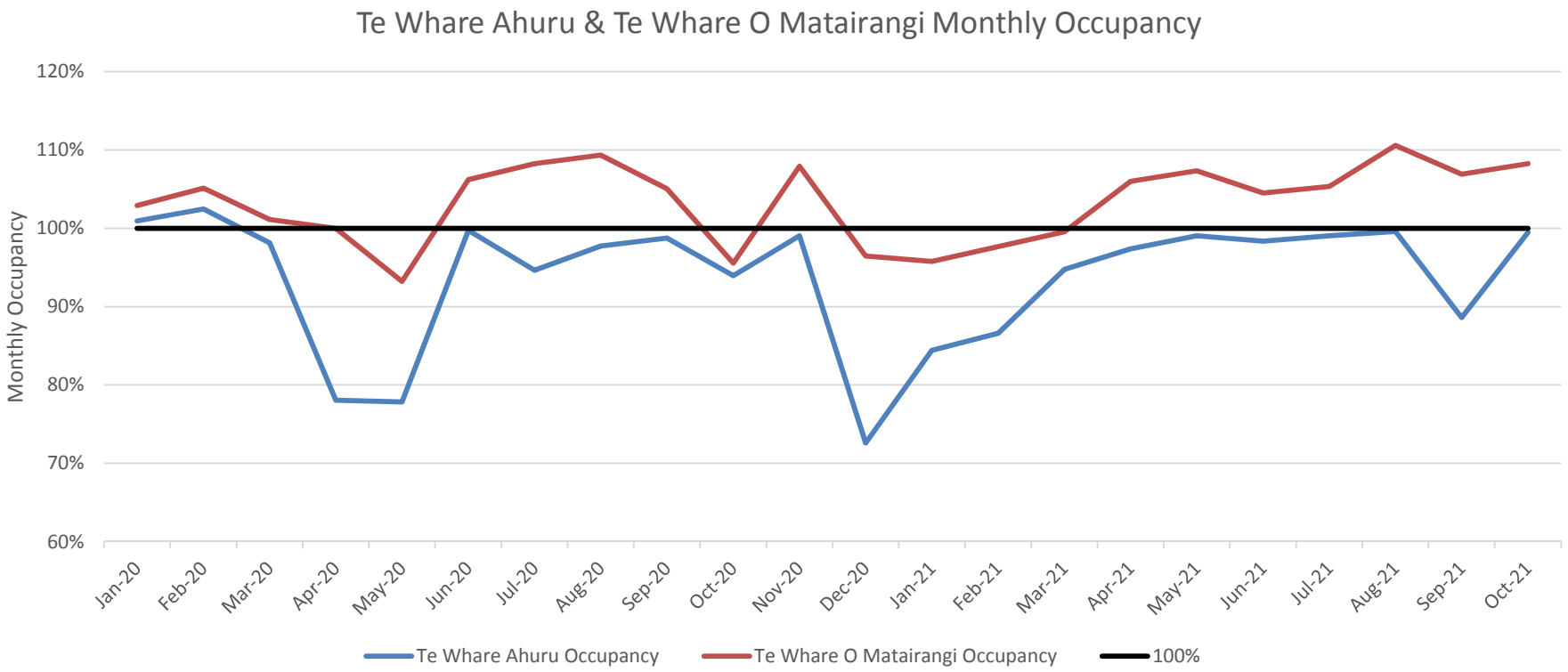
The Adult Community & Addictions sector has slightly higher wait times results – the mean since Jan 2020 is 59% seen within 3 weeks and 87% seen within 8 weeks.



Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Acute Inpatient Services

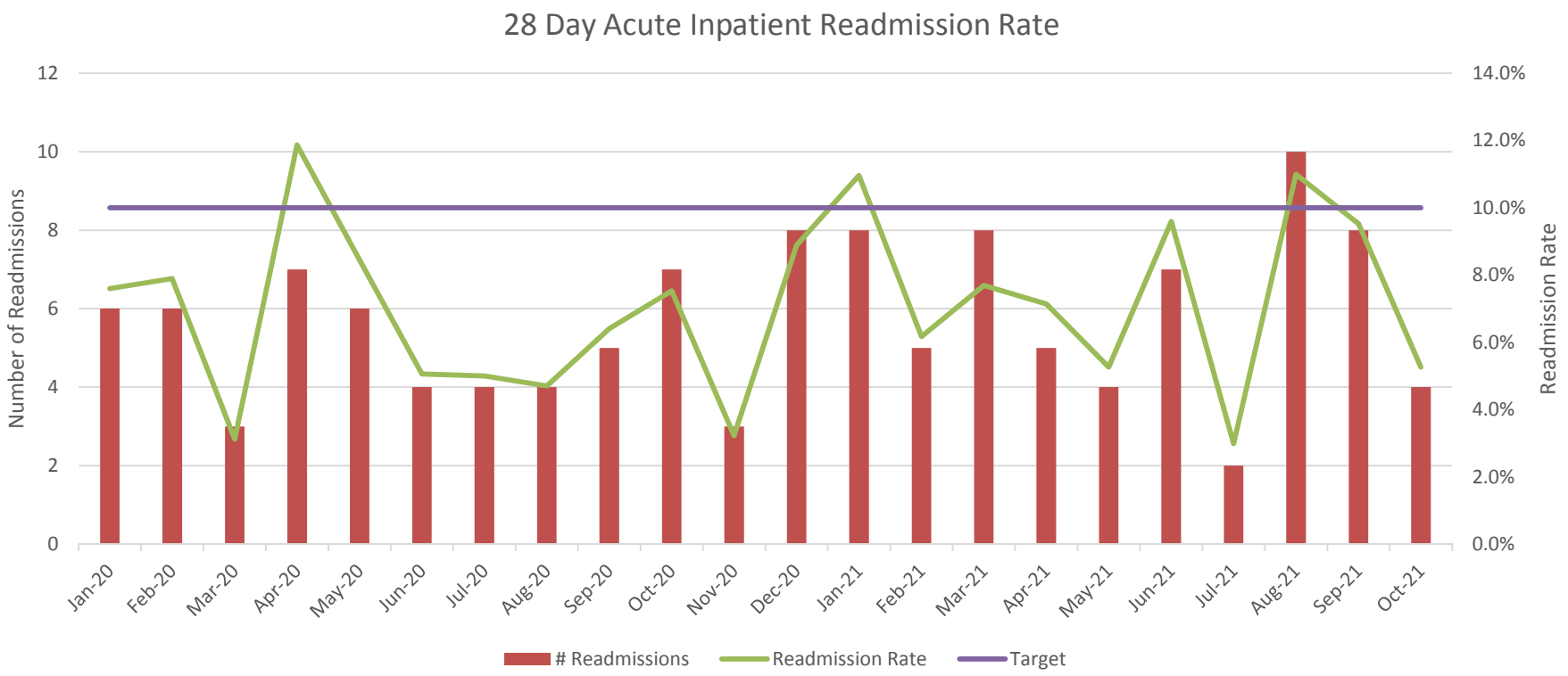
Bed occupancy in the two adult acute inpatient units remains a critical issue with Te Whare O Matairangi in particular regularly being at maximum or over capacity.



Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

28 Day Acute Inpatient Readmission Rate

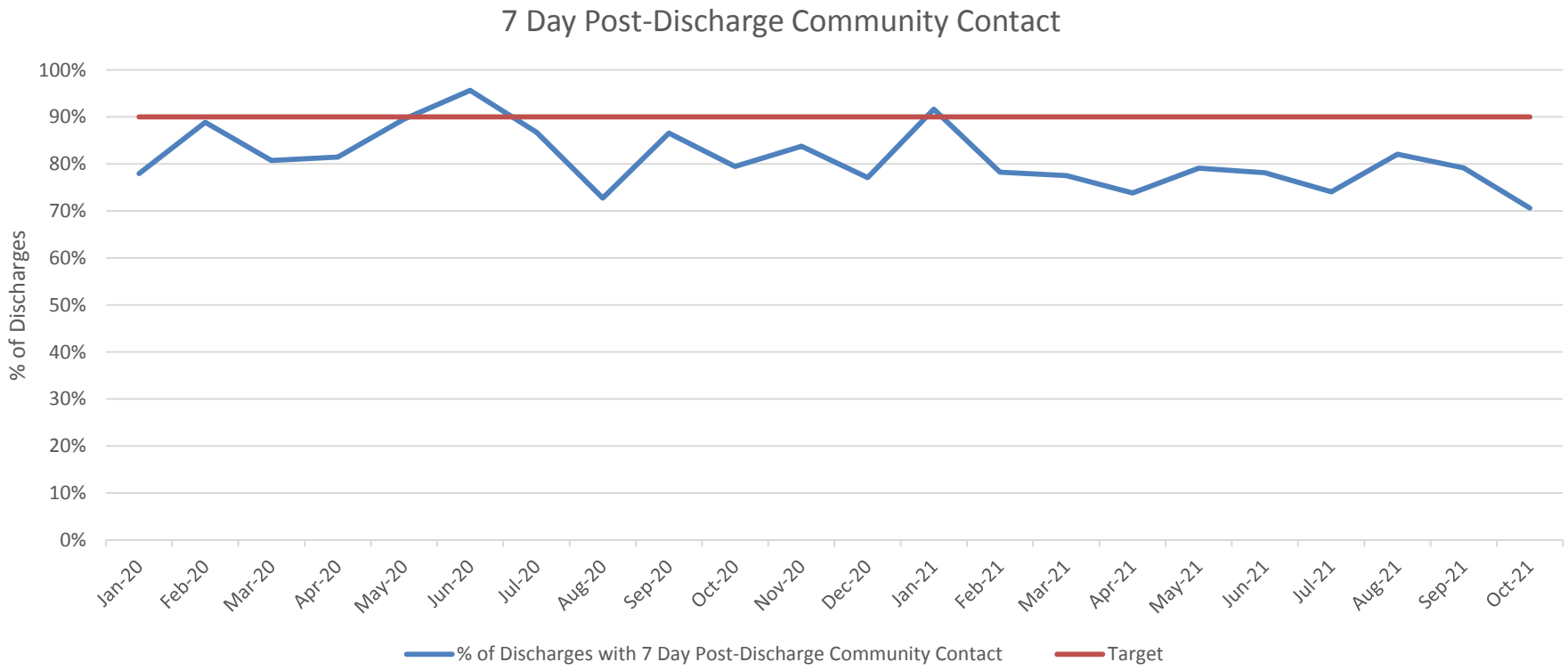
The target for the 28 Day Acute Inpatient Readmission rate is <=10%. MHAIDS inpatient units have only breached this target in three months since January 2020.



Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

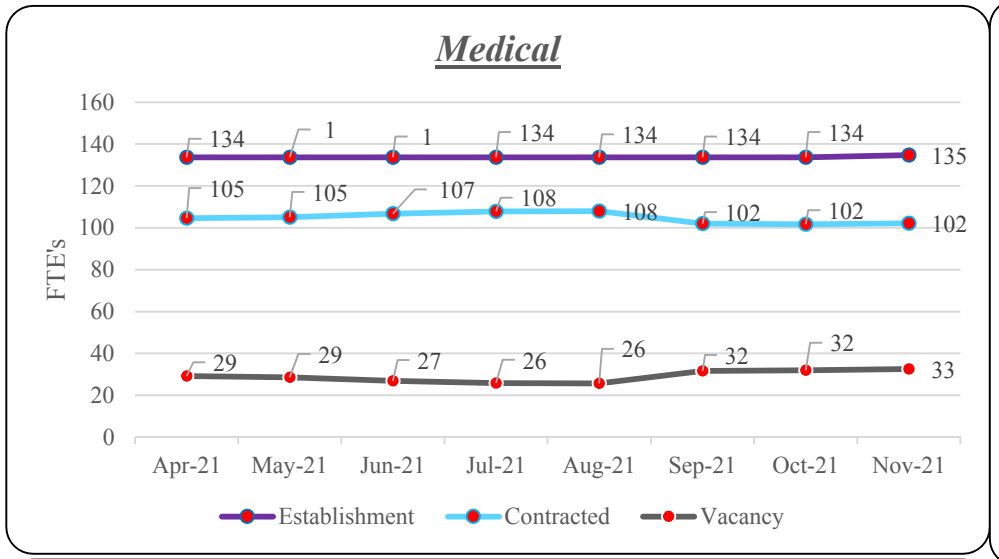
7 Day Post-Discharge Community Contact

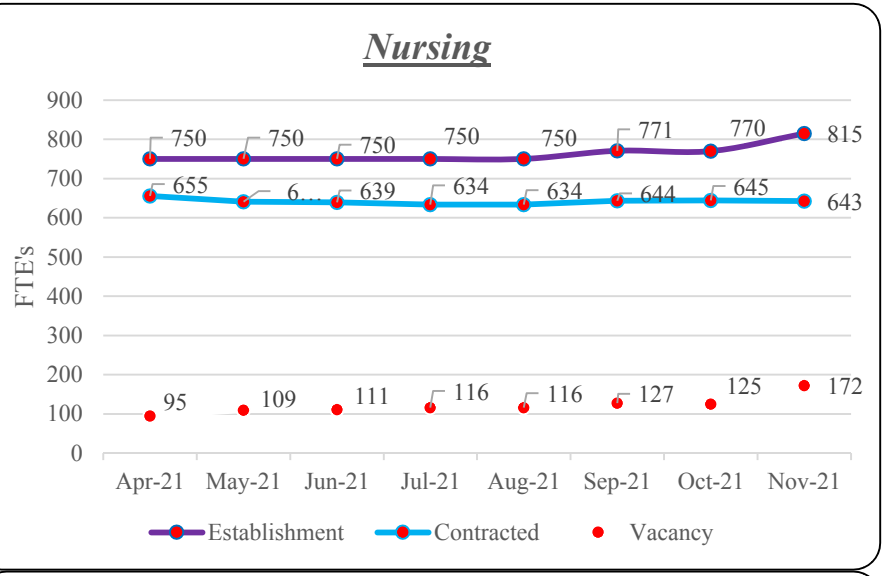
MHAIDS average for this measure since Jan 2020 is 81.1%, slightly below the 90% target.

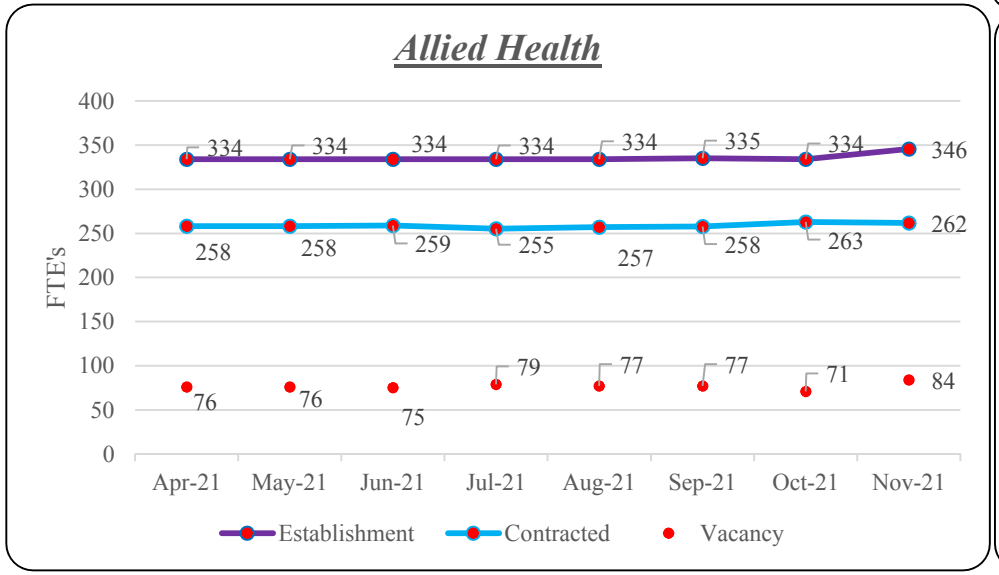


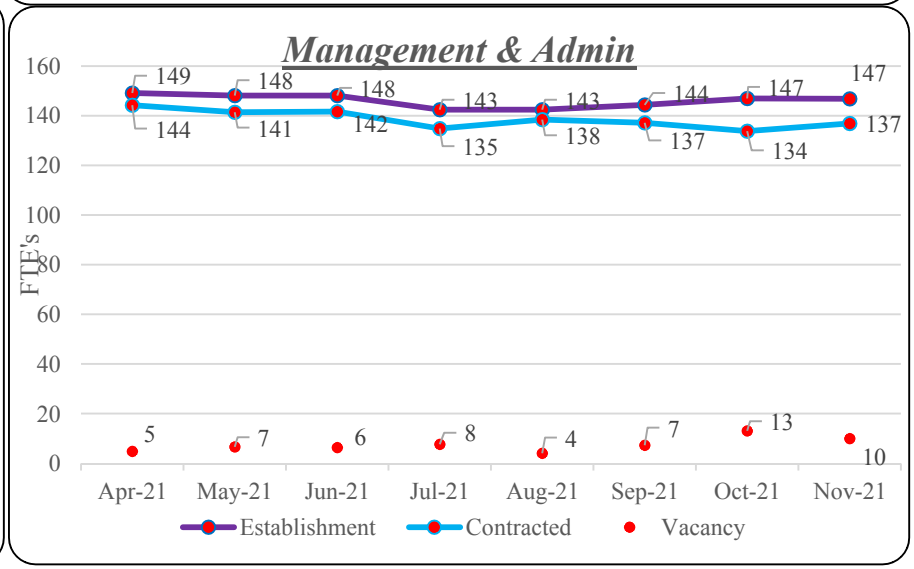
Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Mental Health FTEs Trend April 2021 to October 2021









Te-Upoko-me-Te-Karu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service

Disability Support Advisory Committee

24 November 2021

3DHB Mental Health and Wellbeing Strategy update

Action Required

The Committee notes:

(a) Hutt Valley and Capital & Coast DHBs have formally established the Mental Health and Addiction Change Programme to redesign and implement a pro-equity, whole of population system of care to support the mental health and wellbeing of the people across the subregion.

(b) the continued expansion of the Access and Choice programme across the 3DHB region, with investment increasing monthly to fund a total of 82.4 FTE by June 2023.

(c) the growth of the Primary Care Liaison Service, with the recent establishment of a full-time consultant psychiatrist role in Wellington, two nurse practitioner roles in Hutt Valley DHB, and upgrading of the two liaison roles in Wellington to nurse practitioner level.

(d) a new Acute Alternative service in Lower Hutt will be operational from mid-November 2021, serving as an alternative to inpatient care for those experiencing acute mental illness.

(e) that four Kaupapa Māori and Pacific providers across the Capital & Coast and Hutt Valley regions have been contracted to provide Primary and Community AOD Kaupapa Māori and Pacific Counselling.

(f) an updated 3DHB Suicide Prevention and Postvention Action Plan has been developed. This updated Action Plan incorporates *Every Life Matters* focus areas. It is also responsive to the 2020/2021 annual provisional suicide statistics, the Ministry of Health suicide web tool, and recent 3DHB data.

Strategic Alignment	*Health System Plan 2030* *Living Life Well: A strategy for mental health and addiction 2019-2025* *Taurite Ora: Māori Health Strategy 2019-2030* *Te Pae Amorangi: Māori Health Strategy 2018 -2027* *Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025* *Sub-Regional Disability Strategy 2017 – 2022; Wairarapa, Hutt Valley and Capital & Coast District Health Boards* *He Tapu te Oranga o ia Tangata: Every Life Matters – Suicide Prevention Strategy 2019–2029* *Suicide Prevention and Postvention Action Plan*
Authors	Rowan Magill, System Development Manager, Mental Health & Addictions, Strategy, Planning and Performance (SPP) Catherine Inder, Principal Advisor, Mental Health & Addictions, SPP

Endorsed by	Fionnagh Dougan, Chief Executive Rachel Haggerty, Director Strategy Planning and Performance
Presented by	Rachel Haggerty, Director Strategy Planning and Performance Karla Bergquist, Executive Director MHAIDS Paul Oxnam, Executive Clinical Director MHAIDS
Purpose	This paper provides brief updates on the implementation of our DHBs' mental health and wellbeing strategies: *Living Life Well* and the *Suicide Prevention and Postvention Action Plan*.
Contributors	Matt Fribbens, System Development Manager, Wairarapa DHB Jeanette Harris, Kaiwhakahaere Huringa Punaha, Māori Health The Mental Health and Addiction team, SPP
Consultation	N/A

Executive Summary

Living Life Well and the *Suicide Prevention and Postvention Action Plan* together set the direction for the subregion's mental health and addiction services to improve outcomes and address inequities for people experiencing these significant challenges to their wellbeing.

The *Suicide Prevention and Postvention Action Plan* has been refreshed to align it to the Government's *He Tapu te Oranga o ia Tangata: Every Life Matters – Suicide Prevention Strategy 2019–2029* as well as the subregion's Māori Health and Pacific Health strategies and *Living Life Well*.

Both *Living Life Well* and the *Suicide Prevention and Postvention Action Plan* take a whole of population approach to implementing change. As such, they include initiatives that span the continuum of need, including: health promotion, prevention, primary care, and secondary specialist services. Both plans take a collaborative, networked approach which involve working closely with partners, communities, other health and social services, and people with lived experience along with their families and whānau.

To achieve this change, Hutt Valley and Capital & Coast DHBs have formally established the Mental Health and Addiction Change Programme to redesign and implement a pro-equity, whole of population system of care to support the mental health and wellbeing of the people across the subregion. The four projects to be delivered by the MHA Change Programme are:

- Acute Mental Health Inpatient Unit
- Child and Adolescent Mental Health Development
- Kaupapa Māori Mental Health and Addiction Development
- Community Mental Health and Addiction Change Programme.

Strategic Considerations

Service	Mental Health, Addictions, and Suicide Prevention & Postvention services
People	The resourcing schedule is part of the operating budget for 2020/21.

Financial	The resourcing schedule is part of the operating budget for 2021/2022.
Governance	The Mental Health and Addiction Commissioning Forum

Engagement/Consultation

Patient/Family	Lived Experience Advisory Group
Clinician/Staff	A wide range of clinicians contribute to developing models of care and service delivery.
Community	Engagement through the Partner, Provider & Stakeholder Collaborative Network and other Mental Health and Addiction networks and forums

Identified Risks

None as this is an update.

Attachments

1. The Mental Health and Wellbeing Commission He Ara Oranga Wellbeing Framework
2. Suicide Prevention and Postvention Action Plan (refer Agenda 21 July 2021, item 3.1).
3. The 3DHB Suicide Prevention and Postvention Activities

Mental Health and Wellbeing Strategies Update

Introduction

Purpose

1. This paper provides updates for the Disability System Advisory Committee (DSAC) on the implementation of our DHBs' mental health and wellbeing strategies:
    - *Living Life Well: A strategy for mental health and addiction 2019-2025* (*Living Life Well*), including an update on the Mental Health and Addiction Change Programme, the subject of the 29 September 2021 *Locality Community Mental Health Development (Strategic Priority: Community Mental and Addiction Networks)* DSAC report.
    - *Suicide Prevention and Postvention Action Plan (Action Plan)*.
2. The paper also provides an update on the coordination of the COVID-19 response for Mental Health and Addiction (MHA) NGO providers and the 3DHB Mental Health, Addiction and Intellectual Disability Service (MHAIDS).

Living Life Well

3. *Living Life Well* aims to transform mental health and addiction services to a system that can intervene earlier, both in the life course and when issues arise. Meeting needs earlier will create a positive feedback loop where reduced demand on secondary specialist mental health and addictions services will enable us to focus on improving access for first-time service users, and increase efforts towards prevention, early intervention, and population wellbeing.

Suicide Prevention and Postvention Action Plan

4. On 3 November, the Suicide Prevention and Postvention team presented the 2DHB Boards with the *Suicide Prevention and Postvention – Statistics on suicide and self-harm and the 3DHB Action Plan update*. This paper outlined how the *Action Plan,* endorsed by the Board in April 2021*,* is a living document and was in the process of being reviewed and updated to respond to new national and regional data and the Suicide Prevention Office's requirements.
5. The update of the *Action Plan* is now complete and is attached as one of the appendices to this paper. The *Action Plan* includes a greater focus on equity and locality-based, trauma-informed, and community-led approaches to ensure our efforts are focussed on well-being promotion and suicide prevention for priority groups, including young Māori men, older men, and female rangatahi.

Strategic context

Kia Manawanui

6. The Ministry of Health's *Kia Manawanui: Long-term pathway to mental wellbeing* (2021) outlines a change of policy direction for an approach to mental wellbeing. It establishes the ambitious goal of not only responding to New Zealanders' mental health and addictions needs, but also promoting and protecting mental wellbeing (which *Kia Manawanui* defines as feeling safe, connected, valued, accepted, hopeful, and holding a sense of belonging and identity).
7. *Kia Manawanui* therefore calls for a shift from focussing primarily on providing services that respond to individuals' mental health and addiction needs, towards a greater focus on promoting mental wellbeing and addressing wider determinants of mental wellbeing. This shift

in focus does not mean reducing mental health services, however. To achieve this change in emphasis, *Kia Manawanui* identifies five interconnected focus areas, in order of priority:

- Build the social, cultural, environmental, and economic foundations for mental wellbeing.
- Equip communities, whānau, and individuals to look after their mental wellbeing.
- Foster community-led solutions.
- Expand primary mental wellbeing support in communities.
- Strengthen specialist services.

8. For DHBs, the implications of *Kia Manawanui* include the need to: actively support the development of locality-based and community-driven health networks; strengthen the provision of services and supports in primary care and community settings; and continue to enhance specialist services. These efforts directly align with the Community Mental Health and Addiction Change Programme and, as reflected in this *Mental Health and Wellbeing Strategies Update*, are currently underway across all three DHBs.

Ara Oranga Wellbeing Outcomes Framework

9. The Mental Health and Wellbeing Strategies 31 March 2021 report to DSAC promised an update on the development of a population outcomes framework to support *Living Life Well*. This proposed 3DHB initiative has now been superseded by the *Ara Oranga Wellbeing Outcomes Framework* (the *Framework*) developed by the Mental Health and Wellbeing Commission for measuring performance across the whole mental health and wellbeing system.

10. The *Framework* shows how wellbeing will be achieved from both a te ao Māori perspective and a shared perspective (the 'shared perspective of wellbeing' also applies to Māori). Factors that contribute to a person's or whānau wellbeing are grouped under six different areas and summarise what people need to be and feel well (the *Framework* is attached as one of the appendices to this paper). The Mental Health and Wellbeing Commission are working on the data to know if people are doing well under each of the outcomes and, when completed, will publish a report.

Living Life Well - Mental Health and Addiction Change Programme

Overview

11. The Mental Health and Addiction Change Programme has been formally established to redesign and implement a pro-equity whole of population system of care to support the mental health and wellbeing of the people across the subregion. The four projects to be delivered by the MHA Change Programme are:

- Acute Mental Health Inpatient Unit
- Child and Adolescent Mental Health Development (currently in the discovery phase)
- Kaupapa Māori Mental Health and Addiction Development (an update is provided below on the Kaupapa Māori forensic step-down component of this project)
- Community Mental Health and Addiction Change Programme.

12. A Programme Leadership Group has been established and the programme overview, including a programme schedule, is in development identifying the phases of each project, and providing opportunities for quick wins (where appropriate). The project delivery plans will include timelines, scope, cost and risk as well as programme-wide outcomes.

13. The programme overview will be informed and supported by a number of strategic work streams. The communications and engagement strategy recognises the programme's need for comprehensive, structured, consistent, and regular stakeholder engagement and communications through appropriate and timely channels including Māori engagement (aligned to our 2DHBs pro-equity approach) and Pacific and lived experience engagement.

Acute Mental Health Inpatient Unit – Te Whare Ahuru

14. A review of the existing Te Whare Ahuru inpatient service identified that the current facility presents an unacceptable safety risk, has limited options for use of space, has restrictive practices and seclusion, hinders recovery and does not support bicultural approaches to service delivery.

15. MHAIDS will work alongside key stakeholders in the redesign, service configuration and commissioning of a new 34-bed inpatient unit that will ensure consumer and staff safety and create a more flexible and therapeutic space that will support improved health and wellbeing outcomes.

16. The Health Infrastructure Unit in the Ministry of Health is leading the construction project in partnership with MHAIDS and the 2DHBs' facilities team. The model of care work and detailed design of the new unit will commence in 2022.

Kaupapa Māori Mental Health and Addiction Development - Forensic Step-Down Service update

17. In 2020, the MOH contracted with Capital & Coast DHB to initiate the procurement of a Kaupapa Māori Forensic Step Down facility, to provide rehabilitation support for Māori in forensic inpatient units to transition to lower levels of care. In 2020, secure inpatient units across the subregion served 106 people, 62 (59%) individuals are Māori.

18. By early 2021, a provider was contracted to provide this service and a small working party established to progress the service. A dedicated project manager is assisting the provider to help manage the significant barriers to finding and securing a suitable property.

19. As of November 2021, the provider has been unable to secure a suitable property. As an interim solution, the provider's current Kāinga Ora premises will be repurposed from its present three, two-bed configuration into a single six-bed facility. Kāinga Ora will complete the refurbishment in February 2022. The Regional Forensic Service has advised that tangata motuhake will be ready to transition to the repurposed premises in March 2022.

20. Kāinga Ora cannot commit to building a new facility within a 2-4 year period. With that in mind, the provider will, subject to market availability, accumulate the unbudgeted funding towards the purchase of a suitable property. The provider is exploring access to land with local Iwi on which to build a purpose built facility.

Community Mental Health and Addiction Change Programme

21. The Community Mental Health and Addiction Change Programme has two work streams:

- Te Haika Acute Response Redesign
- Integrated locality-based Community Mental Health and Addiction Services.

Te Haika Acute Response Redesign

22. Te Haika is the 24/7 mental health and addiction telephone contact centre for mental health services for the 3DHBs. This service is under significant pressure and requires a number of short and medium term actions to address clinical and operational risk. Synergia has been contracted to provide a two-month focused sprint to enable this service change, working closely with key

stakeholders to support the longer term transformation project required to reshape community mental health and addiction services.

23. There are a number of other work streams associated with the redesign and the model developed will be piloted in the first quarter of 2022.

Locality-based Service Delivery Models

24. Strategy, Planning and Performance (SPP) is leading the development of locality-specific and data-driven mental health and addiction service design (Locality Service Design). The development of locality-based service delivery models contributes explicitly to the strategic priority of developing Community Mental Health Networks.

25. The purpose of the Locality Service Design process is to enable people who live in specific localities to utilise locality-specific data analytics, and their own insights, to design mental health and addiction services that truly meet their needs.

26. The Locality Service Design process works with our partners, communities, locality community leadership, and provider networks in specific localities, utilising a set of structured tools, approaches and methods to design, test, implement and improve the mental health and addiction system beginning with our highest needs communities.

27. Governance of the Locality Service Design process is provided through the Mental Health and Addiction Commissioning Forum and a separate Iwi governance group established to work alongside the Commissioning Forum.

28. The Locality Service Design process must specifically must answer two questions posed by the Māori Concept Design working group:

    - How will this work improve Māori mental health and addiction outcomes?
    - How will this work support developing a Te Ao Māori investment profile to shift those outcomes positively?

29. Locality Design Groups (LDGs) are to be formed and meet from November 2021 through to early March 2022. Membership will be generated by drawing on existing collaborative forums and networks and identifying local community leaders. Forums will initially discuss the representation that should be considered for community leadership, lived experience, primary care kaupapa Māori, Pacific and NGO providers. The discussions involve our partners in Porirua (Ngāti Toa) and in the Hutt Valley Tākiri Mai te Ata (Kōkiri Marae).

30. The LDG will provide the 'engine' which will drive not only design and development, but will incorporate and operationalise the various inputs to this process. The LDG will consider and advise on how to include:

    - the Māori Concept Design working group direction about Māori models of care, linking with the local Runanga and Marae,
    - Pacific service delivery models
    - Supporting disabled people in that community.
    - incorporate advice and input from the Clinical Services Design working group ensuring that core and defined services are included.

31. This development will include pathways for access that can be different for each of these communities, and still integrate services, including clinical service providers to ensure a seamless delivery across a localised continuum of care.

32. It is expected that undertaking the Locality Service Design process will result in a locality-based pilot for community-design mental health and addiction services in early 2022.

Living Life Well - primary care initiatives

Access and Choice

33. The Access and Choice programme aims to provide accessible support in primary care settings for people experiencing mental distress, mild-moderate mental illness, and/or issues associated with the use of alcohol and other drugs. This support is delivered by a mixture of Health Improvement Practitioners, Health Coaches, and Community Support Workers. Collectively, Access and Choice staff provide time-limited supports such as brief intervention therapy, care planning, navigation of social services, and advocacy.

34. The rollout of the Access and Choice programme continues with a phased expansion. CCDHB received Ministry of Health funding to contract services with PHO and NGO providers in the demographic areas of CCDHB, Hutt Valley DHB, and Wairarapa DHB. Currently the investment in Access and Choice funds a total of 63.4 FTE across the 3DHB region (31.7 FTE Health Improvement Practitioners, 13 FTE Health Coaches, and 18.7 FTE Community Support Workers). This investment will continue increasing monthly, to fund a total of 82.4 FTE by June 2023 (41.2 FTE Health Improvement Practitioners, 13.8 FTE Health Coaches, and 27.4 FTE Community Support Workers).

35. Over the past 12 months, Access and Choice has provided over 19,000 sessions to more than 7,000 individual clients in a primary care setting, across the 3DHB region. Of these service users, 20.5% are Māori and 9.3% are Pacific people. The proportionately high uptake by Māori and Pacific people reflects the focus on improving equity of access and outcomes. The service design included the prioritisation of localities with high Māori and Pacific populations and working in partnership with kaupapa Māori health providers.

Primary Care Liaison Service

36. The Primary Care Liaison Service (PCLS) aims to address a service gap for people with moderate to severe mental health issues who mostly present in primary care settings. The service aims to create an effective and productive relationship between secondary services and primary care to better meet the needs of the moderate to severe group, including enabling early intervention when service users experience deteriorating mental health. To support the provision of care for people with moderate to severe mental health issues in primary care settings, PCLS entails:

    - Supporting primary care to grow the competence, expertise, and behaviour changes necessary to manage people with moderate to severe mental health needs.
    - Increasing capacity and capability to enable shared care and transition management plans for people whose mental health is more stable.
    - Offering incentives such as subsidised joint appointments that provide a “warm handover” from specialist services to primary care.

37. PCLS continues to grow and strengthen across both CCDHB and HVDHB through investment in this service:

    - MHAIDS has allocated a full-time consultant psychiatrist role to the Wellington PCLS. This is in addition to the two existing specialist nursing roles in that service.
    - SPP has proposed and funded two nurse practitioner roles in HVDHB, to match the existing two FTE CCDHB roles. These nurses will work with the consultant psychiatrist to grow the capability and capacity necessary for an integrated PCLS across the 2DHB region. MHAIDS has recruited to these roles with one possible nurse practitioner and another on the nurse practitioner pathway.
    - Wairarapa DHB is keen to explore opportunities to grow this service utilising nursing career pathways. A nurse practitioner role has been advertised within the MHAIDS provided Adult

Community MHS, and WDHB has funded a nurse practitioner development pathway for a nurse specialist within addiction services provided by an NGO (Pathways). This, working alongside an addiction specialist SMO now funded full time, is expected to provide a higher degree of Primary Care Liaison, shared care pathways and development community case management.

- SPP are currently reviewing the PCLS contracts with PHO providers to make improvements to the clarity of service specifications.

Living Life Well – addiction service initiatives

AOD Model of Care Implementation Plan

38. In April, the Board endorsed the subregion's Alcohol and Other Drug (AOD) Model of Care which outlines an implementation plan for the Model of Care. The Model of Care was supported by new investment from the Ministry of Health of $3m over three years. The Model of Care is strategically aligned to, and is a key enabler for *Kia Manawanui*.

39. In April, the AOD Model of Care steering group was disestablished and the AOD Collaborative formed. The Co-Chair roles are currently vacant (due to attrition) and the AOD Collaborative anticipates appointing to these positions before the end of this year. Terms of Reference and a project plan are in place.

40. The procurement process for the Enhanced Primary and Community AOD Kaupapa Māori and Pacific Counselling FTE is now complete, with contracts awarded to the providers below. As the two Hutt Valley providers have not previously received mental health and addiction funding, including for AOD counselling, this investment also contributes to the growth of culturally-specific primary care AOD providers in the Hutt Valley.

Provider	FTE	Service delivery area
Pacific Health	1	Hutt Valley
Taeaomanino Trust	1	Porirua/Kāpiti Coast
Takiri Mai te Ata (Kokiri Marae)	2	Hutt Valley
Kaupapa Māori Collaborative (Leads - Te Paepae Arihi and Te Waka Whaiora)	3	Wellington/Porirua/Kāpiti Coast

41. To support the growth of the innovative AOD peer support network, a one-year contract has also been awarded to Kites Trust (a peer support provider), for the provision of an AOD Peer Support Coordinator role (1FTE). This will help grow the Primary and Community AOD Kaupapa Māori and Pacific peer support workforce across the 2DHB region.

42. A new project manager has been in place since early October. Work has been undertaken with the current AOD Collaborative co-chair and key stakeholders to define deliverables and milestones for the five Model of Care Priority Pathways: Māori, Pacific, Youth, Severe, and Rural. At the request of the AOD Collaborative, the project manager is undertaking a service mapping exercise.

Living Life Well - secondary specialist service initiatives

Acute Care Continuum services

43. The Acute Care Continuum services provide care to about 1200 people across the 3DHB area. The Acute Care Continuum model of care defines core services which require investment and development to create an improved and more coordinated acute care system response. Key components of the model of care are now "business as usual" activity.

44. Both of the 2DHB acute inpatient units, Te Whare Ahuru and Te Whare O Maitairangi, frequently operate at 110% inpatient bed occupancy. The Acute Care Continuum programme of work aims to reduce pressures on these inpatient units by providing alternatives to inpatient care. Acute Care Continuum services also aim to improve access to care for people in crisis by developing services that are better aligned to support recovery.

Crisis Respite

45. In the past year, Crisis Respite across the subregion served 875 people, including 178 Māori (20%) and 59 Pacific people (7%). Young people aged 10-24 years, 33% of whom are Māori, make up 15% of people using Crisis Respite services. One NGO provider has purchased a facility to convert to an improved six bed crisis respite facility and a second NGO provider has recently purchased a second crisis respite facility which will also deliver 6 crisis respite services. Crisis Respite services function as an alternative to inpatient care and also provide a supported discharge pathway. Any additional crisis respite developments to respond to locality-based pressures are subject to investment bids.

Acute Alternative service

46. Our 2DHBs have funded Pathways (NGO provider) to transition their Lower Hutt day activity service into a new mobile Acute Alternative model of care. This project emerged in the context of low utilisation of the day service, high demand on the inpatient unit, and a lack of sufficient alternatives to inpatient care, including care at home, for those experiencing acute mental illness. The new Acute Alternative service will provide seven days per week mobile and after hours support services from an early start to the day until 10 pm and will begin operations in mid-November 2021.

Mobile after-hours support

47. All three large NGO providers (Emerge, PACT, and Pathways) are collaborating to provide an improved home support service partnering with specialist clinical services. Seven days per week mobile after-hours services currently serve 262 people across the 3DHBs, including 71 Māori (27%) and 17 Pacific (7%). Māori and Pacific people from Lower Hutt and Masterton have the highest utilisation rates of the service.

48. The HVDHB population served by the mobile after-hours service is 137 and 37 (27%) are Māori. In HVDHB, NGO providers have developed common pathways and agreements that enable the service to operate seven days per week (until 10 pm) and provide follow up to reduce the need for hospitalisation in Te Whare Ahuru. The service is a significant enhancement of prior mobile support services and the number of clients is expected to continue growing. Wairarapa DHB is supporting this service through its respite review.

Older Persons Crisis Respite

49. In 2020, Crisis Respite services across the subregion served 16 people over the age of 65, only one of whom was Māori. Current Crisis Respite providers are not equipped to handle the complex needs of older people and referrals are regularly declined. The HVDHB older people's mental health (OPMH) service has identified additional clients under their care who would benefit from access to an age-appropriate respite bed. Older people needing acute care were admitted to an acute inpatient setting that was not age appropriate and did not meet their needs.

50. A provider has agreed to develop a prototype crisis respite model of care for older people who are experiencing a deterioration in their mental health, with the aim of preventing any further decline. This is a new service and it is anticipated that service numbers will grow over time. Access to these crisis respite beds is intended to enable earlier discharge for those needing lower intensity support before returning home.

51. The Hutt Valley OPMH team and a Hutt Valley rest home provider have worked collaboratively to develop a robust operating framework. This will ensure that appropriate OPMH service users are referred to the respite bed and that rest home staff are well supported by the OPMH team during the service user's respite period. To date, a small number of service users have used the respite service with excellent outcomes reported. The recent Level 4 & 3 lockdown impacted on OPMH access to the respite bed. An evaluation of this new initiative is scheduled to occur in the first half of 2022, with a view to expanding it to the Wellington region if evaluation findings are favourable.

Mental Health and Addiction Crisis Support (MHACS)

52. The MHACS project, which is integrated within the Acute Care Continuum services programme of work, aims to develop clinical pathways that support the delivery of responsive, compassionate, and safe crisis care for people in crisis and their whānau, particularly focusing on improving experience in Emergency Departments. This project also links closely with the Suicide Prevention and Postvention Programme (see discussion towards the end of this paper).

53. The proposed MHACS enhanced pathway has been endorsed by the MHACS subgroup and MHAIDS. Executive Leadership Team's endorsement is currently being sought. Subgroup members include a broad cross section of both internal and external stakeholders, including lived experience. Some of the key components of the enhanced pathway include:

    - Integration of existing MHAIDS resources to create a dedicated MHA multi-disciplinary team in both Hutt Valley and Wellington Emergency Departments (ED).
    - Establishment of a cross-cultural peer support workforce in both EDs (these roles will be considered an integral component of a MHA multi-disciplinary team).
    - Creation of dedicated space in Hutt Valley and Wellington EDs for the triage and assessment of people presenting with MHA issues and/or in acute distress.
    - Expansion of community-based services (e.g., mobile after hours support services) and strengthening links between these services and the emergency department to reduce the need for people to present to ED.
    - Improved ED discharge planning processes with key NGO and clinical service partners.
    - Increasing the capability of ED staff, in order to support improved quality of care for people in crisis who present at ED. This is to be achieved through ongoing training of ED staff to increase their knowledge and confidence when working with people in crisis.

54. The project has narrowed its focus to improving the quality of treatment and support at Hutt Valley and Wellington EDs in line with the Ministry of Health investment. With additional resource, components of the enhanced pathway could be expanded into the community (for example, additional training and education to increase staff knowledge and confidence within community-based services).

Mental Health and Addiction Service for the Deaf

55. The MHA and Disability Teams in Strategy Planning and Performance are considering two options for funding MHA services for deaf people. The options include funding for a clinical mental health service (mental health nurses, clinical psychologist, psychiatrist, sign-language interpreters); the establishment of a network of support provided by peer support workers; and packages of care. A project manager would be needed to establish and grow the service over a three year timeframe. The service has the potential to be a prototype for regional services. A proposal is being developed to fund these services as a pilot project.

Living Life Well - subregion and central region initiatives

Wairarapa DHB

Mental Health and Addiction Crisis Support (MHACS)

56. The funding for the MHACS role in Wairarapa has been contracted to MHAIDS and as such, the development will be included within the 3DHB project group. However, an adjusted model of delivery is needed considering existing local acute service resources. This role has been recruited to and will be inducted and active for the beginning of 2022.

Needs assessment and service provision for older people with complex mental health and addiction needs

57. A review of locally provided NASC function has been initiated. Considering the Wairarapa has the highest per capita population of those over 65 of any region nationally, the current allocation of resources are not considered to be sufficient for an increasing number of those identified as needing specialist services.

Crisis Respite Review

58. The location of the current crisis respite facility has long been a source of concern regarding both the building being fit for purpose, and the model of care not having had investment or development for over a decade. A review has been initiated with the support of MHAIDS and local providers and consumer group as stakeholders.

Social Detox (residential) review

59. The value of having a local social detox facility to act as a step up to community based detox programmes and preparation for residential rehabilitation, as well as a step down option to support successful return to the community, is clear from a review of subjective feedback and objectively assessed outcomes. However, utilisation in the Wairarapa is low, and so a review of this service as a parallel process to the Crisis Respite review is under proposal. This will be with the current provider, Pathways NGO.

60. The intention for this review will be to consider a combined model for both crisis respite and social detox that makes most value and opportunities for investment into the wider MH&A services, as well as to consider development of a mobile acute facet to the model of service delivery.

Local Consumer Group

61. The Wairarapa MH&A services benefit from the MHAIDS consumer group. However, further development of a local group is needed to ensure effective contribution to the growing level of review and development occurring across the locality. This work has been initiated and appropriate volunteers identified, but a formal set of expectations and responsibilities needs to be developed.

Regional Mental Health and Addiction Services

62. The Central Region includes Capital Coast (central Wellington), Hutt Valley, Wairarapa, Whanganui, MidCentral (Palmerston North) and Hawkes Bay DHBs. A programme of work to establish a regional system of care for specialist MHA services is underway. The phased work programme aims to support greater equity (particularly for Māori) of access and to improve outcomes across the Central Region.

63. A regional steering group has been established building on the review of regional specialist services completed by Francis Health in June 2021. In August 2021, the regional steering group

agreed priority areas for the regional programme of work. September and October meetings have resulted in a shortlist of nine areas and four key deliverables. Central TAS (Technical Advisory Service) supports this work programme and recruitment is underway for a project manager. The four areas of focus are:

- Recruit a regional project manager role to support the mental health work programme.
- Establish a regional service level forum to improve regional specialist service relationships.
- Improve activity and quality reporting for the Regional Specialist services.
- Establish a multi-disciplinary team approach to integration (pilot) across the region in the Rangatahi Service.

Suicide Prevention and Postvention Action Plan

64. The *Action Plan* is a living document and the Suicide Prevention & Postvention (SP&P) team has continued to review and refine it, to ensure it is well aligned to the work of the Suicide Prevention Office, and that it reflects the most recent national and regional data. The updated and improved *Action Plan* is attached as an Appendix to this paper. Key improvements are:

    - Programme delivery prioritisation for the next 12 months.
    - The inclusion of our 2DHBs' Equity Definition, Goal, and Principles and introduction of the Te Whare Tapa Whā model of care into the Action Plan together with a description of how these inform *the Action Plan*.
    - A more in-depth description of what it means to take a locality-based, trauma-informed, and community-led approach to suicide prevention and postvention.
    - More information about our priority populations and how the SP&P team can best work alongside these groups to support their needs.

65. The SP&P team is now fully staffed, with 4 coordinators across the 2DHBs (including a coordinator, Māori) and one coordinator in the Wairarapa. Other SP&P team activities include:

    - Attending regular national suicide prevention meetings (co-led by CCDHB and the Suicide Prevention Office).
    - Attending hui with the Lower North Island SP&P co-ordinators, to ensure shared learning and best-practice.
    - Emphasising well-being promotion and suicide prevention for priority groups, including young Māori men, older men and female rangatahi (for self-harm). Two new members of the SP&P Governance Group represent youth and provide valuable insights that guide the *Action Plan* programme delivery.
    - Supporting the 2DHB roll-out of Aoake te Rā (a new bereavement service for individuals and whānau who have lost someone to suicide).
    - Developing and implementing a 2DHB postvention process in collaboration with MHAIDS, Victim Support, the Ministry of Education, and Clinical Advisory Services, Aotearoa.
    - Continuing to network and build relationships with key partners such as iwi, hapu, and groups that serve the Pacific Island community.
    - Developing and delivering a suicide prevention training package to various partners, including regional public health nurses, a sports club, and a high school.
    - Working with the MHACS project to plan a suicide prevention training for Wellington ED.
    - Exploring the development of internal DHB postvention guidelines.

COVID-19 Coordination

66. During the COVID-19 lockdown, Strategy Planning and Performance's (SPP) MHA team facilitated a twice-weekly online forum for all MHA NGO providers and MHAIDS. The online forum, that included representation from the Lived Experience Advisory Group, was a vehicle for ensuring that all MHA services were supported and could continue to operate under levels four and three. This support included:

    - Ensuring that providers had access to PPE gear.
    - Partnering with local PHOs to enable providers to get quick access to COVID-19 testing, including mobile testing.
    - Supporting providers to get priority access to vaccinations for both staff and tāngata whaiora.
    - Sharing the latest Ministry of Health updates and other relevant sector information.
    - Sharing service delivery innovations, such as online approaches to service delivery and creative ways of engaging with tāngata whaiora during lockdown.
    - Ensuring that additional wellbeing needs were met, such as access to food, technology etc.
    - Updating protocols for emergency housing and respite services during lockdown.
    - Ensuring integrated transitions between MHAIDS and NGO services.
    - Developing specifications for a 'redzone' respite house, for those with both acute mental health needs and a possible or confirmed COVID status.
    - Partnering with public health and infection protection control to ensure that all guidance and processes remained current with best practice.

67. After the second week at level 2, the forum changed from video conference to an email update forum, with a protocol in place to immediately return to video conferencing should the lockdown levels increase.

68. Feedback from both MHAIDS and NGO providers was that this forum was highly useful, meaningful, and enjoyable. Collaboration and support were freely given from all involved and actions and information were gathered and implemented swiftly.

69. In the last month, SPP's MHA team have been working with closely with the 2DHB COVID-19 response team, to identify what MHAIDS and NGO providers need to support their staff and tāngata whaiora to get vaccinated. Plans for information packs for those who have concerns about vaccination are underway and offers of on-site vaccinations have been extended to providers.

He Ara Oranga
Wellbeing Outcomes Framework

Our vision:

"Tū tangata mauri ora, flourishing together."

This will be achieved when tāngata | people, whānau | families, and hapori | communities in Aotearoa experience...

Mental Health and Wellbeing Commission

Wellbeing from a te ao Māori perspective

Tino rangatiratanga me te mana motuhake

Legal, human, cultural, and other rights of whānau are protected, privileged, and actioned.

Rights are in line with Te Tiriti o Waitangi and te ao Māori, which includes application of tikanga tuku iho.

Māori exercise authority and make decisions about how to flourish. Tino rangatiratanga is expressed in many self-determined ways.

Upholding whānau[1] rights is recognised as beneficial to Aotearoa.

Whakaora, whakatipu kia manawaroa

Whānau are culturally strong and proud – whānau flourish through the practical expression of ritenga Māori, tikanga Māori, and mātauranga Māori.

Māori express connection through awhi mai, awhi atu and the use of te reo me ōna tikanga every day – starting from infancy.

The beauty of Māori culture is celebrated and shared by all people in Aotearoa and globally.

Whakapuāwaitanga me te pae ora

Thriving whānau and equitable wellbeing are the norm.

Whānau have the resources needed to thrive across the course of their lives – especially mokopuna, who are unique taonga.

Whānau needs are met, and unfair and unjust differences are eliminated.

Whānau live in a state of wai ora, mauri ora, and whānau ora, which enables pae ora.

Whanaungatanga me te arohatanga

Whānau flourish in environments of arohatanga and manaaki.

Kaupapa and whakapapa whānau collectively flourish intergenerationally.

The active expression of strengths-based whakawhanaungatanga supports positive attachment and belonging.

Kotahitanga is realised.

Wairuatanga me te manawaroa

The mauri and wairua of whānau are ever-increasing, intergenerationally.

While whānau are already resilient, whānau skills, capabilities, and strengths continue to grow.

Taonga Māori are revitalised and nurtured – the unique relationship and spiritual connection Māori have to te taiao, whenua, whakapapa, and whānau is actively protected, enhanced, and strengthened.

Tūmanako me te ngākaupai

Whānau are hopeful.

Whānau feel positive about self-defined future goals and aspirations.

Whānau have the resources and capacity needed to determine and action preferred futures.

Wellbeing from a shared perspective

The 'shared perspective of wellbeing' and 'te ao Māori perspective of wellbeing' should not be read as direct translations. They represent related concepts of wellbeing from different worldviews. The 'shared perspective of wellbeing' may also apply to Māori.

Being safe and nurtured

People have nurturing relationships that are bound by kindness, respect, and aroha (love and compassion).

People of all ages have a sense of belonging in families and / or social groups. Where people experience disconnection, reconnecting or forming new positive connections is possible.

People feel safe, secure, and are free from harm and trauma.

People live in, learn in, work in, and visit safe and inclusive places.

Having what is needed

People, families, and communities have the resources needed to flourish.

This includes (among other things) enough money, financial security, access to healthy food, healthy and stable homes, safe physical activity, lifelong learning, creative outlets and time for leisure, including play for children.

People have the support and resources needed to maintain their health across their life course, and experience equity of health.

All people live in communities and environments that enable health and wellbeing.

Having one's rights and dignity fully realised

All people have their rights fully realised and are treated with dignity.

People can fully participate in their communities and broader society, and live free from all forms of racism, stigma, and discrimination.

Rights framed by Te Tiriti o Waitangi, other New Zealand law, and international commitments are fully met.

The negative impacts of colonisation and historic breaches of rights are recognised and addressed.

Healing, growth, and being resilient

People and families experience emotional wellbeing.

This includes having the skills, resources, and support needed to navigate life transitions, challenges, and distress in ways that sustain wellbeing and resilience.

People and families can experience and manage a range of emotions – celebrating each other's strengths and practising empathy and compassion – personal and collective.

Where adversity or trauma occurs, people experience support and belief in their capacity to heal and grow.

Being connected and valued

All people are valued for who they are and are free to express their unique identities.

People are connected to communities in ways that feel purposeful and respectful. People are meaningfully connected to their culture, language, beliefs, religion and / or spirituality, and can express important cultural values and norms.

People experience connection to the natural world and exercise guardianship of the environment.

Having hope and purpose

People, families, and communities have a sense of purpose and are hopeful about the future.

There is respect for people's voices, perspectives, and opinions.

People make self-determined decisions about the future and have the resources needed to pursue goals, dreams, and aspirations.

Communities of belonging make their own choices, have resources, and are trusted to develop solutions for themselves.

1 'Whānau' is used here to include people, families, hapū, iwi, and communities.

THE 3DHB SUICIDE PREVENTION AND POSTVENTION ACTIVITIES

This document is part of the 3DHB Suicide Prevention and Postvention Action Plan (the *Action Plan*), July 2021 and beyond.

The *Action Plan* sets the 3DHB's direction for Suicide Prevention and Postvention and guides the equitable, community-led, trauma-informed and collaborative approach needed to reduce suicides and increase well-being in the 3DHB locality (Capital and Coast, Hutt Valley and Wairarapa DHBs).

The *Action Plan* details four priority areas for suicide prevention (promoting well-being, suicide prevention, intervention and postvention).

Detailed activities and timeframes, together with the rationale, outcomes and measures are set-out in this document, the *3DHB Suicide Prevention and Postvention Activities*. This is a living document that can evolve in collaboration with partners and communities to ensure it meets existing and emerging. It is updated regularly to ensure activities are meeting the needs of our DHB communities.

1. Well-being Promotion

	Action	Rationale	Outcome	Measures	Current Status (updated 09.11 2021)
1.1	Identify, support and engage with promotion activities and programmes related to reducing the risk of suicide.	Health and well-being are protective factors against suicide.	Suicide Prevention and Postvention Team (SPP) working with agencies to reduce suicide.	4 promotional activities are held per annum with agencies such as Regional Public Health, Ministry of Education, Health & Safety managers, Human resources managers, and Community Centres Councils.	**In Progress:** Supported International Suicide Prevention day (in-person promotion day postponed to 2022 due to COVID). Taking part in the 16 Days of Action against Gender-based Violence Nov/Dec 2021.
1.2	Provide increased wellbeing support for children and young people in places of learning (schools and tertiary settings) through engagement with organisations	The rate of suspected suicides in youth (11-24-year-olds) is	Programmes are available in schools and places of learning.	A needs analysis is completed to understand what programmes are in place in 3DHB schools and tertiary settings.	**In Progress:** Contacted Ministry of Education (MoE) and arranged a meeting end October 2021 to establish what

	like Youthquake/Ora Toa Community Health Centre, as well as Ministry of Education.	consistently high across the 3DHBs.[1]			increased support can be provided to schools Meeting held with Hutt Valley High School counsellor team and head of Wellington Counsellor Network Suicide Prevention Tertiary group been extended to include alternative providers representation Tertiary student representation now on Suicide Prevention Postvention Governance Group
		Over the 2020 calendar year, 3DHB emergency departments saw an increase in youth presenting for self-harm. Presentations for self-harm are highest during term time.	Tertiary education providers are supported to develop plans that promote resilience and support for staff and students.	2 new initiatives implemented per annum.	
1.3	Work with first responders and intersectoral agencies e.g. Police, Construction, Forestry, and others to support wellness promotion/suicide prevention programmes.	First responders and low pay/high stress workforces can witness and experience high levels of distress.	A developed workforce that promotes community resilience.	Engagement with programmes evidenced by a trial of at least 1 programme.	
1.4	Work with and seek Māori leadership to support the development of well-being initiatives for Māori delivered by Māori (particularly tamariki and rangatahi Māori).	Māori suicide rates per head are higher than any other group and require an approach that restores equity and mana.	Programmes for Māori are designed and delivered by Māori.	2 promotional initiatives run per annum.	**In progress:** Men's Wellbeing Group Pou-Toko-Ora was held in 2021, using Kaupapa Māori wellbeing frameworks, haka, waiata, Te Hā breathing techniques. This group had its last wananga in August.

[1] 3DHB Suicide Prevention and Postvention Database 2014-2020

1.5	Support Tepou's MH101 programme delivery within the 3DHB community.	Tepou (are mandated to) provide MH101 – a training programme that equips people to respond to people experiencing mental health challenges.	Well-being, mental health programmes are made more accessible to the 3DHB community.	MH101 provided to groups/sites.	**Planned:** Planned start - January 2022
1.6	Support the delivery of well-being programmes by community-based organisations and NGOs. This will be done by identifying existing resources/ developing new resources (through a co-design process).	At-risk and minority groups require specific well-being solutions that appropriate for their needs.	Well-being programmes are facilitated/made available to community-based organisations.	Evidence of engagement and development of improved systems to access resources (where possible).	**Not started:** Planned start - Feb 2022.
1.7	Identify and support the development of community-based well-being activities and supports for men.	73% of people who died due by suspected suicide in the 2DHBs are male, and males are overrepresented across all age groups[1].	Improved well-being supports for Men in the 3DHB.	Men's initiatives set up in localities. Establish a Kāpiti Men's Group. 4 training sessions for groups working with men at risk held per annum.	**In progress:** Supporting a proposal for 2 FTE (Suicide prevention Community Support Workers) for Kāpiti Coast and Otaki.
1.8	Link in and support services that are work with new mothers and women with young children, such as Midwives and Maternal Mental Health services, and organisations like Perinatal, Anxiety and Depression Aotearoa).	New mothers and women with young children are priority for the 3DHB**Error! Bookmark not defined.**.	Increased support to new mothers and women with young children.	Evidence of established links with maternal mental health and midwives.	**Started:** Initial scoping of services and groups to link in with has commenced.
1.9	Work with agencies and groups who support older people.	The rate of suspected suicides in the 80-84 age range increased	Develop linkages with key partners, e.g. Age Concern,	Development of postvention and prevention guidelines for age care homes and	**Not started:** Planned start - Feb 2022.

		nationally in 2019/2020 and 75+ age group for 3DHB[2].	Alzheimer's NZ, Grey Power, Kaumātua/Runanga and Iwi.	groups/organisations that support older people such as Grey Power, Mycare NZ and Age Concern NZ.	

2. Prevention					
	Action	Rationale	Outcome	Measure	Current Status (updated 09.11 2021)
2.1	Develop a comprehensive database for the collection and reporting of suspected suicides within 3DHB.	An up-to-date and regional specific local data provides insight into suicide patterns in the sub-region that can be used to improve responses.	A quality and confidential database. Those working in services and agencies can be informed in a timely way of changes in prevalence and respond appropriately.	Secure 3DHB secure database developed and maintained. Evidence of insights being used to inform activities within *Action Plan* activities.	**In progress:** Database has been developed and is updated regularly
2.2	Develop quality and effective suicide prevention training that is context-specific and tailored to different communities	The training currently offered in the 3DHB is generic and focuses on gatekeepers. There is an opportunity to develop and facilitate more easily accessible and consumer-specific training.	Training is delivered where there is an identified need.	Training is delivered where a need is determined. Evaluation of training to understand if the training meets the objectives to increase knowledge, confidence and competence to prevent suicide.	**In progress:** Training package has been developed and has been delivered to various groups including Regional Public Health Nurses, workplaces, sports clubs and schools (to name a few).

[2] Ministry of Justice, (2020)

					Evaluation forms have been developed with a 6 month follow up planned.
2.3	Support the delivery and development of suicide prevention guidelines for groups and organisations that work with groups at higher risk e.g. Construction companies.	Having internal capability is a core aspect of early intervention and prevention.	Workplaces have an increased ability to recognise and support people experiencing suicidal distress including connecting people to community support services.	Guidelines developed.	**Started:** Initial discussions have commenced with CCDHB HR department to enquire about internal guidelines. This will form a template for future work with other groups/organisations.
2.4	Partner with Māori to support current investment in Māori DHB, NGO and community suicide prevention services and to develop and implement new kaupapa Māori suicide prevention and postvention supports (including resources/information).	For effective Māori prevention and postvention, it is vital to include Māori leaders, tāngata whaiora, iwi/hapu and whanau.	Māori whānau and Māori Iwi are connected well to community support services that are involved in suicide prevention and postvention. Improved health pathways for Māori.	Māori kaupapa suicide prevention and postvention supports are developed. Engagement from Māori whānau with Māori Iwi community support entities.	**Started:** Initial hui's held with Ngāti Toa and Raukawa ki te tonga. Purpose is to form an advisory group that represents regional Iwi/Hapū/whānau cultural practices.
2.5	Work with Pacific people to support current investment in Pacific DHB, NGO and community suicide prevention services and to develop and implement new suicide prevention and postvention resources.	For effective suicide prevention and postvention for the Pacific community, it is vital to include Pacific people in the development and delivery of these initiatives.	Suicide prevention and postvention supports are developed for Pacific people.	To adequately and culturally appropriately address the needs of the many pacific communities, a Pacific Suicide Prevention and Postvention Co-ordinator (SPPC) would need to be appointed. This person would work closely with the Director of Pacific health and the Pacific health team and have an extensive Pacific community network.	**Started:** Meeting held with Porirua Pacific Services Network (PPSN) Presentation given to members of PPSN. Content was role of SPPC, historical and current suicide rate for Pacifica and, support available within the community of Porirua.

2.6	Support activities that responds to the needs of young people experiencing suicidal distress within their learning environment.	Over the 2020 calendar year, 3DHB emergency departments saw an increase in youth presenting for self-harm. Presentations for self-harm are highest during term time.	Education providers are supported to develop plans for managing suicidal distress.	Developed guidelines.	**Started:** Links made between MoE, NZQA and SPO to assist in Pastoral Code development. Meeting with MoE to determine how to increase support in schools.
2.7	Work with the Mental Health and Addiction Crisis Support Capability Project (MHACs) team to support the development of enhanced clinical pathways for Tangata whaiora and their whanau in ED services at Wellington Hospital.	A review of the acute/crisis response services provided by 3DHBs has identified several issues and gaps related to the quality of treatment and support. MHACs has been tasked by MoH to address these.	Improved clinical pathway and care for Tangata whaiora, including those who present for self-harm, suicidal ideation and suicide attempts.	Increased services specifically those for Pacific and Kaupapa Māori services. Increased Mental Health & Addictions (MH&As) acute/crisis service responsiveness. Increased Tangata whaiora and whanau satisfaction with acute/crisis service provision. Increased staff knowledge and capability (pre and post-training). Increased FTE – peer support and MH liaison nurses.	
2.8	Work with the Department of Corrections and Oranga Tamariki (including Rangatahi) to develop systems and programmes that ensure young people in care and people in correctional facilities have access to intervention and support when experiencing self-harm or suicidal distress.	Studies in Aotearoa have identified young people who receive welfare services as a population with an elevated risk of suicide compared with	Staff and young people have support around preventing suicide and responding to suicide.	Suicide prevention and postvention guidelines/policies developed.	**Not started:** Planned start - March 2022

		peers who do not receive such services.[3]			
2.9	Work with DHBs to support the implementation of a range of whānau and community-led responses for people experiencing suicidal distress.	Preventing and responding to suicide requires coordinated action across all levels of government, business, non-government organisations and the community to create resilient and well communities. For effective outcomes, whānau and communities need to lead prevention.	Communities are better supported.	A community-led response to suicidal distress and suicide within the 3DHB.	**Not started:** Planned start - March 2022
3.0	Link with and provide support to police, Alcohol and other drugs (AOD) services and family violence practitioners.	Substance use is a known risk factor for suicide[4]. Family violence is also a suicide risk factor[5].	Increased links with Police, AOD services and FV practitioners to provide improved care for their clients affected by suicide.	Initiatives developed in partnership (and for) Police, AOD providers, and family violence practitioners.	**Not started:** Planned start – February 2022
3.1	Work with people and service providers (e.g., DHB, peer support, NGOs, local council community support advisors) who support people from the rainbow community to provide guidance on the	The Rainbow community experience higher levels of distress and are higher risks of suicide[6].	DHB staff and other service providers know link between rainbow and risk and are equipped. Support Rainbow organisations to highlight the	Increased engagement with partner organisations.	**Not started:** Planned start – Nov 2021

[3]Smith DAR, Beautrais AL., (1999)

[4] Cobiac L, Wilson N., 2018

[5] Gulliver, P,. Fanslow, J., 2013

[6] Clunie, M. (2018)

	development of trauma informed and inclusive suicide prevention practices.		link and provide support for prevention and postvention.		

3. INTERVENTION					
	Action	Rationale	Outcome	Measure	Current Status (updated 09.11 2021)
3.1	Work across the 3DHB to develop and enhance early intervention primary and secondary health care guidelines for people experiencing suicidal distress and to support community-led programmes.	Recent 2DHB data suggests that many people who die by suicide had never received specialised mental health services[i].	Primary and secondary health sectors as well as community-led programmes are better supported to prevent suicide.	Guidelines developed for primary, secondary and community settings.	**In progress:** Held hui with Human Resources 2DHB to develop training packages for suicide prevention and managing grief as well as guidelines.
3.2	Investigate the opportunities for peer lead support post-discharge from a suicide attempt.	Emerging research shows peer support is effective for supporting recovery and offering hope[7].	People are provided increased support post-discharge to reduce re-presentation and risk.	Individual journeys post discharge mapped and opportunity for peer support investigated.	**In progress:** SPP Data & Analytics team have investigated the patient pathway for those who have taken their own lives. Continued work with Mental Health and Addiction Crisis Support Project to improve clinical pathways for people who experience distress.

[7] Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012).

3.3	Scope additional support for the assessment and response to suicidal behaviour within the rural population.	Suicide rates are higher in rural areas at 16 per 100,000 people compared to urban being 11.2[8].	Mental health promotion and education in rural communities and stronger bonds between such organisations and rural communities.	Links with mental health promotion in rural areas e.g. Rural Support	**Not started:** Planned start – January 2022
3.4	Work collaboratively with Māori to develop suicide intervention resources for DHBs, NGOs, iwi, hapū and whānau that recognise and support kaupapa Māori practices.	For improved and equitable health outcomes for Māori, the DHB needs to develop relationships with local Iwi health entities and Māori NGO's.	Improved relationships between DHB and local Māori. Culturally appropriate suicide prevention and postvention resources are developed. Improved culturally appropriate initiatives/resources.	Suicide prevention resources/supports in place.	**In progress:** See 2.4 above.
3.5	Work with Pacific peoples to develop suicide intervention resources for DHBs, NGOs, whānau and families and communities that recognise and support Pacific practices.	For improved and equitable health outcomes for Pacific people, the DHB needs to develop relationships with local Pacific communities and NGO's.	Improved relationships between DHB and local Pacific people. Culturally appropriate suicide prevention and postvention resources are developed. Improved culturally appropriate initiatives/resources.	This task will best be addressed by 3DHB Pacific SPPC who has strong networks within the Pacific community.	**Not started:** This task will best be addressed by 3DHB Pacific SPPC who has strong networks within the Pacific community.
3.6	Review the systems and range of current responses available for people who have been discharged from an emergency	People with lived experience have reported negative experiences with	Improved patient experience for people accessing	Increased number of people and whanau leaving with an	**In progress:** Continued work with Mental Health and Addiction Crisis

[8] Ministry of Health. (2011).

	department or inpatient services following a suicide attempt.	emergency and crisis response services. There are long wait times in emergency departments and high rates of re-presenting to emergency departments following self-harm.	emergency department services.	adequate safety plan and resources.	Support Project to improve clinical pathways for people who experience distress.
3.7	Provide effective and tailored training and support for frontline staff in Health, Police, education and those likely to provide initial support to acute suicidal distress	Building skills and capability in frontline workers and community will lead to a more informed and compassionate intervention for those in distress.	3DHB community service providers and community members are equipped with tools and resources to prevent suicide.	Training package developed that can be adapted for different environments and audiences.	**In progress:** Training has commenced with health staff.

4. Postvention					
	Action	Rationale	Outcome	Measures	Current Status (updated 09.11 2021)
4.1	Work with established groups within the 3DHB locality to ensure suicide postvention plans promote utilisation of interagency postvention networks to monitor and support local and community-led postvention activity.	Postvention is critical to prevent suicide.	Community-led postvention response for suspected suicides in the sub-region to ensure whānau/families, partners, friends, peers and wider communities are well supported when bereaved by suicide.	A postvention process is implemented and is evaluated.	**In progress:** Developed and implemented a 3DHB Postvention processes in collaboration with Mental Health Disability Intellectual Disability Service, Victim Support, Ministry of Education and CASA
4.2	Develop a 3DHB Māori postvention process.	Māori require a culturally safe postvention.	Whānau, friends and communities are well supported through a frontline Kaupapa Māori postvention response.	This will be measured as part of the evaluation stated above, however, the specific focus will be on Māori's feedback on the postvention process in respect of meeting the needs of Māori.	**In progress:** See 3.4 above.
4.3	Development a 3DHB Pacific postvention process.	Pacific people require a culturally safe postvention response.	Aiga, friends and communities are well supported through a frontline Pacific postvention response	This will be measured as part of the wider postvention evaluation stated above, however, specific focus will be on Pacific people's feedback on the postvention process in respect of meeting the needs of this population.	**Not started:** See 3.5 above

4.4	Develop and provide Tangihanga and Funeral Celebrant resources to people and services in the community.	Having access to information that can help them plan a funeral/tangi can provide support to bereaved families/whānau.	Marae and Funeral Celebrants have suicide specific information to inform them when providing services to those Bereaved by suicide Bereaved families/whānau have access to information that can help them plan a funeral/tangi and support the bereaved	Resources developed and available.	**Not started:** Planned start – Jan 2022
4.5	Bereavement options register is developed	Whānau may need access to support at different times following a death by suicide.	Information about the available options is regularly collated and made available.	Register is current	**Not started:** Planned start – Jan 2022
4.6	Supporting awareness of and increased access to local programmes and peer support groups for people bereaved by suicide.	Offering support for people bereaved by suicide is an important component of postvention activity.	Increased referrals to Aoake te Rā Waves programme and other peer-support programmes and increased support provided to bereaved.	Evidence of promotion and referrals.	**Started:** Supported the standing up of Aoke te Rā in the 2DHB.
4.7	Funding the development of a support programme and service for children and young people bereaved by suicide.	Children and young people are a high-risk population of the bereaved who are at greater risk of suicide later in life.	Bereaved children and young people have access to developmentally appropriate support provided by trained professionals and peer-support facilitators.	Increased number of bereaved children and young people reporting access to and benefit from postvention support programmes	**Not started:** Planned start – March 2022

[i] Suicide and Self-harm in the 2DHB, 2021