

DISABILITY SERVICES ADVISORY COMMITTEE

PUBLIC Agenda

4 February 2019, 10am to 12.30pm

Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital



	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS						
1.1	Karakia				10am	
1.2	Apologies	RECORD	F Wilde			
1.3	Continuous Disclosure - Register of Interest	ACCEPT	F Wilde			2
1.4	Confirmation of Draft Minutes from 3 December 2018	APPROVE	F Wilde			6
1.5	Matters Arising	NOTE	F Wilde			
1.6	Action List	NOTE	F Wilde			11
1.7	Terms of Reference	APPROVE	F Wilde			12
2 DECISION						
2.1	3DHB Mental Health & Addictions Strategy, Living Life Well 2019 – 2025 2.1.1 - 3DHB Mental Health & Addictions Strategy, Living Life Well 2019 – 2025		R Haggerty H Carbonatto J Cooper			14
3 INFORMATION						
3.1	Suicide Prevention/Postvention Update		R Mariner			98
3.2	Summary and update of activities post the Sub-Regional Disability Advisory Group (SRDAG) meeting on 25 January 2019 3.2.1 – SRDAG Terms of Reference		R Haggerty / B Francis			101
3.3	Resolution to Exclude the Public		F Wilde			113
DATE OF NEXT MEETING 6 MAY – BOARD ROOM, PILMUIR HOUSE HUTT VALLEY DISTRICT HEALTH BOARD						



3 DHB DISABILITY SUPPORT ADVISORY COMMITTEE

Conflicts & Declarations of Interest Register

UPDATED AS AT FEBRUARY 2019

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

Wairarapa, Hutt Valley and Capital & Coast District Health Boards

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

Name	Interest
	- Member, Wairarapa Te Iwi Kainga Committee - Kaiahi, Takiri Mai Te Ata, Kokiri Hauora - Member, Occupational Therapy Board of New Zealand (23 February 2016)
Mr Alan Shirley <i>Member</i>	- Member, Wairarapa District Health Board (includes HAC) - Member, Wairarapa, Hutt Valley and CCDHB CPHAC DSAC Committee - General surgeon at Wairarapa Hospital - Wairarapa Community Health Board Member - Wairarapa Community Health Trust Trustee (15 September 2016)
Kim Smith <i>Member</i>	- Employee of Te Puni Kokiri - Trustee for Te Hauora Runanga o Wairarapa - Brother is Chair for Te Hauora Runanga o Wairarapa - Chair, Te Oranga o Te Iwi Kainga - Sister, Member of Parliament
John Terris <i>Member</i>	- Member, Hutt Valley District Health Board - Member, Hutt Valley District Health Board Hospital Advisory Committee - Member, 3DHB combined Community and Public Health and Disability Support Advisory Committees
Sue Driver <i>Member</i>	- Community representative, Australian and NZ College of Anaesthetists - Board Member of Kaibosh - Daughter, Policy Advisor, College of Physicians - Former Chair, Robinson Seismic (Base isolators, Wgtn Hospital) - Advisor to various NGOs
'Ana Coffey <i>Member</i>	- Member of Capital & Coast District Health Board - Councillor, Porirua City Council - Director, Dunstan Lake District Limited - Trustee, Whitireia Foundation - Brother is Team Coach for Pathways and Real Youth Counties Manukau District Health Board - Father is Acting Director in the Office for Disability Issues, Ministry of Social Development
Bob Francis <i>Member</i>	None
Fa'amatuainu Tino Pereira <i>Member</i>	- Managing Director Niu Vision Group Ltd (NVG) - Chair 3DHB Sub-Regional Pacific Strategic Health Group (SPSHG) - Chair Pacific Business Trust - Chair Pacific Advisory Group (PAG) MSD - Chair Central Pacific Group (CPC) - Chair, Pasefika Healthy Home Trust - Establishment Chair Council of Pacific Collectives - Chair, Pacific Panel for Vulnerable Children - Member, 3DHB CPHAC/DSAC
Dr Tristram Ingham <i>Member</i>	- Senior Research Fellow, University of Otago Wellington - Member, Capital & Coast DHB Māori Partnership Board

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



DRAFT Minutes of the 3DHB DSAC
Held on Monday 3 December 2018 at 10am
CSSB Lecture Room, CSSB Building, Masterton Hospital
PUBLIC SECTION

PRESENT:

BOARD

Bob Francis (Chair)
Eileen Brown
Roger Blakeley
Sue Kedgeley, *via video conference*
Lisa Bridson
Derek Milne
Jane Hopkirk
Alan Shirley
Kim Smith
John Terris
Sue Driver
Dr Tristram Ingham
Dame Fran Wilde, *via video conference*

STAFF:

Ms Dale Oliff, Interim Chief Executive, Hutt Valley DHB (HVDHB) *via video conference*
Ms Helene Carbonatto, General Manager, Strategy Planning and Outcome, HVDHB
Mr Nigel Fairley, General Manager, MHAIDS (3DHBs) *via video conference*
Ms Rachel Haggerty, Director, Strategy Innovation and Performance, CCDHB
Mr Rod Bartling, Mental Health Improvement Manager HVDHB

GENERAL PUBLIC: No members of public in attendance

1 PROCEDURAL BUSINESS

1.1 PROCEDURAL

The Karakia was led by Tristram Ingham. Committee Chair, Bob Francis, welcomed the members and DHB staff.

It was noted that a quorum had not been reached.

1.2 APOLOGIES

Apologies received from Yvette Grace, Andrew Blair, Prue Lamason, Tino Pereira.

1.3 INTERESTS

1.3.1 REGISTER OF INTERESTS

No changes were registered.

1.4 CONFIRMATION OF PREVIOUS MINUTES: 10 SEPTEMBER 2018

The committee endorsed the record of the DSAC Committee meeting, held on 10 September without a quorum.

1.5 TERMS OF REFERENCE

The committee noted that the terms of reference had been updated with the changes to subcommittee membership.

It was agreed to bring back a resolution to the February meeting where representatives from the Māori Partnership Board and Pacific Advisory Board would be present.

Actions:

1. To bring a resolution on the terms of reference to the February meeting.

1.6 MATTERS ARISING

The action from the September meeting for SIP to write a one page report for Boards to clarify the new regional alcohol and other drugs service was not produced as a full report went to the Boards in October which clarified all the issues regarding that contract.

1.7 ACTION LIST

The reporting timeframes on the other open action items were **noted**.

2 FOR DECISION

2.1 MENTAL HEALTH STRATEGY

The paper was taken as **read**.

The Committee:

- a) **Noted** the strategy has been developed in conjunction with a range of stakeholders including mental health consumers, Māori, Pacific, non-governmental organisations, primary health care, specialist mental health and addictions providers and other DHB staff.
- b) **Noted** the strategy is cognisant of the 2018 Government Inquiry into mental health and addiction. It is expected that the Inquiry will provide valuable insight to further inform the 3DHBs' implementation of this strategy, as well as providing additional context to ensure successful application of its underlying principles and direction.
- c) **Noted** this Strategy will be reviewed against the report from the Inquiry. If there is any malalignment the Strategy will be reviewed and the Chief Executives will provide advice to the Board Chairs if the strategy needs to be revised.
- d) **Recommended** that after further amendments at the February 2019 meeting, the Board of each DHB adopt the 3DHB Mental Health & Addictions Strategy, Living Life Well 2019 – 2025, for release in early 2019 to support the Mental Health and Addiction Improvement Programme.
- e) **Noted** that we recognise that this is a living document that is the beginning of a process of change. The important of co-design and working with our consumer networks both in our communities and our service to engage our community.
- f) **Recommended** that we ensure the advisory committees have adequate opportunity to provide comment and feedback.
- g) **Endorsed** the adoption of our strategy and recommend it to our Boards, recognising that we will bring the strategy back to our February meeting following the outcomes of the Mental Health enquiry and any review is required and that the implementation

planning would be presented in May 2019. The final endorsement would happen in February 2019. Include resources in February update. And proof read before it comes back.

Discussion:

1. The Chair advised that the Minister of Health now has the recommendations from the Mental Health inquiry and the Government will announce the findings the week before Christmas. This will clearly have implications for the budgets in 2019/2020.
2. This was not an investment plan. It gives guidance as to where you might like to consider changes and differences. Financials will rest with each Board to make their own decisions on how they would like to progress towards giving effect to the strategy to each of their localities.
3. The workforce plan behind this strategy addresses the way we are training staff and encouraging new staff and the aging workforce which exists with NGO partners in the community. There are current strategies which support such things as specialist training programmes for psychologists and people currently in general roles moving to this specialist area e.g. nurses.
4. It was intended that the Māori Partnership Boards and the Iwi Partnership Boards at each of the DHBs be consulted on the development of this strategy. There is ongoing conversation at Wairarapa District Board to ensure that the strategy reflects the established values. There has overall been support for the direction of this strategy.
5. Some community groups may not feel that they own this if they have not been a recent part of the conversation.
6. Behind this needs to be an implementation plan, beyond the strategy. With outcome framework and a co-design. It also needs to shift the way in which we invest money. One of the challenges in this space is the support of community shift. A five year implementation plan, dependent on new resourcing. And a list of outcomes.
7. There are good directions issues in where we want to go in respect of change to service delivery but it did not have the specific about what this region is facing and what are the services in this region.
8. Clinical involvement in the critiquing the strategy has occurred through a 3DHB reference group and different clinical advisory groups. A primary health care group was also involved in getting to this point. Dr Alison Masters, Medical Director of MHAIDS, fully endorses this strategy.
9. This is a system change, a people approach to mental health, not about medicalisation and clinical treatment as much as they are about connection and outcomes for people in their lives. Tu Tangata, the Mental Health Outcomes Framework, endorsed by the Ministry of Health, could be part of the discussion associated with the implementation plan of the strategy.
10. A five year plan of action with definable outputs and indicative costings and how the outputs relate to outcomes be prepared.

Recommendations to the Board:

- a) *The Committee noted the revised recommendations*

Moved: Derek Hopkirk

Seconded: Eileen Brown

Carried:

3 FOR DISCUSSION

3.1 3DHB MENTAL HEALTH AND ADDICTIONS IMPROVEMENT PROGRAMME

The paper was taken as **read**.

The Committee:

- a) **Noted** this update on the Mental Health and Addictions improvement programme.
- b) **Noted** the updates on the AOD Model of Care, Suicide Prevention and Postvention services, Acute Care Continuum Project and the Te Whare Ahuru (TWA) Reconfiguration.

Discussion:

- 1. This programme is the MHAIDS business as usual work and is complementary to the Mental Health Strategy.
- 2. The Strategy will be reviewed to ensure it reflects the Mental Health Inquiry.
- 3. Think about stating the need to talk about suicide because in Māori communities they talk and this works.
- 4. Youth hubs are not part of the improvement plan as they are part of the Mental Health strategy.
- 5. Regarding the possibility of merging the 3DHB MHAIDS services and having one lead DHB, there is a strong message from government that we do not do anything until the findings from the Inquiry are delivered.

3.2 WHOLE OF LIFE NASC UPDATE

The paper was taken as **read**.

The Committee:

- a) **Noted** the activity and outcomes of the Whole of Life Needs Assessment Service Co-Ordination (NASC) project.
- b) **Noted** that co-design with the Sub-Regional Disability Advisory Group, Māori Partnership Board, Sub-regional Pacific Advisory Group and the Integrated Care Collaborative will proceed to enable the development of an implementation plan.

Discussion:

- 1. This project is welcomed as it will alleviate issues with patient navigation and patient support e.g. taxis
- 2. Background information as to what are the issues and project outcomes will be included in the recommendations which will come to a later meeting.
- 3. It would be helpful to include earlier meeting papers referred to in reports with current meeting papers.
- 4. Pleasing to see there is a whānau centred approach to NASC.

3.3 3DHB SUB-REGIONAL DISABILITY STRATEGY

The paper was taken as **read**.

The Committee:

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

- b) **Agreed** to take the next available opportunity to ensure that DSAC's membership includes more people with lived experience of disability
- c) **Noted** progress on:
 - o Recruiting staff to the vacancies in the 3DHB Disability Responsiveness Team
 - o The Disability Dashboard

Discussion:

1. The reviewed terms of reference of the Sub-regional Disability Advisory Group will come to the February meeting.
2. We now have a Māori Disability Sub-regional Group operating with some good leadership. We now have a Pacific Disability Sub-regional group. Sipaia Kupa is leading this group and doing impressive work.
3. The group is involved in the New Zealand Sign Language Project.
4. The group did some work with the Mental Health and Addictions Leadership Group. One of the outcomes was the importance of people with disabilities, especially Māori and Pacific being represented in decision making and the need for baseline data cross population groups.
5. E-passport work will be a priority in 2019 including getting our clinicians better engaged around alerts and passports.
6. The disability dashboard was discussed. It is still under development. Only CCDHB data was included at present. Patient experience is a piece of work that the group is looking at. Wairarapa is doing a specific piece of work which has come out of the New Zealand Sign Language Project around access to iPads for interpreting.
7. The next work programme will come back to DSAC and will confirm what the last agreed priorities were.
8. We have very few young people with disabilities engaged and involved and we will do some work around that to get some traction. Consideration should be taken around the format of meetings if young people are to be included and engaged. We need to have fair representation when we engage with young people.

Actions:

1. Distribute original strategy
2. Upload Tristram's paper to Boardbooks

The meeting closed at 12.30pm with a Karakia by Tristram.

4 DATE OF NEXT MEETING

4 February, 10am, Board Room, Grace Neill Block, Wellington Regional Hospital.

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

Closed since last meeting – 3 December 2018

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
DSAC Public Meeting 3 December 2018					
1.7	Action List Item 1.7 Terms of Reference	1. The Chair will recommend to the Board, 2 members from each advisory group be invited to attend this meeting, with a note to revisit the Terms of Reference.	Rachel Haggerty	Letter has been sent to the Chairs of Sub-Regional Disability Advisory Group, Sub-Regional Pacific Health Advisory Group and Maori Partnership Board to request endorsement on the amended Quorum.	Closed
3.3	3DHB Sub-Regional Disability Strategy	1. Distribute original strategy 2. Upload Tristram's paper to Boardbooks	Committee Secretary	Both papers are loaded to the Resource Centre on Boardbooks.	Closed
DSAC Public Meeting 10 September 2018					
1.5	Terms of Reference	To bring a resolution on the terms of reference to the February meeting	Rachel Haggerty	Terms of Reference to be approved at the February meeting.	Closed



Terms of Reference

Wairarapa, Hutt Valley and Capital & Coast District Health Boards Disability Services Advisory Committee

January 2019

Compliance	In accordance with section 35 of the New Zealand Public Health and Disability Act 2000, the Boards shall establish a Disability Support Advisory Committee (hereinafter called “The Committee”) whose members and chairperson shall be as determined by the Boards from time to time. The Committee shall comply with the New Zealand Public Health and Disability Act 2000. The terms of reference of the Committee shall be to do the following in a manner not inconsistent with the New Zealand Health Strategy. The Committee shall comply with the Boards’ Standing Orders for Statutory Committees. These Terms of Reference: • are supplementary to the provisions of the Act and Schedule 4 to the Act; • supersede the previous Terms of Reference dated 30 July 2017; • are effective from March 2018.
Functions of the Committee	The functions of this Committee are to give the advice to the full Board of each DHB on: • the needs, and the factors that may affect the mental health and addiction, and disability status, of the residents of the DHB; • the mental health and addiction, and disability support needs of the resident population of the DHB; • priorities for the use of mental health and addiction, and disability support funding. The aim of the Committee’s advice is to ensure that each DHB maximise the independence of the people with mental health and addiction, and disability support needs within the DHBs resident population through: • the range of disability support and mental health and addiction, services the DHB has provided or funded or could provide or fund for those people; • the service interventions the DHB has provided or funded or could provide or fund for the population; • policies the DHB has adopted or could adopt for those people. The Committee’s advice will be consistent with the New Zealand Health Strategy. The Committee shall present its findings and recommendations to the Boards for their consideration.
Objectives and Accountability	The Committee shall: • monitor the disability support and mental health and addiction, needs of each DHB resident population providing advice to each Board; • provide advice to each Board on the implications of mental health and addiction, and disability related needs and status for planning and funding of nation-wide and sector-wide system improvement goals ; • provide advice to each Board on policies, strategies and commissioning (planning and funding) to support improved health and wellbeing outcomes for the target population in each district;

	• provide advice to each Board on priorities for improvement and independence of people experiencing mental health and addiction, and disability as part of the strategic and annual planning process to improve wellness outcomes and independence within each district; • provide advice to each Board on strategies to achieve equity in modifiable mental health and addiction, and disability status amongst the population of each DHB including but not limited to Māori, Pacific, people living in high deprivation, people with mental health and addiction, and addiction conditions and people with disabilities; • monitor and advise each Board on the impact and effectiveness of disability support and mental health and addiction services being provided for the resident population of each DHB; • provide advice to each Board on the delivery of health services accessed by people with mental health and addiction, and disabilities including how it can effectively meet its responsibilities towards the government's vision and strategies for both populations; • identify issues and opportunities in relation to the provision of mental health and addiction, and disability services that the Committee considers may warrant further investigation and advise the Board accordingly; • ensure that this Committee is appropriately engaged with, and informed by, the other advisory groups of each DHB; • identify when 'expert' assistance will be required in order for the Committee to fulfill its obligations, and achieve its annual work plan by co-opting experience when required; • report regularly to each Board on the Committee's findings (generally the minutes of each meeting will be placed on the agenda of the next Board meeting); • collaborate as required with Committees of other district health boards in the interests of providing optimum, economical and efficient services; • perform any other functions as directed by the respective DHB Boards.
Authorities and Access	The following authorities are delegated to the Committee to: • require the Chief Executive Officers and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request; • interface with any other Committee(s) that may be formed from time to time.
Meetings	The Committee shall hold no less than four meetings per annum, but may determine to meet more often if considered necessary by the Committee or upon that instruction of the Boards.
Quorum	A quorum is a majority of Committee members, and must include at least one member from each Board and two members from the subcommittees: Sub-Regional Disability Advisory Group (SRDAG), Sub-Regional Pacific Advisory Group (SRPAG) and Maori Partnership Board (MPB). The subcommittees will nominate a delegate to attend if the first member is unable to attend.
Membership	Membership of the Committee shall be as directed by the Boards. The Committee has the ability to co-opt expert advisors as required.
Procedure	Schedule 4 of the New Zealand Public Health and Disability Act will apply to the business and procedure of the Committee.

  		3DHB DISABILITY SERVICES ADVISORY COMMITTEE DECISION PAPER 25 January 2018
Author	Marilyn Hunt, Project Manager, Mental Health & Addiction Services, Strategy, Innovation & Performance, CCDHB	
Endorsed by	Rachel Haggerty, Director – Strategy, Innovation & Performance Helene Carbonatto, General Manager – Strategy, Planning and Outcomes Joy Cooper, Acting Executive Leader Planning and Performance Nigel Fairley, General Manager – MHAIDS Alison Masters, Medical Director - MHAIDS	
Subject	3DHB Mental Health & Addictions Strategy, <i>Living Life Well 2019 - 2025</i>	
RECOMMENDATION It is recommended that the Committee: a) NOTES the strategy has been developed in conjunction with a range of stakeholders including mental health consumers, Māori, Pacific, non-governmental organisations, primary health care, specialist mental health and addictions providers and other DHB staff. b) NOTES that this Strategy has been reviewed against the report from the Mental Health Inquiry and is well aligned. c) ENDORSES that the Board of each DHB adopt the 3DHB Mental Health & Addictions Strategy, Living Life Well 2019 – 2025, for release in early 2019 to support the improvement of Mental Health and Addiction services.		
APPENDICES 1. 3DHB MENTAL HEALTH & ADDICTIONS STRATEGY, <i>LIVING LIFE WELL 2019 - 2025</i>		

1 INTRODUCTION

1.1 Purpose

This paper seeks the endorsement of the 3DHB Mental Health & Addictions Strategy *Living Life Well 2019 – 2025*, (the Strategy) attached as an appendix.

1.2 Purpose of this Strategy

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

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

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

2 PROCESS OF DEVELOPMENT

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

This paper was originally presented to DSAC in December 2018. In principle, the committee endorsed the adoption of the strategy. They requested it come back to the February meeting for final endorsement, revised to address the following:

- Including additional reference to increased support for maternal mental health
- Incorporates any immediate changes that might be required after the publication of the report from the Government Inquiry into mental health and addictions was published in December
- Includes a reflection that the strategy is a living document, which will be updated, particularly as the DHBs understand the government's formal response to the Government Inquiry into mental health and addictions, due in March 2019.
- Co-design is emphasised for planning and implementation and as being crucial for success.

In addition, the committee asked that finalising the strategy includes provision of adequate opportunity for advisory committees to examine and comment.

2.1 Revisions Included

Revisions have been included to address the bullet points noted above.

- An appendix (Appendix 1) has been included which maps key ideas from the strategy to the recommendations from the Government Inquiry into mental health and addiction.
- An additional reference to maternal mental health has been included on page 24, and the final two bullet points are now reflected in the Next Steps section on page 53.

2.2 Advisory Committee Comment

The Strategy was presented to the CCDHB Māori Partnership Board (MPB) on December 12 2018, and feedback from the MPB has also been incorporated in the revised document. It was also discussed at Te Iwi Kainga in the Wairarapa, the 3DHB Māori Disability Roopu, and circulated to the sub-regional Pacific Advisory Group and the sub-regional Disability Advisory Group for comment.

The 3DHB Māori Disability Roopu raised concerns regarding the limited involvement of Māori in the development of the Strategy, and requested more inclusion of te reo and greater reference to kaupapa Māori services e.g. to reduce Māori youth suicide. They asked for a rewrite of the Strategy to include this. As the Strategy has been established as a living updateable document, we intend to address their concerns in the design, planning and implementation phases, and as part of a process of continual review to ensure the Strategy's direction continues to meet our populations' needs. We are mindful of expectations in the sector and the mental health and addictions community of taking action sooner rather than later and believe the best approach is to address their concerns as part of the review and implementation process.

In line with DSAC's earlier feedback, the 3DHB Māori Disability Roopu also want true co-design emphasised; this has been acknowledged in amendments to the CE's foreword.

The HVDHB Māori Partnership Board is in the process of being established, so was not able to review the Strategy; however the board looks forward to having input into future phases.



Wairarapa, Hutt Valley and Capital & Coast District Health Boards

Living Life Well

A strategy for mental health and addiction

2019–2025

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Foreword

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

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

The publication of this strategy follows the national inquiry into mental health and addiction and, as a living document, the directions and proposed actions in this strategy will be reviewed to ensure they reflect the government's formal response to the inquiry.

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

This strategy is far broader than specialist mental health and addiction services; it is a foundation for all of us with a goal of living life well: accomplishing this with resilience, a focus on recovery, and the freedom from addiction harm. This includes addressing our commitment as DHBs to partner with tangata whenua. We recognise the impact that systemic challenges such as institutionalised racism play in contributing to poorer health and wellbeing outcomes and as DHBs acknowledge the role we have in proactively addressing these challenges. We acknowledge that we still have more to do to meet the aspirational goals of Māori, including adequately partnering with Māori in the development and delivery of services that meet their needs. Our committed intention is to truly partner with Māori in the design, planning and implementation of this strategy.

This strategy strongly promotes co-design and we as Chief Executives expect authentic co-design will be an essential feature of the phases that flow on from the release of this strategy. We are accountable for ensuring this happens and will report on this process to our advisory committees. We trust that they and our communities will hold us to account on this crucial element and all aspects of this strategy.

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

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

Adri Isbister
Chief Executive
Wairarapa DHB

Dale Oliff
Interim Chief Executive
Hutt Valley DHB

Julie Patterson
Interim Chief Executive
Capital & Coast DHB

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

About *Living Life Well*

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

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

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

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

needs. It is based on a people-centred¹ approach in which individuals, families/whānau and communities are served by, and able to participate in, trusted health services that respond to their needs in humane and holistic ways. The strategy has a focus on people's needs and enables individuals, families/whānau and communities to collaborate with health practitioners, health care service providers, and cultural specialists.

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

Contributors to this document

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

The following groups of stakeholders/partners have been consulted (either in meetings or by phone/email communications) and provided input to this strategic plan. Some people were involved as members of several different groups over time.

Consumer Leadership Group (CLG) 2016

MHA Integrated Leadership Group 2016

AOD Leadership Group 2016

Wairarapa Consumer Leadership Group

Māori Health, the 3DHBs

Pacific Health, the 3DHBs

Non-governmental organisations, including the following

Atareira, Care NZ, Earthlink Inc, Emerge Aotearoa, Mix, Oasis Network, Pathways, Refugee Trauma Recovery Services, Salvation Army, Salvation Army Bridge and Oasis, Te Waka Whaiora, Wellbeing Wellington

Primary health care

Compass Health, Te Awaikairangi Health Network, Kokiri Hauora Whānau Ora collective, Ora Toa Mauriora Te Runanga o Toa Rangatira

The 3DHBs want to acknowledge the work of Sandra Murray and Marion Thomas in holding the flag for this strategy and its development.

Strategic context

In setting the strategic directions necessary to achieving the vision as described by this strategy, the 3DHBs are guided by core legislative and governmental strategic directions including: the New Zealand Public Health and Disability Act 2000, the Treaty of Waitangi, the New Zealand Health Strategy and its accompanying strategies: He Korowai Oranga – the Māori Health Strategy, 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018, and Enabling Good Lives Disability Strategy. The 3DHBs are also guided by the Government's commitment to the United Nations Convention on the Rights of Persons with Disabilities.

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

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

The most recent context for this strategy is *He Ara Oranga*, the report of the Government inquiry into mental health and addictions, completed in November 2018 (Government Inquiry into Mental Health and Addictions, 2018). The forty recommendations from the report specify changes aimed at improving New Zealand's approach to mental health and addictions, with a particular focus on equity of access, community confidence in the mental health system and better outcomes, particularly for Māori and other groups with disproportionately poorer outcomes. On analysis, this 3DHB strategy is well aligned with *He Ara Oranga's* direction and recommendations. Once the government's formal response to the inquiry is announced, a further review of the strategy will be undertaken to check alignment of its direction and anticipated actions.

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

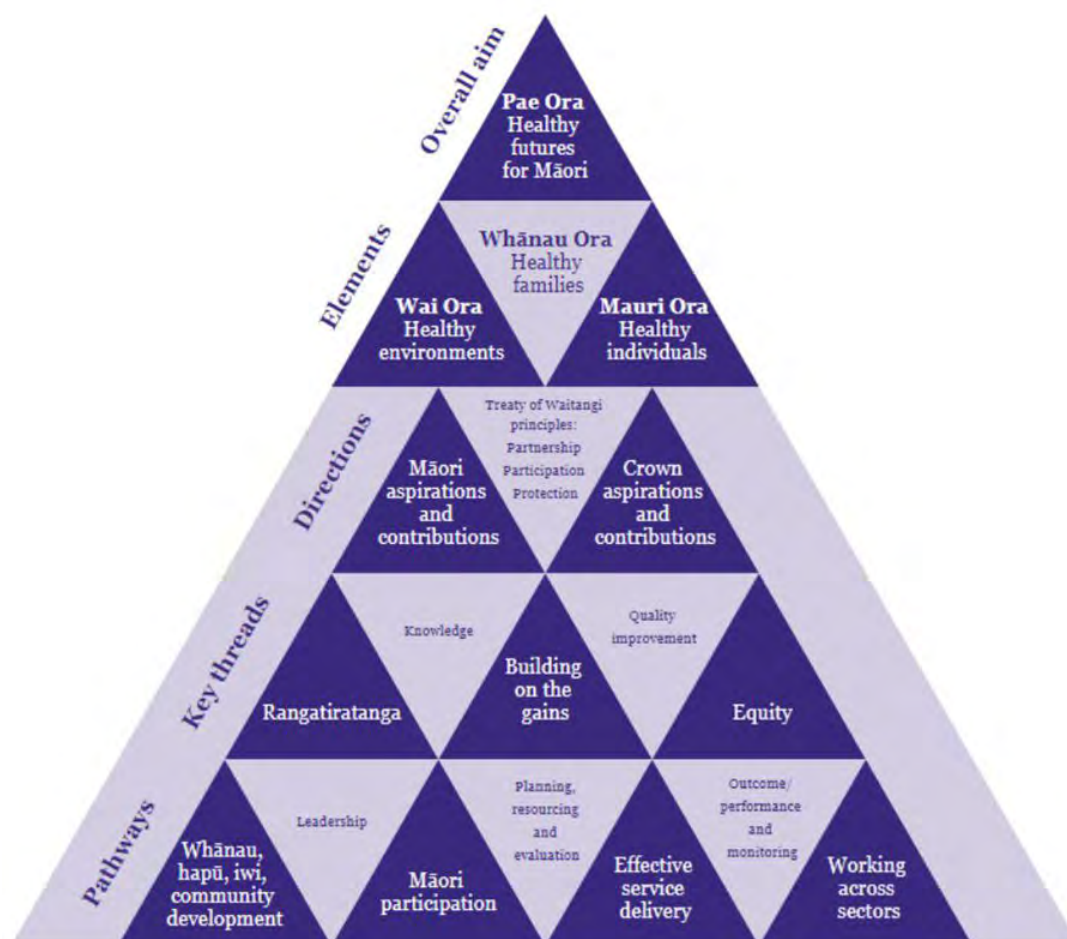
Figure 1: He Korowai Oranga framework

Figure 1 illustrates Māori aspirations on the left and Crown aspirations and obligations on the right. A key thread of HKO is rangatiratanga, enabling whānau, hapū, iwi and all Māori to exercise control over their own health and wellbeing. In alignment with that, this 3DHB strategy recognises that Māori are both a legitimate and an essential part of decision-making in the health and disability sector. This strategy envisages Māori actively participating in decision-making regarding the commissioning and provision of kaupapa Māori models of practice to address Māori mental health needs.

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

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

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

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

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

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

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

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

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

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

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

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

Setting the foundation

Rangatiratanga

A key thread of He Korowai Oranga is rangatiratanga, “enabling whānau, hapū, iwi and Māori to exercise control over their own health and wellbeing, as well as the direction and shape of their own institutions, communities and development as a people” (Ministry of Health, 2014). Enabling Māori to exercise power in relation to the commissioning and providing of mental health and addiction services for Māori is a significant impetus of this strategy.

As part of working well for everyone, the health system needs to demonstrate that it is achieving as much for its Māori population as it is for everyone else. For example, among the responsibilities of DHBs are to reduce the disparities between population groups, improve Māori health and ensure Māori are involved in both decision-making and service delivery. (Ministry of Health, 2014). This responsibility is enshrined in the New Zealand Public Health and Disability Act 2000 as an objective for DHBs. The 3DHBs understand that implementing this strategy means following the Treaty of Waitangi principles, as stated in He Korowai Oranga:

The principles of partnership, participation and protection underpin the relationship between the Government and Māori under the Treaty of Waitangi.

- *Partnership involves working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.*
- *Participation requires Māori to be involved at all level of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services.*
- *Protection involves the Government working to ensure Māori have at least the same level of health as non- Māori, and safeguarding Māori cultural concepts, values and practices.*

(Ministry of Health, 2014, p. 12)

Getting the basics right – addressing inequity

People using MHA services want to see significant change in the services they receive. They want to receive support before they reach a crisis point, and they want the health professionals they interact with to take a whole-person² approach to their treatment and recovery.

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

Equity is the absence of avoidable or remedial differences among groups of people, whether those groups are defined socially, economically,

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

demographically, or geographically. Health inequities therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms.

(World Health Organization, 2018)

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

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

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

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

The significance of system deficiencies for achieving equity

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

- Improved quality, safety and experience of care
- Improved health and equity for all populations
- Best value for public health system resources

“The health system must work well for all New Zealanders, including Māori. As the majority of Māori continue to receive most of their health care from mainstream services, considerable effort is required to ensure that mainstream services make it a key priority to reduce the health inequalities that affect Māori and to work effectively for Māori. Within the health and disability sector, efforts need to also focus on reducing risk, strengthening prevention and more effectively managing disease and long-term conditions, as well as improving overall Māori health and disability outcomes.”
(Ministry of Health, 2014)

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

- (1) Every consumer has the right to have services provided with reasonable care and skill.
- (2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
- (3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

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

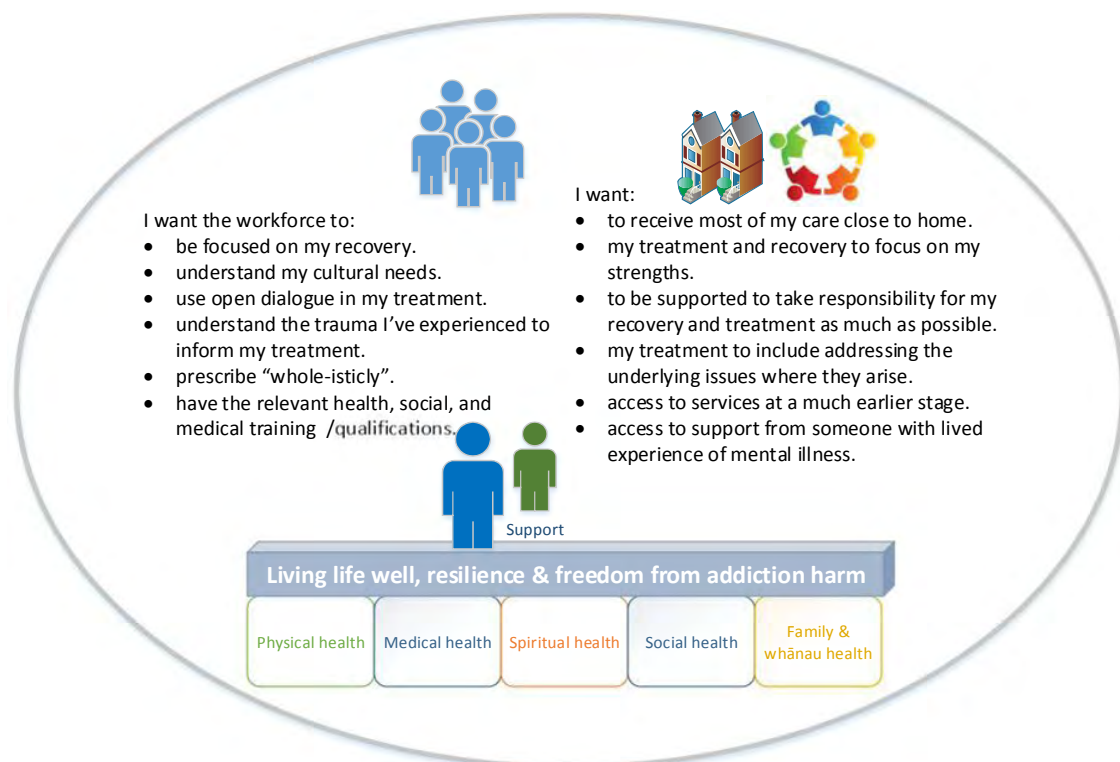
(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

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

Consumer perspectives and responsiveness

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

Figure 2: The consumer perspective (3DHB MHA Consumer Leadership Group 2016)



This broad approach to care is often referred to as social prescribing and enables health professionals to refer people to a range of local, non-clinical services and supports. It recognises that people's health is determined primarily by a range of social, economic, and environmental factors

and seeks to address people's needs in a holistic way. The approach also aims to support individuals to take greater control of their own health (The King's Fund, 2017).

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

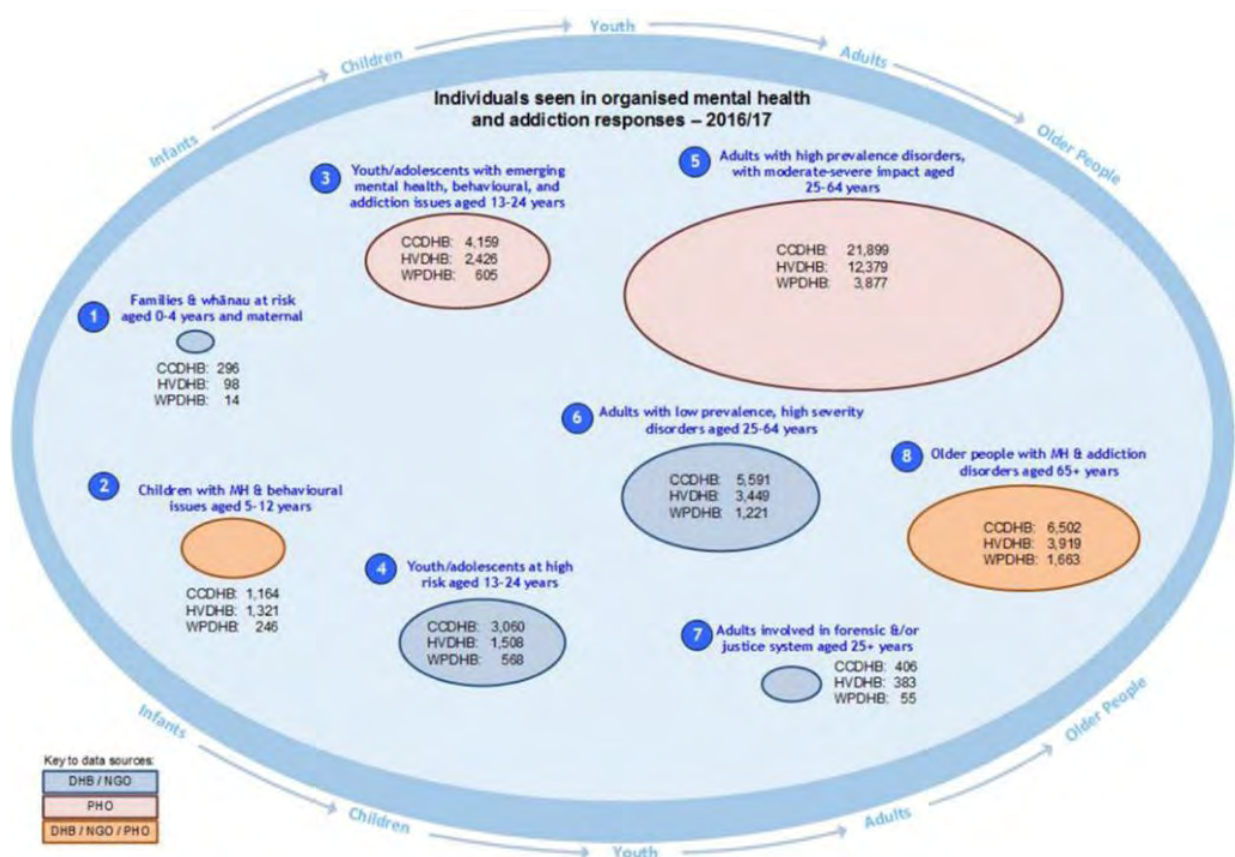
Health needs assessment

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

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

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

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



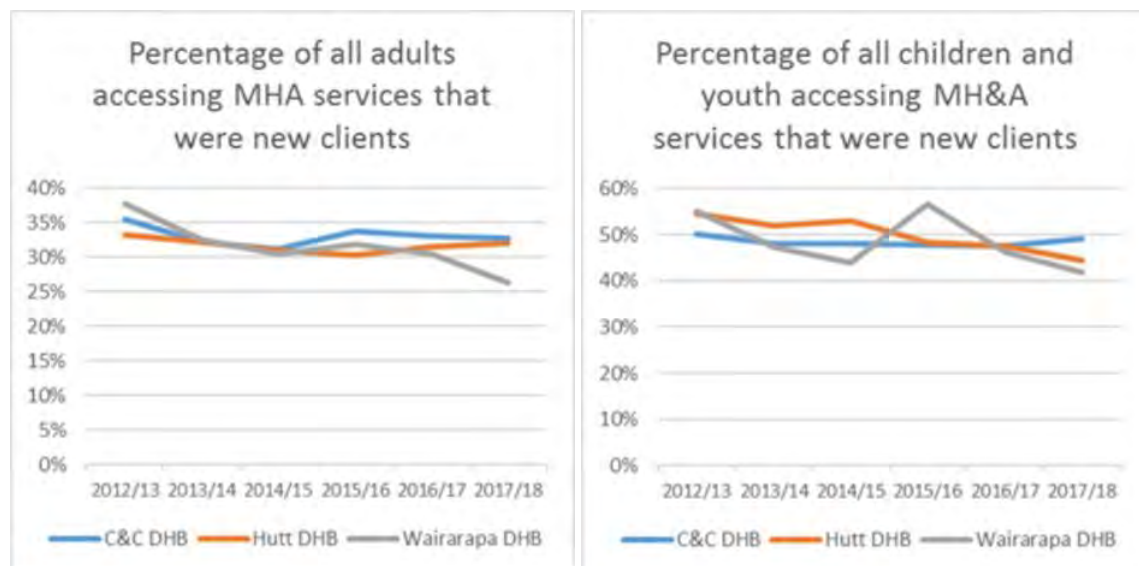
Emerging trends

Of all adults aged 20 years or over accessing MHA services across the 3DHBs in 2015/16, approximately 23 percent were considered to meet the Ministry of Health criteria for a long-term client³. In 2006, King and Welsh (King & Welsh, 2006) estimated that long-term users of mental health services accounted for approximately 65 percent of acute bed days and more than 90 percent of social support services provided by NGOs.

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

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

Figure 4: People accessing services for the first time⁴



The populations we serve

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

Population in our 3DHBs' area is growing slowly and is projected to increase gradually in all three. The level of population growth is slower than in other parts of the country. Despite this, demand for mental health services is increasing. Our mental health services decline referrals for those people

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

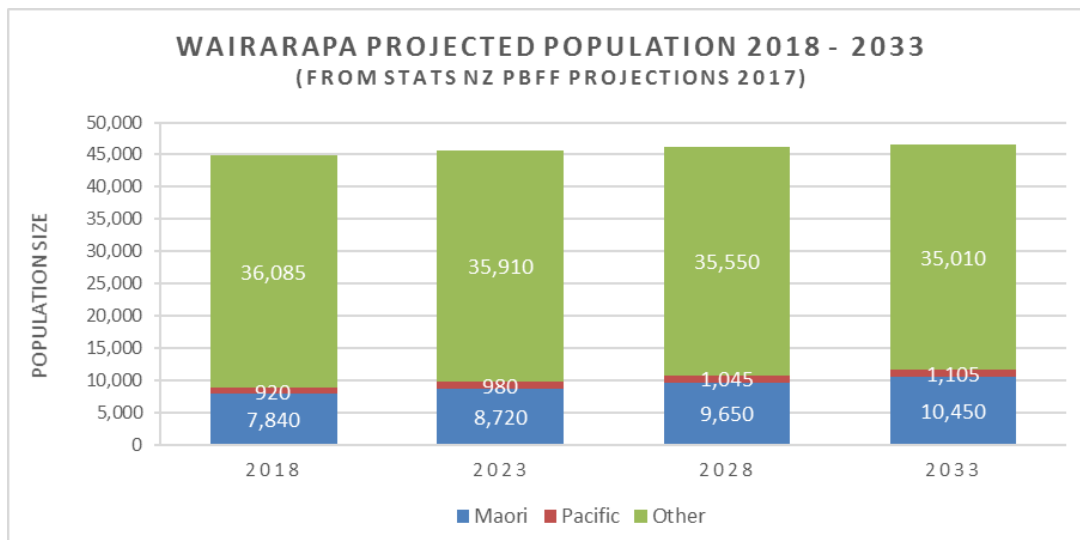
⁴ Data taken from PRIMHD. A new client is a person who has not had any type of contact with MHA services in the previous 5 years (adults) or 3 years (child and youth).

who do not meet the specified threshold, and we adjust our criteria to cope with what is available in our funding pool. We recognise that this does not serve our community completely, as there is significant unmet need.

Wairarapa: population summary

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

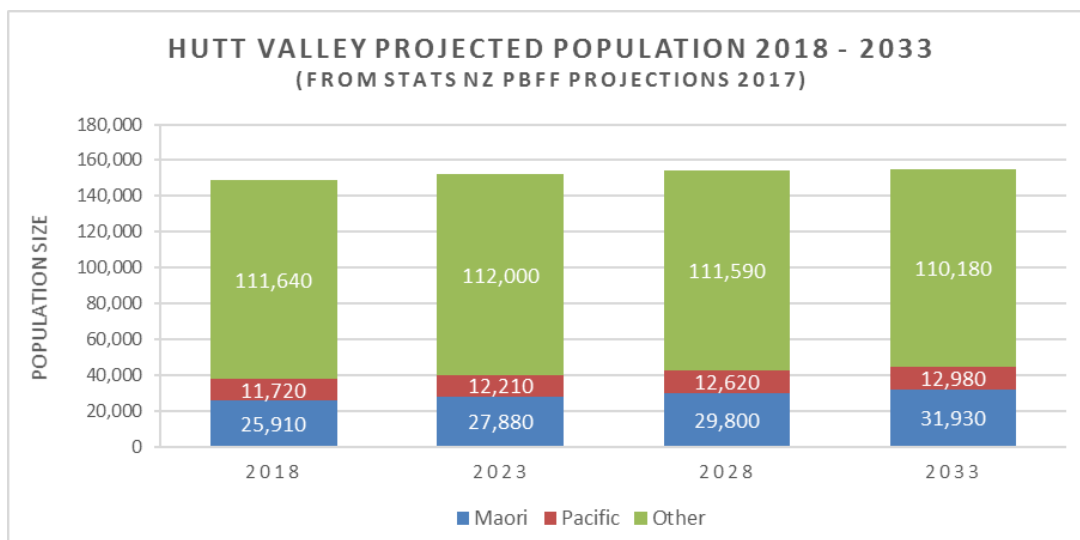
Figure 5: Wairarapa projected population (2018 to 2033)



Hutt Valley: population summary

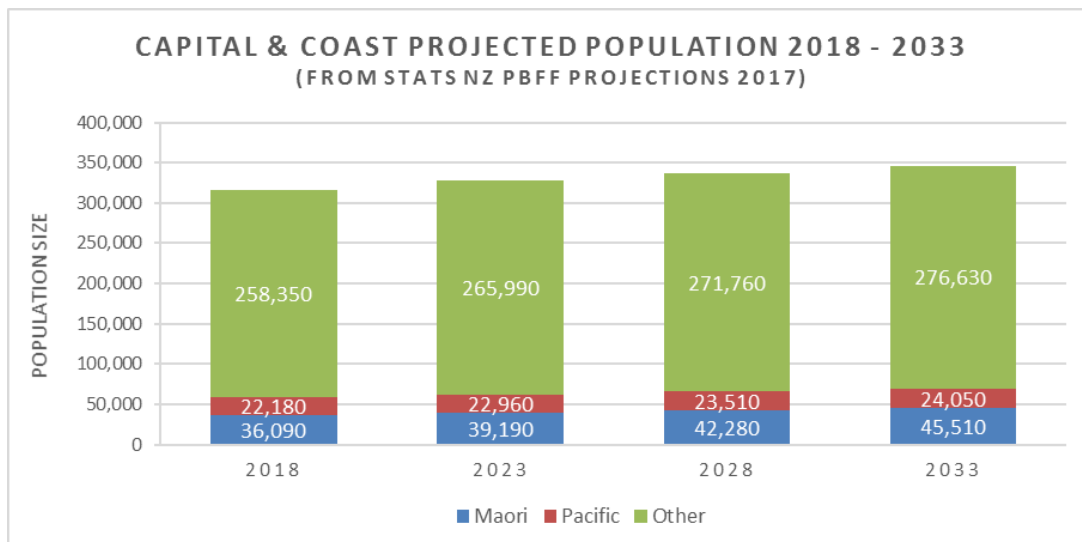
Hutt Valley DHB (HVDHB) meets the needs of roughly 147,000 citizens of Hutt City, Upper Hutt, Petone, Wainuiomata and Eastbourne.

Figure 6: Hutt Valley projected population (2018 to 2033)



Capital & Coast: population summary

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

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

Priority populations

Consumers and their families/whānau should be able to experience the same quality of care, service experience, and outcomes regardless of who they are. Population groups who experience disparity in MHA service provision are Māori and Pacific peoples, children and youth (HDC, 2018). The report just referenced (*New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner*) published by the Health and Disability Commission acknowledged that it was not able to cover other cover “a number of important consumer groups, including disabled people, gay, lesbian, bisexual, transgender and intersex populations, older people, and refugee, migrant and rural communities” and commented on the need for monitoring and advocacy for these groups too (HDC, 2018, p. 15). This strategy seeks to address those groups as well; we particularly acknowledge the rainbow community⁵ as a priority population.

Māori

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

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

⁵ The term “rainbow community” is used to as an umbrella term for sex characteristic, sexuality and gender diverse communities, also known as “LGBTIQ+”.

2017). The overall population rate for access to mental health and addiction services in New Zealand is 3.6%, with the rate for Māori being almost double that at 6.3% (Ministry of Health, 2018).

Pacific peoples

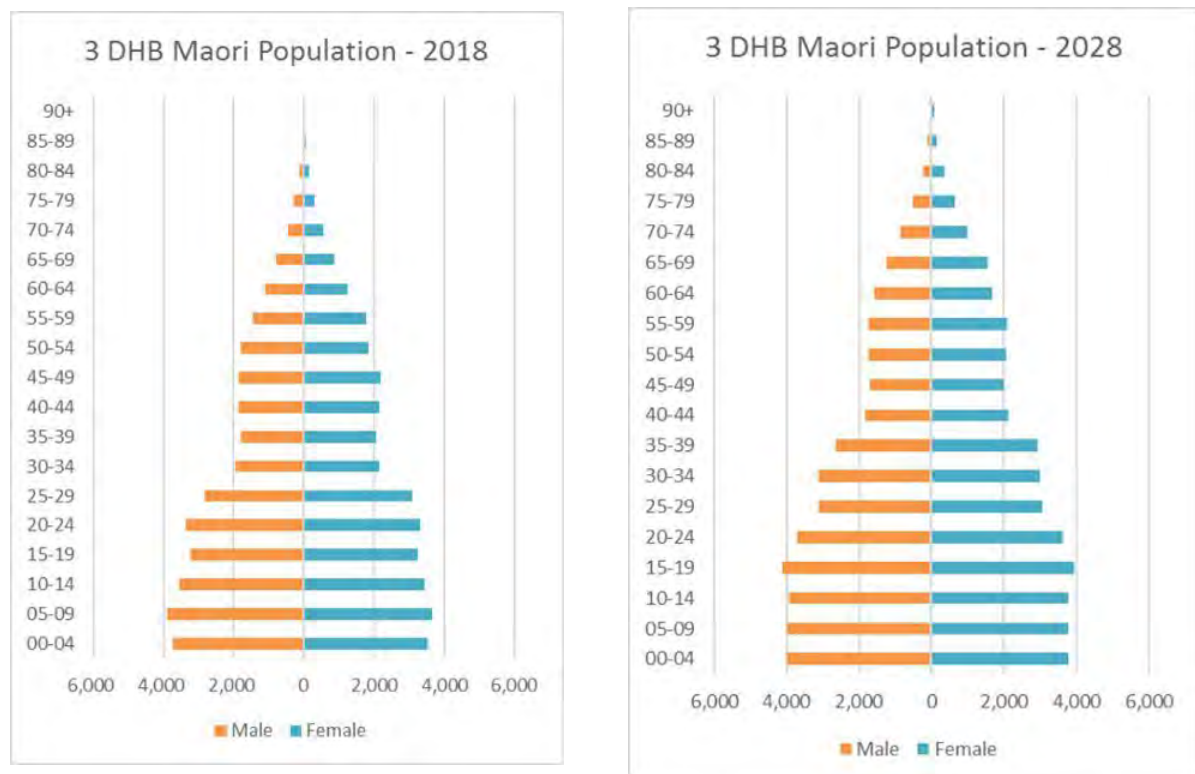
Pacific peoples also experience mental illness and/or addiction at higher rates than others, with 25 percent experiencing a disorder within the previous 12 months (compared with 21 percent overall). The prevalence of medium to high levels of psychological distress reported over the previous four weeks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

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

Population trends among different ethnic groups

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

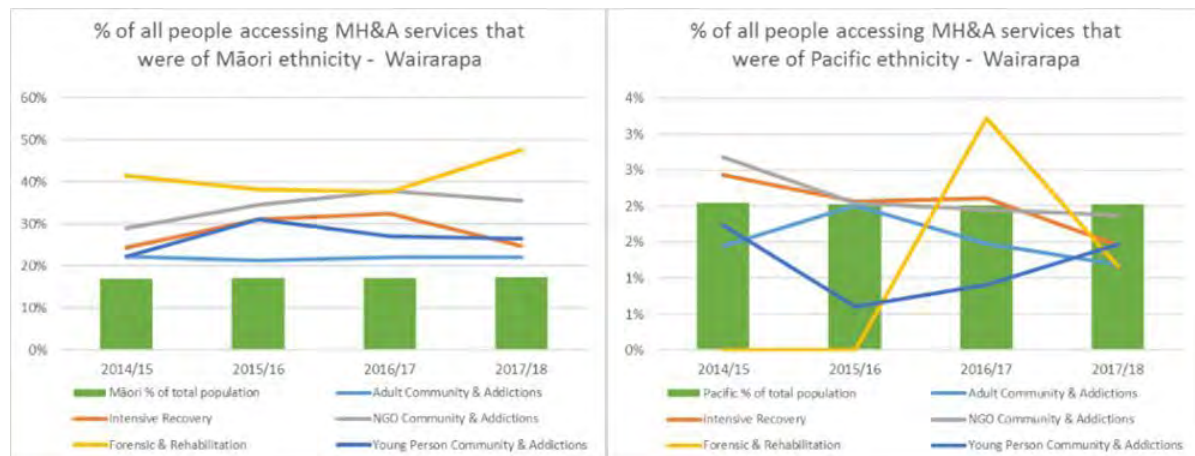
Figures 8 and 9: 3DHB Māori population 2018 and 2028 (taken from Stats NZ PBFF projections)



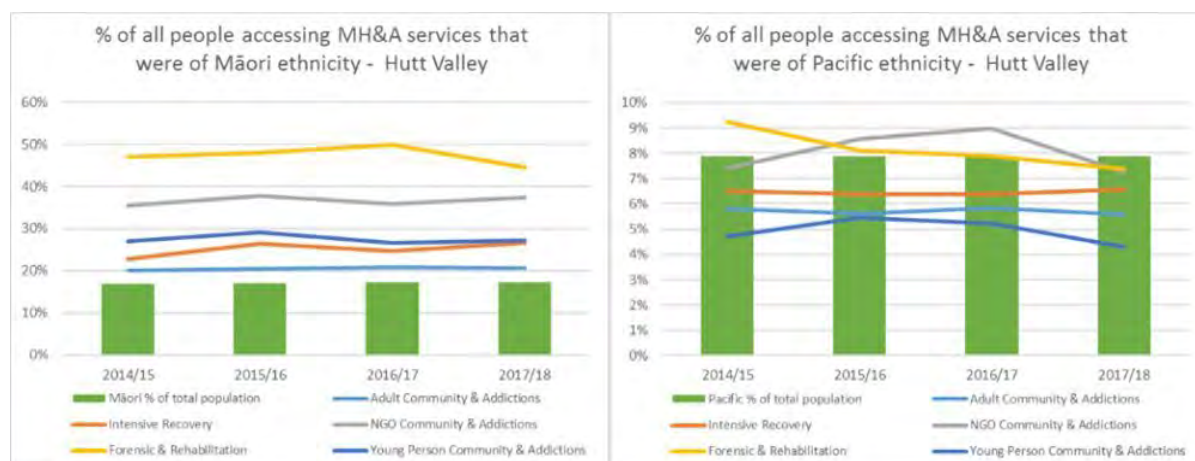
The following graphs illustrate the access rates for Māori and Pacific into 3DHB mental health and addictions services (both provider arm services, Mental Health, Addictions and Intellectual Disability Services / Te Upoko me Te Karu o Te Ika – MHAIDS, and Non-Government Organisations - NGOs),

over the last 4 years. Clearly the Māori population are over represented in our service, and we need to ensure equitable health outcomes for Māori through access to high-quality services that are responsive to their aspirations and needs.

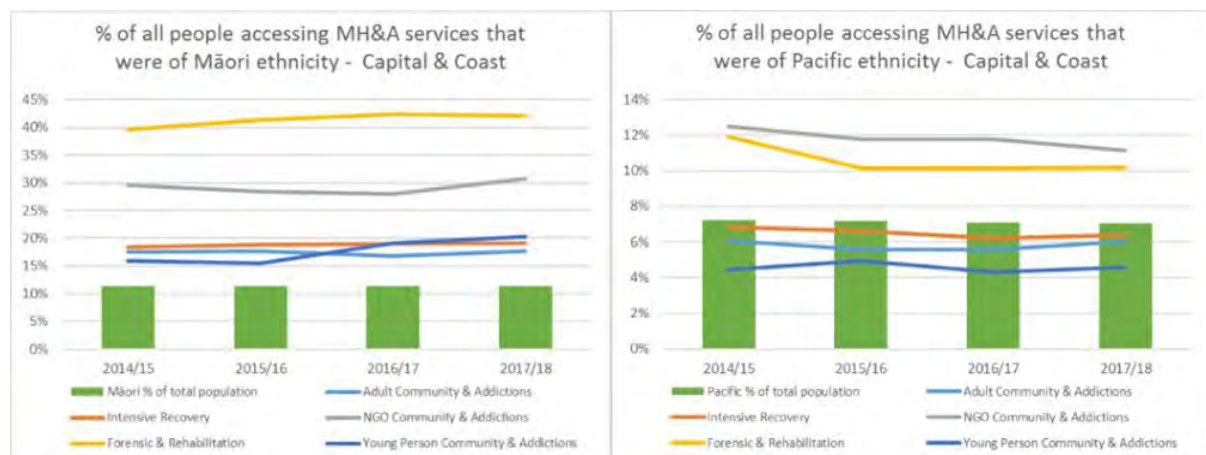
Figures 10 and 11: Wairarapa, percentage of consumers of Māori and Pacific ethnicity accessing MH&A services (taken from PRIMHD)



Figures 12 and 13: HVDHB, percentage of consumers of Māori and Pacific ethnicity accessing MH&A services



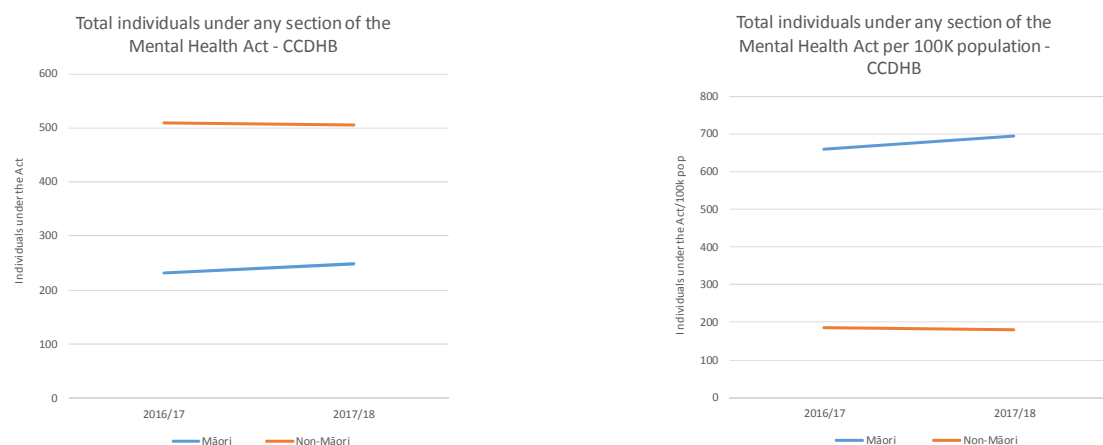
Figures 14 and 15: Capital & Coast, percentage of consumers of Māori and Pacific ethnicity accessing MH&A services



Rates of placement under any section of the Mental Health Act for Māori

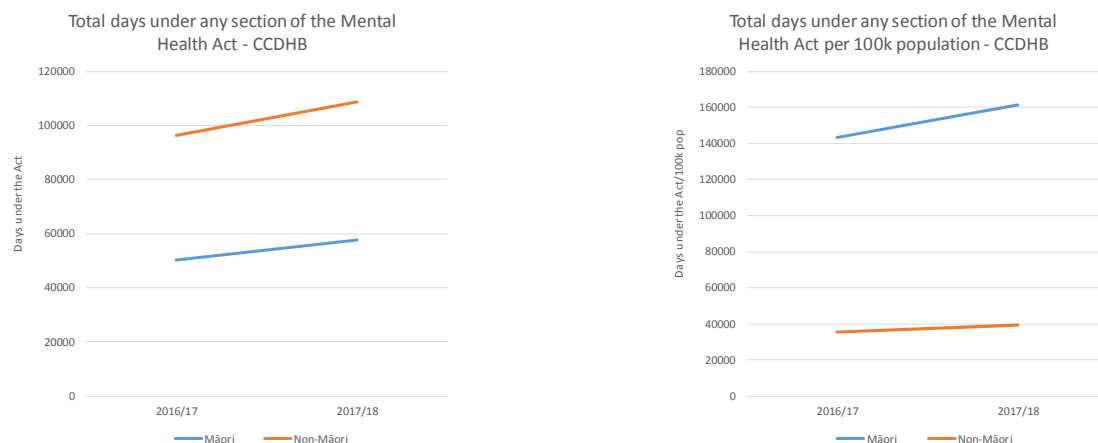
CCDHB data clearly shows a much higher rate in both the number of Māori placed under a section of the Mental Health Act, and the number of days spent under the act. The rate per 100,000 of population for Māori people placed under any section of the Mental Health Act was 3.8 times higher than for Non-Māori in 2017/18. The rate for Māori increased by 5.4% since 2016/17, the rate for non-Māori fell slightly over the same period.

Figures 16 and 17: total individuals under any section of the Mental Health Act and per 100K population (CCDHB only)



*From MHAIDS legal status data

The total number of days that Māori spent under the act increased by 14.6% between 2016/17 and 2017/18. The rate of days under the act per 100,000 population was 4 times higher for Māori in 2017/18.

Figures 18 and 19: Māori/non- Māori ethnicity split - total days under any section of the Mental Health Act and per 100K population (CCDHB only)

*From MHAIDS legal status data

Suicide outcomes for Māori as compared to non – Māori

Because of the small number of suicides per each DHB, it is helpful to look at national data. The table below uses data from the 2015 MOH suicide tables based on the national mortality collection. As it only includes confirmed suicides, it means that suicide can be expressed as a percentage of total deaths. The percentage of suicide per total deaths is over double for Māori than for Non-Māori, and suicide is the leading cause of death for Māori and Non-Māori aged 15 to 24 years.

Figure 20: Suicide rates for all ages, with a Māori/non- Māori ethnicity split

All Ages						
		Total Deaths in NZ	Total Suicides	% suicides of total deaths	NZ Population	Suicides per 100k of population
Māori	Male:	1,801	77	4.3%	347,200	22.2
	Female:	1,612	41	2.5%	365,000	11.2
	Total:	3,413	118	3.5%	712,300	16.6
Non-Māori	Male:	14,128	306	2.2%	1,911,700	16.0
	Female:	14,255	101	0.7%	1,975,400	5.1
	Total:	28,383	407	1.4%	3,887,000	10.5
All ethnicities	Male:	15,929	383	2.4%	2,258,900	17.0
	Female:	15,867	142	0.9%	2,340,400	6.1
	Total:	31,796	525	1.7%	4,599,300	11.4

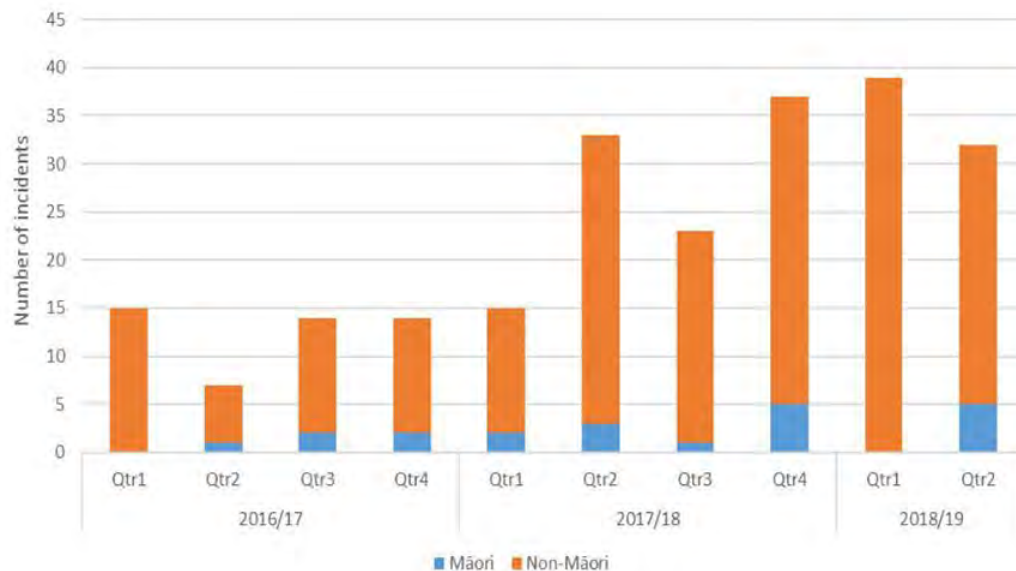
Figure 21: Suicide rates for 15-24 years, with a Māori/non- Māori ethnicity split

15 - 24 years						
		Total Deaths in NZ	Total Suicides	% suicides of total deaths	NZ Population	Suicides per 100k of population
Māori	Male:	64	19	29.7%	66,890	28.4
	Female:	40	23	57.5%	65,190	35.3
	Total:	104	42	40.4%	132,080	31.8
Non-Māori	Male:	173	50	28.9%	272,430	18.4
	Female:	62	19	30.6%	252,050	7.5
	Total:	235	69	29.4%	524,480	13.2
All ethnicities	Male:	237	69	29.1%	339,320	20.3
	Female:	102	42	41.2%	317,240	13.2
	Total:	339	111	32.7%	656,560	16.9

Seclusion and restraint: CCDHB data only

Data has been provided via the QLIK data analysis tool (implemented in mid-2018) for CCDHB information relating to seclusion. From July 2017 to November 2018, 27 Māori and 31 non-Māori, non-Pacific people were secluded. The percentage of inpatients who were secluded was higher for Māori (10.5%) than for non-Māori, non-Pacific people (4.1%). The seclusion hours per person were lower for Māori (49 hours) than non-Māori, non-Pacific people (159 hours). It is not possible to interpret the data fully, without having reasons for seclusions. However, the higher proportion of Māori who are secluded, with a shorter time in seclusion suggests the possibility that Māori are being secluded unnecessarily. Further work to fully understand this is warranted.

Over the past 2½ years, 9.2% of all restraint incidents reported by MHAIDS in CCDHB involved a Māori service user. These data have been sourced from CCDHB reportable events data (SQUARE).

Figure 22: The number of incidents involving restraint of a service user, CCDHB only

Infants, children, and young people

Childhood events and experiences can have a major impact on a person's future health. Many adult mental health and/or addiction problems have origins from childhood, with 50 percent of those problems becoming apparent by the time a person reaches the age of 18 years. Central to this is an increased emphasis on supporting perinatal and maternal mental health more effectively. An increased emphasis on the early identification of children who exhibit behavioural problems will also assist with this. This requires "a comprehensive network of services to assist and support families where mental health concerns or psychosocial issues are identified." (CCDHB, 2015, p. 30)

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

Addiction

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

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

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

Prison population

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

A focus on the prison population as a priority population achieves more significance when ethnicity is also taken into account. Māori make up the largest proportion of the prison population, in contrast to their proportion of New Zealand's population as a whole. This makes it doubly important to ensure that our models of care meet the needs of the prison population, including access to services on release into the community or DHB of domicile.

Figures 23 and 24: Department of Corrections, Trends in offender population, 2014 to 2015

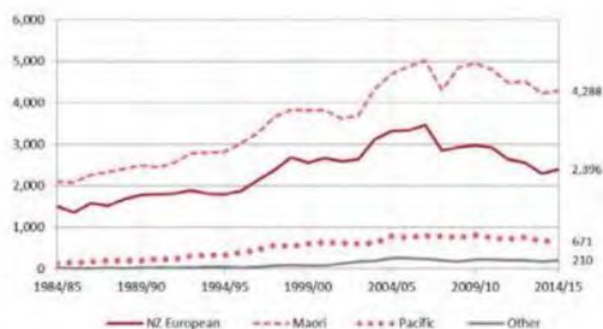
The presentation of more serious conditions is also more prevalent among people in prison,

Ethnicity

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

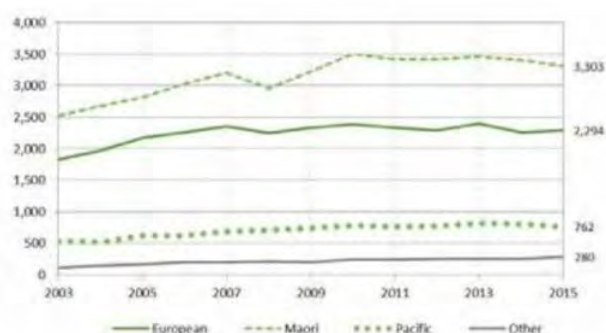
Proportionally, prisoners starting a prison sentence who are Maori increased by only very slightly from 56 percent to 57 percent between 1984/85 and 2014/15.

A number of offenders have no recorded ethnicity; these offenders are excluded from this calculation.

**Ethnicity**

Maori over-representation has been a feature of the prisoner population for a considerable amount of time.

The proportion of sentenced prisoners in each ethnicity has not changed since 2003. Maori accounted for 50 percent of all sentenced prisoners on 30 June 2015.



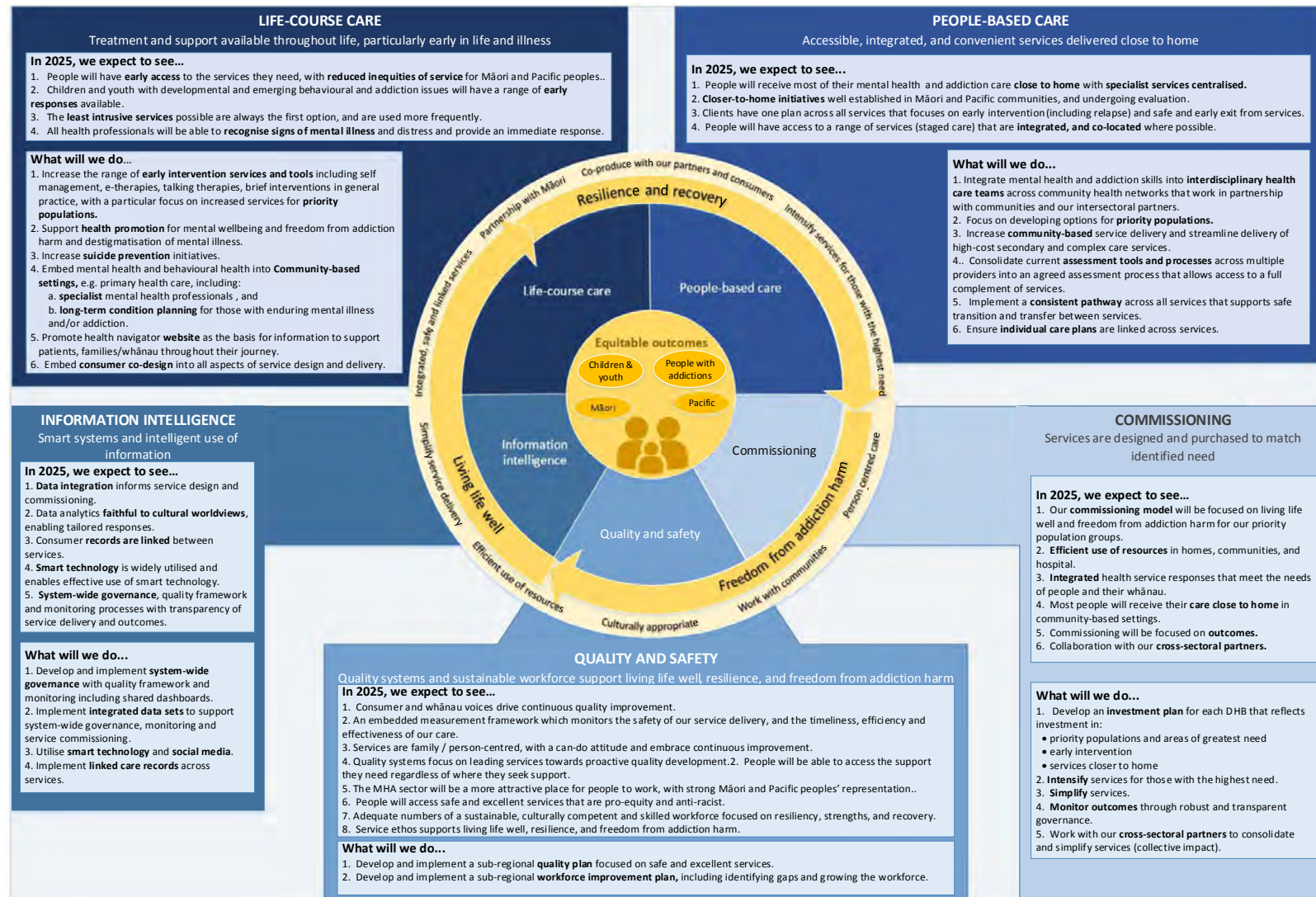
including conditions such as post-traumatic stress disorder and bipolar disorder associated with high levels of distress and disability, especially in acute phases.

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

Living Life Well 2019 – 2025: a summary

The diagram below summarises the *Living Life Well* strategy as a whole, placing people attaining equitable outcomes at the centre, and outlining the two strategic directions of Life-Course Care and People-Based Care, along with the three enabling directions related to Information Intelligence, Quality and Safety, and Commissioning. The strategy is outlined in detail beginning on page 37. As previously mentioned, the earlier work to develop these ideas deliberately sought service change, and as a result this final document includes some proposed specific actions in addition to high-level strategic direction.

Figure 25: Living Life Well 2019-2025 – strategy summary



Determinants of health

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

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

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

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

Figure 26: Health links with the wider environment



(Ministry of Health, 2016b)

Integration of mental health with other health and social services

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

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

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

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

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

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

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

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

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

Workforce capacity and capability

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

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

Workforce planning

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

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

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

Workforce practice

People working in MHA services, including primary and community services, will work closely with individuals and their families/whānau, to centre the person's wellbeing within a wider community context. People working in MHA services will also understand the importance and significance of cultural practices, and kaupapa Māori models of care.

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

It is a medical model; pills first – it should be talk first.

There is over reliance on medication. They should be balancing medication with CBT [cognitive behavioural therapy] and other therapies.

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

Our workforce extends beyond specialist MHA services in hospitals and NGOs; it includes staff working in primary health care and community services. Individuals do not interact solely with MHA services but also with a multitude of other health and social organisations. We need to shift to an

approach that more closely aligns with how people live their lives and provide meaningful support in appropriate settings. To do this, we need to bring our workforce along on the journey, making greater use of multidisciplinary teamwork, integrating services, increasing collaboration between services, piloting innovative service delivery arrangements, and eliminating the needless cycles of assessment and referral (Platform Trust & Te Pou o Te Whakaaro Nui, 2015).

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

Our workforce will be characterised by:

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

New approaches

Figure 27: Current and future approach to MHA care of the community (built from information collected at workshops across the 3DHBs)

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

Figure 17 describes our current approach and its associated issues and challenges, alongside the new approach we expect future workforce and services to embrace and implement. We envisage a service-level alliance structure⁶ made up of a range of stakeholders with oversight of the needs in the region and how current services and resources deliver the required outcomes.

Utilising cultural partnerships in approaches

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

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

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

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

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

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

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

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

⁶ Person-centred care involves mental health providers, other health providers, and professionals from other sectors working together more proactively to manage people’s health, avoid illness, and provide safe and appropriate services.

Whole-of-system model of care

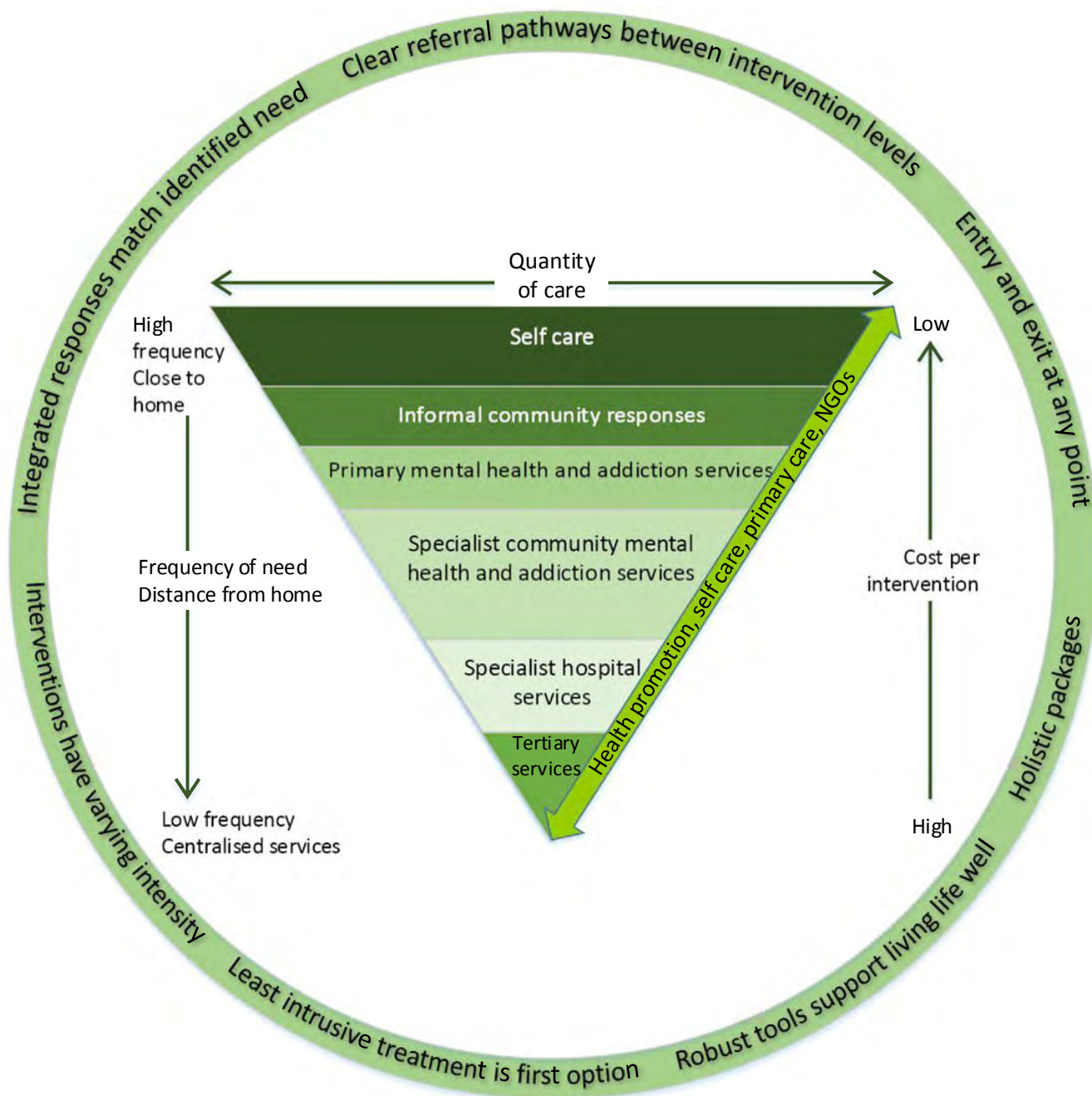
Given the inequity of access across the sub-region for Māori, Pacific peoples and child and youth, overstretched specialist resources, and the large unmet demand in the inpatient units and community, we need to move towards a consistent, coordinated, and integrated model in responding to MHA care. The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

Our model of care will guide us so that people experiencing mental distress and/or substance-use harm, as well as their families/whānau, will be able to access care appropriate to their needs when they require it. Health professionals will recognise when they need to intervene and be able to offer a broader range of MHA responses in a broader range of settings. It means intervening in the least intensive way, such as through self-help and e-therapies, as well as across primary and secondary health, NGO, and specialist services. Knowing where and how people in mental distress and/or experiencing substance-use harm and their families/whānau can access the right support will mean implementing a transparent staged care⁷ approach. This will involve health professionals working at the top of their scope, a greater role for primary care, and people receiving most of their care close to home from health specialist and other services.

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

⁷ Staged care must span primary health, NGO, community, and specialist services and create opportunities for collaboration with other organisations, such as in the education, justice, and social sectors.

Figure 28: Staged-care approach adapted from *Blueprint II*



Strategic directions

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

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

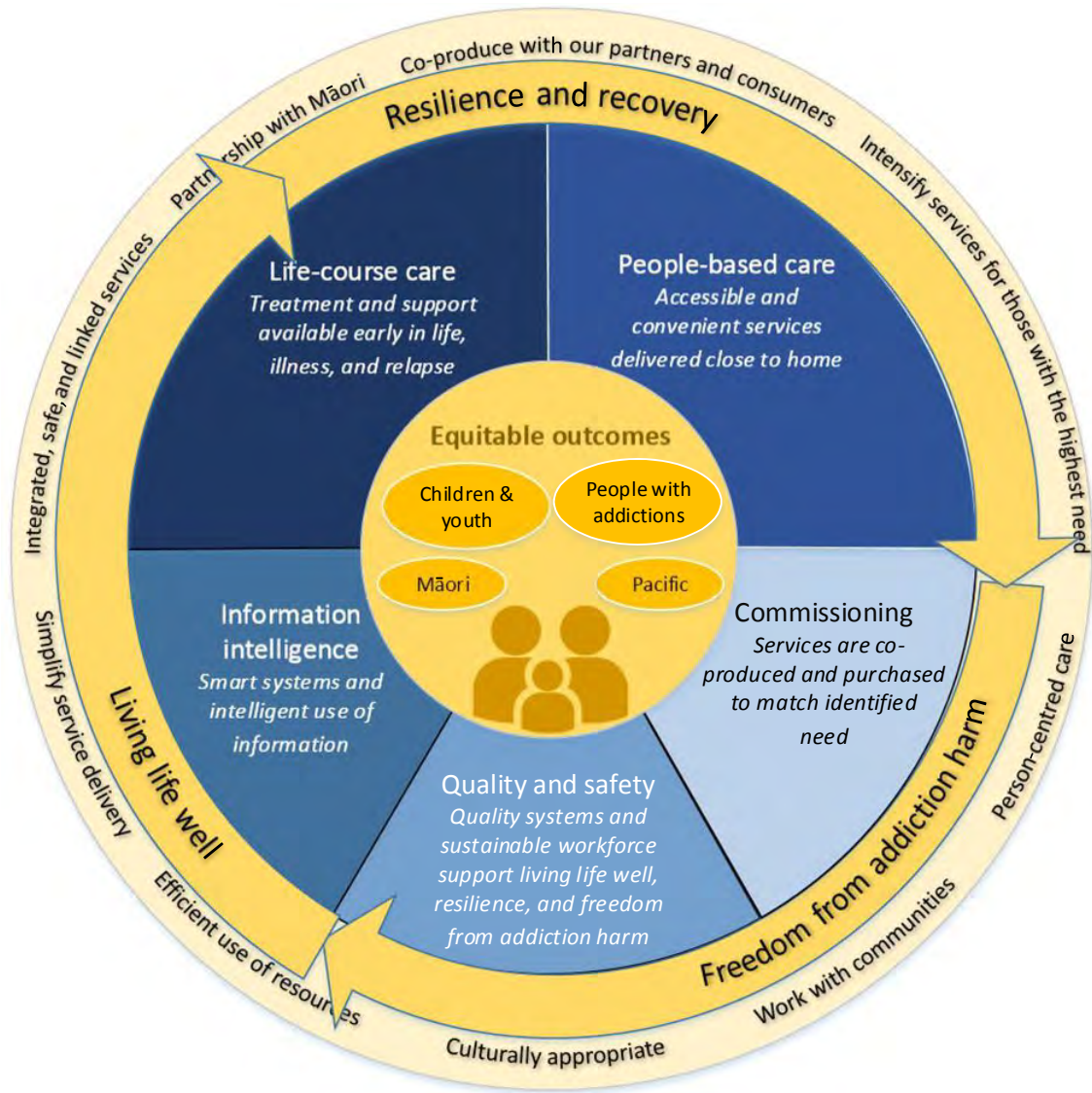
- use the principles of integrated and linked services
- advance our Treaty relationships by working in partnership with Māori
- reduce inequities in access to services, quality of care and health outcomes for Māori
- co-design⁸ with our partners and consumers
- intensify services for those with the highest needs
- simplify service delivery
- build on efficient use of resources
- develop culturally appropriate services, working with communities
- focus on person-centred care.
- set specific targets for outcomes, including:
 - a reduction in compulsory treatment orders
 - a target of zero seclusion
 - a reduction in suicides

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

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

⁸ This strategy's definition of co-design aligns with HQSC's definition: "an approach to design attempting to actively involve all stakeholders (e.g. employees, partners, customers, citizens, end users) in the design process to help ensure the result meets their needs and is usable. Often also called Participatory design." Accessed via www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/Dr_Lynne_Maher_-_Co-designing_Health_and_Care_Services_May_2017.pdf

Figure 29: Strategies for integrated, people-centred care



Life-course care

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



What does this look like?

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

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

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

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

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

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

- easy access to self-management tools
- evidence-based interventions to support maternal mental health
- e-therapies, brief interventions in general practice
- kaupapa Māori models of care
- kaupapa Māori cultural specialists and practitioners
- primary health care responses
- talking therapies

- early and timely entry to specialist services.

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

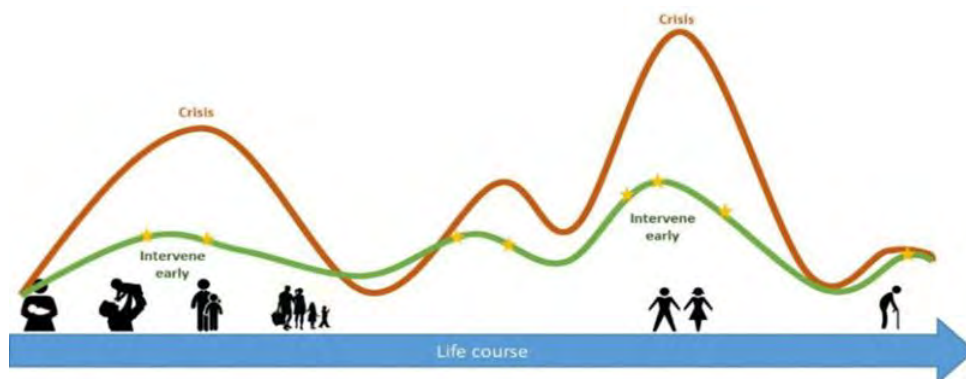
Embedding mental health and behavioural health professionals into primary health care services provides benefits beyond the immediate aim of providing timely support to people with mental distress, illness, and substance-use harm. For example, interdisciplinary teams should address the range of factors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

What will we do?

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

Why should we do this?

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

Figure 30: Proposed intervention time-line

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

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

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

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

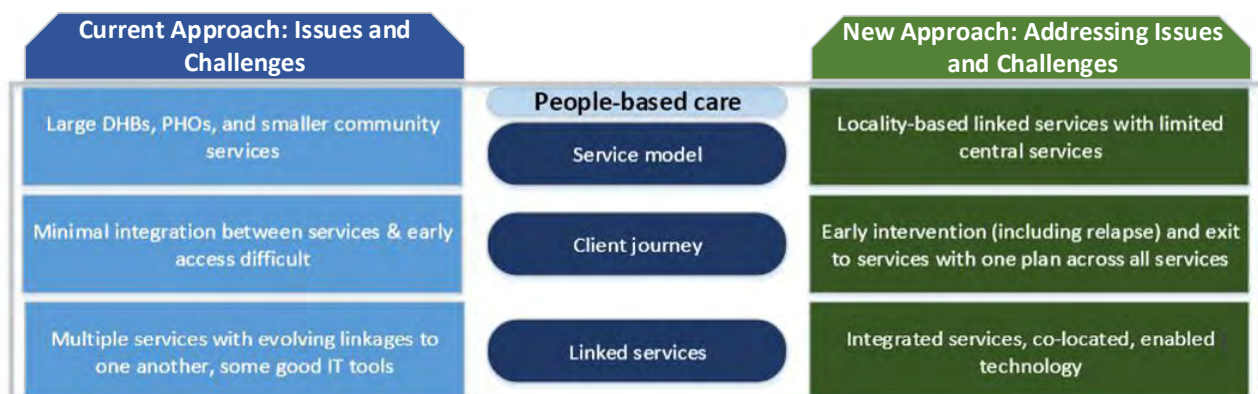
Untreated mental illness contributes to a significant and tragic burden of suicide for young people, particularly young men. Mental illness remains the biggest risk factor for suicide. In 2009, over three-quarters (76.6 percent) of suicides in New Zealand were males, making suicide the tenth leading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

In 2025, we expect to see...

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

People-based care

Accessible and convenient services delivered close to home



What does this mean?

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

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

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

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

Currently, for many people with high and complex needs, the only solution is specialist mental health care in inpatient settings, followed by specialist community care. For people experiencing substance-use harm, there are both residential and in-community treatment options, however, these can be difficult to access, with long waiting lists. We need to create additional capacity for people to access treatment in

the community and, alongside this, we need to assist communities to accommodate people without fear and stigma. By working with communities to co-design new programmes, we can inform the wider community about the continuum on which mental distress, substance-use harm, and substance-use disorder sit and how that impacts people's lives in different ways.

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

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

What will we do?

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

Why should we do this?

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

Person-centred care does not mean giving people whatever they want or just providing information; it means putting people and their families/whānau at the centre of everything we do. When decisions are made, we see consumer and their families/whānau as experts, working alongside professionals to get the best outcome. Person-centred care considers people's desires, values, family situations, social circumstances, and lifestyles. It means we see the person as an individual and work together to develop appropriate solutions. We are compassionate, think about things from the point of view of the person and their family and whānau, and are respectful. This might be shown through sharing decisions with

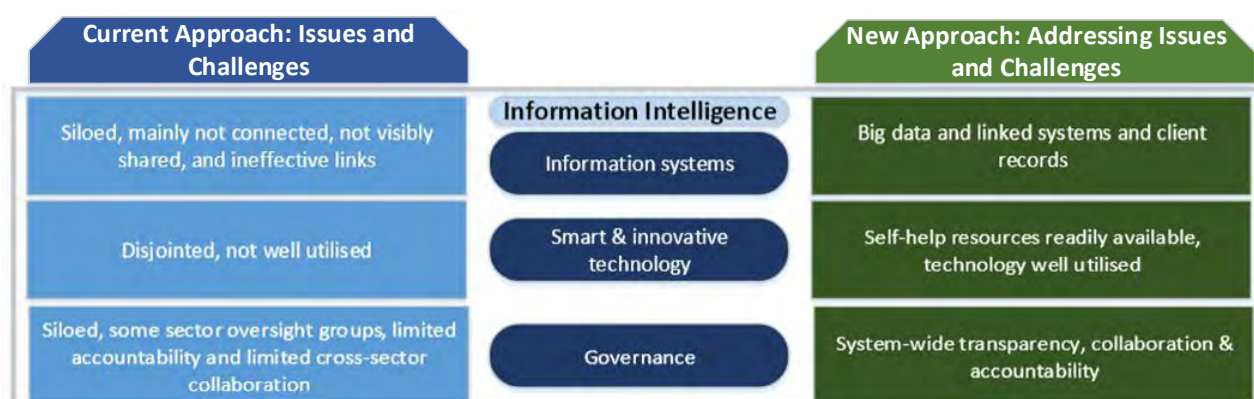
the person and their family and whānau and helping people manage their health. Person-centred care isn't just about what we do, it is also about the way professionals and consumers think about health care and their relationships across the whole of their life course and between services, sectors, and communities (HIN, 2016).

In 2025, we expect to see...

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

Information intelligence

Smart systems and intelligent use of information



What does this mean?

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

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

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

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

information about the health of communities, patterns within those communities, and changes over time.

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

What will we do?

- 1: Develop and implement **system-wide governance** with quality framework and monitoring, including shared dashboards.
- 2: Implement **integrated data sets** to support system-wide governance, monitoring, and service commissioning.
- 3: Utilise **smart technology** and **social media** (maximise the use of digital technology to improve productivity, reducing the system costs incurred in managing access, waiting lists, and failure demand).
- 4: Implement **linked care records** across services.

Why should we do this?

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

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

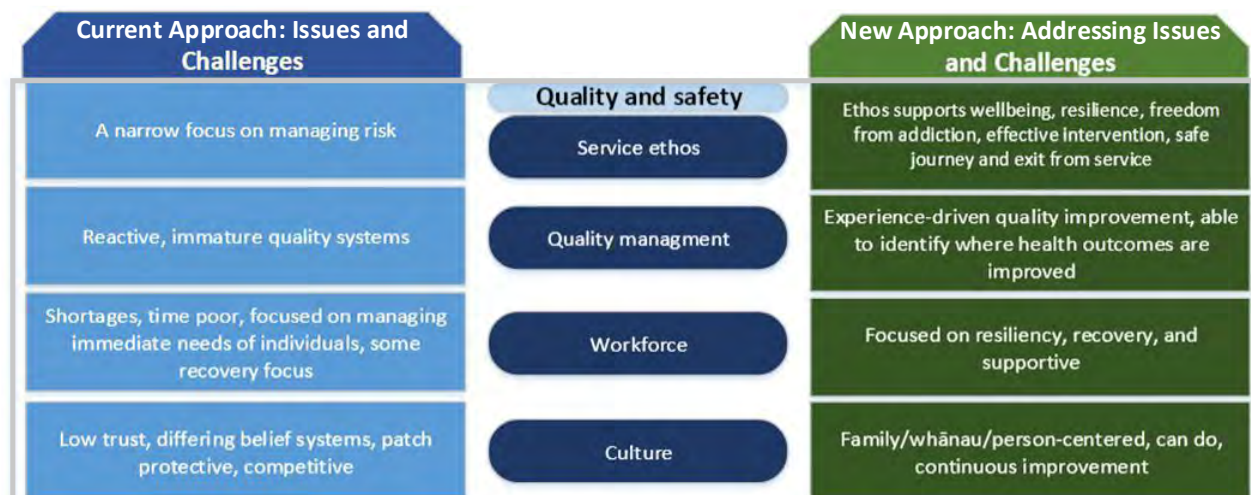
Better information on MHA needs and on the effectiveness of interventions will lead to more effective commissioning of services to improve health and care.

In 2025, we expect to see...

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

Quality and safety

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



What does this mean?

Transformational improvements in MHA will require new, less medicalised models focused on working with communities, reducing the pressures on acute care and having a workforce aligned with the new models of care and ways of working. Our quality systems must draw more on utilising experience and quality systems to drive quality improvement. The organisational cultures must move from competitive patch protection to person-centred solutions with a can-do attitude focused on continuous improvement. To address inequities, we must link quality with equity, and address the six steps as recommended in *A Roadmap to Reduce Racial and Ethnic Disparities in Health Care* (Clarke, et al., 2014):

1. Link quality and equity
2. Create a culture of equity
3. Diagnose the disparity
4. Design the intervention
5. Secure buy-in
6. Implement and sustain change

We want a workforce that has empathy and compassion.

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

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

This involves changing the discourse in the MHA workforce, moving beyond risk management to a focus on the general health and wellbeing of consumers, encouraging safe and effective earlier intervention,

supporting freedom from addiction harm, and facilitating recovery and exit from specialist services. This means:

- building a culture and system for continuous improvement and learning
- co-design and co-production driving a system-wide quality culture
- workforce development, particularly for the health care practitioners who are best placed to deliver talking therapies to our population
- all frontline staff receiving appropriate training in MHA, regardless of the setting in which they work. Training should equip staff to recognise and manage common mental health problems at different stages in the life course and to understand the psychological components of physical illness (Naylor, Taggart, & Charles, 2017)
- workforce training that better prepares and educates our staff so they can learn how to work effectively with children and families/whānau and use kaupapa Māori frameworks and other cultural lenses for viewing mental health and wellbeing
- relevant tertiary education providers delivering training that more closely aligns with the transformed models of care
- increasing the capability of the primary health care workforce
- making the work sufficiently rewarding, thus incentivising staff to work in primary health care and community settings (rather than remaining predominantly in secondary health care specialist services).

What will we do?

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

Why should we do this?

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

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

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

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

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

In 2025, we expect to see...

1. **Consumer and whānau voices** will drive continuous quality improvement.
2. An embedded **measurement framework** which monitors the safety of our service delivery, and the timeliness, efficiency and effectiveness of our care.
3. Services will be **family, whānau and person-centred**, with a can-do attitude, and embracing continuous improvement.
4. The focus will be on **quality systems** leading services towards proactive quality improvement.
5. The MHA sector will be a **more attractive place** for people to work.
6. The mental health workforce will be a strong Māori and Pacific peoples' health workforce.
7. People will be able to **access** the support they need regardless of where they seek support, including those services that best meet their cultural needs e.g. rongoā Māori.
8. People will be able to access **safe and excellent** services that are pro-equity and anti-racist.
9. There will be **adequate numbers** of workers available to meet demand across the continuum of need.
10. There will be a sustainable, culturally competent and skilled **workforce** focused on resiliency, strengths, and recovery.
11. The **service ethos** will support living life well, recovery, and freedom from addiction harm.

Commissioning

Services are co-designed and purchased to match identified need



What does this mean?

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

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

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

Our patterns of investment will change to support earlier intervention in the life course and when things start to go wrong. This means increasing resourcing in primary and community-based health services and support services to attend to mild to moderate needs – in many cases, using these services to intervene earlier would not only be more efficient and effective but also less intrusive in people's lives. We will also ensure that commissioning works to remove any bias that may currently exist in patterns of investment, ensuring that what we contract truly meets our populations' needs.

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

Successful locality-based work across the whole health and social care system requires several elements to come together. Strategic commissioning must focus on the needs of the wider population, as well as consumers, while taking responsibility for long-term planning and bringing accountability and contestability to place-led decision-making.

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

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

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

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

What will we do?

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

Why should we do this?

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

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

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

In 2025, we expect to see...

- 1: Our **commissioning model** will focus on living life well and freedom from addiction harm for our priority population groups, addressing inequities and improving Māori and Pacific health outcomes in doing so.
- 2: There will be more **efficient use of resources** in homes, communities, and hospitals.
- 3: **Integrated** health service responses will aim to meet the needs of people and their families and whānau.
- 4: Most people will receive their **care close to home** in community-based settings.
- 5: Commissioning will be focused on **outcomes**.
- 6: We will collaborate more with our **cross-sectoral partners**.

Investment approach

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

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

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

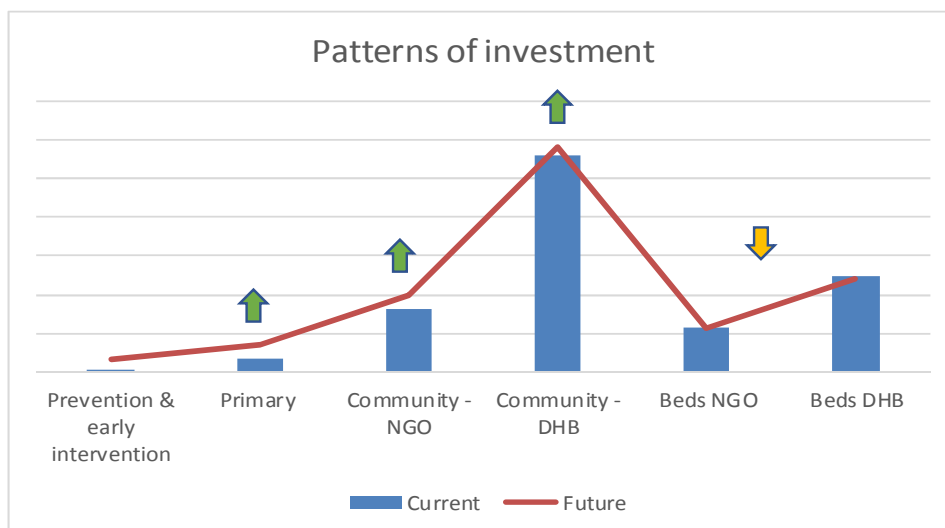
Disinvesting to reinvest remains an unsuccessful approach in funding-constrained environments with competing demands. We will invest in the areas of greatest need, with wellbeing and freedom from addiction harm being our priority areas. Alongside this, we will continue our current approach of utilising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

Principles for investment

The following principles should guide investments in this area.

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

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

Figure 31: Patterns of investment

Next steps

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

We expect He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction will influence and inform the implementation of this strategy. The recommendations from the Inquiry report have been mapped to this strategy as part of Appendix 1. The strategy is a living document which will be updated, particularly as the DHBs integrate the government's formal response to the Government Inquiry, due in March 2019.

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

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

Authentic co-design for planning and implementation is crucial for success, and we see this specifically acknowledged in He Ara Oranga (Government Inquiry into Mental Health and Addictions, 2018, p. 114). Principles for implementation will be developed and include a principle of collaboration for working with specific localities.

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

Appendices

Appendix 1: He Ara Oranga – the Report on the Government Inquiry into Mental Health and Addictions recommendations mapped to this strategy

In November 2018, the Government Inquiry into Mental Health and Addiction published He Ara Oranga – the Report on the Government Inquiry into Mental Health and Addictions (Government Inquiry into Mental Health and Addictions, 2018). It is our assessment that key areas addressed as part of He Ara Oranga are reflected in the 3DHBs' mental health and addictions strategy, particularly:

- Expanding access and choice: the 3DHBs' strategy recognises the urgent need to expand the spectrum of care, ensuring a wider range of mental distress is able to be addressed.
- Transforming primary care: the 3DHBs' strategy recognises a shift of substantial magnitude is required in how primary care responds to people's mental distress and mental health needs.
- Placing people at the centre: the 3DHBs' strategy has people-based care as one of its two key strategic directions, recognising that people (consumers/tangata whaiora, along with family and whānau) must be at the centre, and involved when designing and delivering services.
- Recognising the obligations under the Treaty of Waitangi to Māori as tangata whenua, including ensuring there are services available to reflect their specific needs e.g. kaupapa Māori services.
- Addressing priority populations that currently suffer from inequitable access to mental health services, including children and young people, Māori, Pacific peoples and prison populations.

The table below maps He Ara Oranga recommendations more directly to *Living Life Well*. We see the 3DHBs' strategy as highly complementary to the Inquiry recommendations, and believe the strategy's approval will enable us to move quickly to prepare the ground for the Government's formal response to the Inquiry's recommendations as they apply to our populations.

He Ara Oranga recommendations	3DHB <i>Living Life Well</i> links
Expand access and choice Expand access 1. Agree to significantly increase access to publicly funded mental health and addiction services for people with mild to moderate and moderate to severe mental health and addiction needs. 2. Set a new target for access to mental health and addiction services that covers the full spectrum of need. 3. Direct the Ministry of Health, with input from the new Mental Health and Wellbeing Commission, to report back on a new target for mental health and addiction services. 4. Agree that access to mental health and addiction services should be based on need so: - o access to all services is broad-based and prioritised according to need, as occurs with other core health services - o people with the highest needs continue to be the priority.	People-based care strategic direction: • Increasing access, creating additional capacity for people to access treatment in the community. (p35) Commissioning enabling direction: • Supporting the call to broaden what MHA services provide to include addressing need across the spectrum from mental distress through to trauma and serious mental illness and addiction. (p41)
Increase choice of services 5. Commit to increased choice by broadening the types of mental health and addiction services available. 6. Direct the Ministry of Health to urgently develop a proposal for Budget 2019 to make talk therapies, alcohol and other drug services and culturally aligned therapies much more widely available, informed by workforce modelling, the New Zealand context and approaches in other countries.	Life-course care strategic direction: • Increase the range of early intervention services and tools, including kaupapa Māori models of care, self-management, e-therapies, talking therapies, and brief interventions in general practice, with a focus on increased services for priority populations. (p33)
Facilitate co-design and implementation 7. Direct the Ministry of Health, in partnership with the new Mental Health and Wellbeing Commission (or an interim establishment body) to:	Life-course care strategic direction: • Embed consumer co-design into all aspects of service design and delivery. (p33)

He Ara Oranga recommendations	3DHB <i>Living Life Well</i> links
- o facilitate a national co-designed service transformation process with people with lived experience of mental health and addiction challenges, DHBs, primary care, NGOs, Kaupapa Māori services, Pacific health services, Whānau Ora services, other providers, advocacy and representative organisations, professional bodies, families and whānau, employers and key government agencies - o produce a cross-government investment strategy for mental health and addiction services. 8. Commit to adequately fund the national co-design and ongoing change process, including funding for the new Mental Health and Wellbeing Commission to provide backbone support for national, regional and local implementation. 9. Direct the State Services Commission to work with the Ministry of Health to establish the most appropriate mechanisms for cross-government involvement and leadership to support the national co-design process for mental health and addiction services.	Commissioning enabling direction: • Services are co-designed and purchased to match identified need. (p41)
Enablers to support expanded access and choice 10. Agree that the work to support expanded access and choice will include reviewing and establishing: - o workforce development and worker wellbeing priorities - o information, evaluation and monitoring priorities (including monitoring outcomes) - o funding rules and expectations, including DHB and primary mental health service specifications and the mental health and addiction ring fence, to align them with and support the strategic direction of transforming mental health and addiction services. 11. Agree to undertake and regularly update a comprehensive mental health and addiction survey. 12. Commit to a staged funding path to give effect to the recommendations to improve access and choice, including: - o expanding access to services for significantly more people with mild to moderate and moderate to severe mental health and addiction needs	Information intelligence enabling direction: • Data integration will inform service design and commissioning. (p38) Quality and safety enabling direction: • Develop and implement a sub-regional quality plan focused on safe and excellent services. • Develop and implement a sub-regional workforce improvement plan, including identifying gaps and growing the workforce. (p40) Commissioning enabling direction: • Develop a co-designed investment plan for each DHB that reflects investment in:

He Ara Oranga recommendations	3DHB <i>Living Life Well</i> links
- o more options for talk therapies, alcohol and other drug services and culturally aligned services - o designing and implementing improvements to create more people-centred and integrated services, with significantly increased access and choice.	d) priority populations and areas of greatest need e) early intervention c) services closer to home. (p42)
Transform primary health care 13. Note that this Inquiry fully supports the focus on primary care in the Health and Disability Sector Review, seeing it as a critical foundation for the development of mental health and addiction responses and for more accessible and affordable health services. 14. Agree that future strategies for the primary health care sector have an explicit focus on addressing mental health and addiction needs in primary and community settings, in alignment with the vision and direction set out in this Inquiry.	People-based care strategic direction: • Embed mental health and behavioural health into community based settings, for example, primary health care services, including: c. specialist mental health professionals d. long-term condition planning for those with enduring mental illness and/or addiction. (p33) • Integrate MHA skills into interdisciplinary health care teams across community health networks that work in partnership with communities and our inter-sectoral partners. • Increase community-based service delivery, including Māori for Māori services, with a locality focus and streamline delivery of high-cost secondary and complex health care services. (p36) • Closer-to-home initiatives led by Māori and Pacific providers well established in Māori and Pacific communities, and undergoing evaluation. (p37)
Strengthen the NGO sector 15. Identify a lead agency to:	<i>This recommendation is out-of-scope for the 3DHBs' strategy, however if it is enacted, its application will be supported by the strategy's people-based care strategic direction.</i>

He Ara Oranga recommendations	3DHB <i>Living Life Well</i> links
- o provide a stewardship role in relation to the development and sustainability of the NGO sector, including those NGOs and Kaupapa Māori services working in mental health and addiction - o take a lead role in improving commissioning of health and social services with NGOs.	
Enhance wellbeing, promotion and prevention Take a whole-of-government approach to wellbeing, prevention and social determinants 16. Establish a clear locus of responsibility for social wellbeing within central government to provide strategic and policy advice and to oversee and coordinate cross-government responses to social wellbeing, including: - o tackling social determinants that impact on multiple outcomes and that lead to inequities within society - o enhancing cross-government investment in prevention and resilience-building activities. 17. Direct the State Services Commission to report back with options for a locus of responsibility for social wellbeing, including: - o its form and location (a new social wellbeing agency, a unit within an existing agency or reconfiguring an existing agency) - o its functions.	<i>This recommendation is out-of-scope for the 3DHBs' strategy, however if it is enacted, its application will be supported by overall implementation of the 3DHBs' mental health and addiction strategy.</i>
Facilitate mental health promotion and prevention 18. Agree that mental health promotion and prevention will be a key area of oversight of the new Mental Health and Wellbeing Commission, including working closely with key agencies and being responsive to community innovation. 19. Direct the new Mental Health and Wellbeing Commission to develop an investment and quality assurance strategy for mental health promotion and prevention, working closely with key agencies.	Life-course care strategic direction: • Support health promotion for mental wellbeing, freedom from addiction harm, and destigmatisation of mental illness. (p33) Quality and safety enabling direction: • workforce training that better prepares and educates our staff so they can learn how to work effectively with children and families/whānau and use kaupapa Māori frameworks and other

He Ara Oranga recommendations	3DHB <i>Living Life Well</i> links
	cultural lenses for viewing mental health and wellbeing (p40)
Place people at the centre Strengthen consumer voice and experience in mental health and addiction services 20. Direct DHBs to report to the Ministry of Health on how they are including people with lived experience and consumer advisory groups in mental health and addiction governance, planning, policy and service development decisions. 21. Direct the Ministry of Health to work with people with lived experience, the Health Quality and Safety Commission and DHBs on how the consumer voice and role can be strengthened in DHBs, primary care and NGOs, including through the development of national resources, guidance and support, and accountability requirements. 22. Direct the Health and Disability Commissioner to undertake specific initiatives to promote respect for and observance of the Code of Health and Disability Services Consumers' Rights by providers, and awareness of their rights on the part of consumers, in relation to mental health and addiction services.	Life-course care strategic direction: • Embed consumer co-design into all aspects of service design and delivery. (p33)
Support families and whānau to be active participants in the care and treatment of their family member 23. Direct the Ministry of Health to lead the development and communication of consolidated and updated guidance on sharing information and partnering with families and whānau. 24. Direct the Ministry of Health to ensure the updated information-sharing and partnering guidance is integrated into: - o training across the mental health and addiction workforce - o all relevant contracts, standards, specifications, guidelines, quality improvement processes and accountability arrangements.	People-based care strategic direction: • We envisage seeing consumer and their families/whānau as experts, working alongside professionals to get the best outcome. (p36)
Support the wellbeing of families and whānau 25. Direct the Ministry of Health, working with other agencies, including the Ministry of Education, Te Puni Kōkiri and the Ministry of Social Development, to:	Commissioning enabling direction:

He Ara Oranga recommendations	3DHB <i>Living Life Well</i> links
- o lead a review of the support provided to families and whānau of people with mental health and addiction needs and where gaps exist - o report to the Government with firm proposals to fill any gaps identified in the review with supports that enhance access, affordability and options for families and whānau.	• Integrated health service responses will aim to meet the needs of people and their families and whānau. (p43)
Take strong action on alcohol and other drugs 26. Take a stricter regulatory approach to the sale and supply of alcohol, informed by the recommendations from the 2010 Law Commission review, the 2014 Ministerial Forum on Alcohol Advertising and Sponsorship and the 2014 Ministry of Justice report on alcohol pricing. 27. Replace criminal sanctions for the possession for personal use of controlled drugs with civil responses (for example, a fine, a referral to a drug awareness session run by a public health body or a referral to a drug treatment programme). 28. Support the replacement of criminal sanctions for the possession for personal use of controlled drugs with a full range of treatment and detox services. 29. Establish clear cross-sector leadership and coordination within central government for policy in relation to alcohol and other drugs.	<i>This recommendation is out-of-scope for the 3DHBs' strategy, however if it is enacted, there is no conflict with the implementation of the 3DHBs' mental health and addiction strategy.</i>
Prevent suicide 30. Urgently complete the national suicide prevention strategy and implementation plan and ensure the strategy is supported by significantly increased resources for suicide prevention and postvention. 31. Set a target of 20% reduction in suicide rates by 2030. 32. Establish a suicide prevention office to provide stronger and sustained leadership on action to prevent suicide. 33. Direct the Ministries of Justice and Health, with advice from the Health Quality and Safety Commission and in consultation with families and whānau, to review processes for investigating deaths by suicide, including the interface of the coronial process with DHB and Health and Disability Commissioner reviews.	Life-course care strategic direction: • Increase suicide prevention initiatives. (p33)
Reform the Mental Health Act	<i>This recommendation is out-of-scope for the 3DHBs' strategy, however if it is enacted, its application will be</i>

He Ara Oranga recommendations	3DHB <i>Living Life Well</i> links
34. Repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 so that it reflects a human rights–based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment. 35. Encourage mental health advocacy groups and sector leaders, people with lived experience, families and whānau, professional colleges, DHB chief executive officers, coroners, the Health and Disability Commissioner, New Zealand Police and the Health Quality and Safety Commission to engage in a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk.	<i>supported by the strategy’s people-based care strategic direction.</i>
Establish a new Mental Health and Wellbeing Commission 36. Establish an independent commission – the Mental Health and Wellbeing Commission – to provide leadership and oversight of mental health and addiction in New Zealand. 37. Establish a ministerial advisory committee as an interim commission to undertake priority work in key areas (such as the national co-designed service transformation process). 38. Direct the Mental Health and Wellbeing Commission (or interim commission) to regularly report publicly on implementation of the Government’s response to the Inquiry’s recommendations, with the first report released one year after the Government’s response.	<i>This recommendation is out-of-scope for the 3DHBs’ strategy, however if it is enacted, there is no conflict with the implementation of the 3DHBs’ mental health and addiction strategy.</i>
Wider issues and collective commitment 39. Ensure the Health and Disability Sector Review: - o assesses how any of its proposed system, structural or service commissioning changes will improve both mental health and addiction services and mental health and wellbeing - o considers the possible establishment of a Māori health ministry or commission. 40. Establish a cross-party working group on mental health and wellbeing in the House of Representatives, supported by a secretariat, as a tangible demonstration of collective	<i>This recommendation is out-of-scope for the 3DHBs’ strategy, however if it is enacted, there is no conflict with the implementation of the 3DHBs’ mental health and addiction strategy.</i>

He Ara Oranga recommendations	3DHB <i>Living Life Well</i> links
and enduring political commitment to improved mental health and wellbeing in New Zealand.	

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Appendix 3: Other plans informing this strategy

New Zealand Health Strategy

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

- 1: Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi
- 2: The best health and wellbeing possible for all New Zealanders throughout their lives
- 3: An improvement in health status of those currently disadvantaged
- 4: Collaborative health promotion, rehabilitation, and disease and injury prevention by all sectors
- 5: Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
- 6: A high-performing system in which people have confidence
- 7: Active partnership with people and communities at all levels
- 8: Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing.



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

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

Figure 32: New Zealand Health Strategy framework



He Korowai Oranga

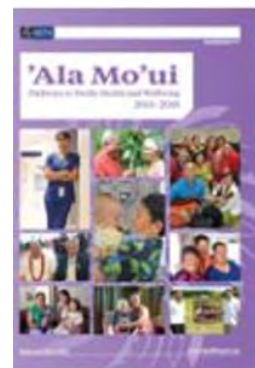
As New Zealand's Māori Health Strategy, He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. It was last updated in 2014.

- 1: It has two key directions: Māori aspirations and contributions, and Government aspirations and contributions.
- 2: It has three key threads of rangatiratanga, building on the gains, and equity.
- 3: It is strengthened by six core components:
 - Treaty of Waitangi principles
 - Quality improvement
 - Knowledge
 - Leadership
 - Planning, resourcing, and evaluation
 - Outcome/performance measures and monitoring.



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

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



Rising to the Challenge

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

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



Blueprint II

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

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

Blueprint II identifies eight priorities to achieve this vision.

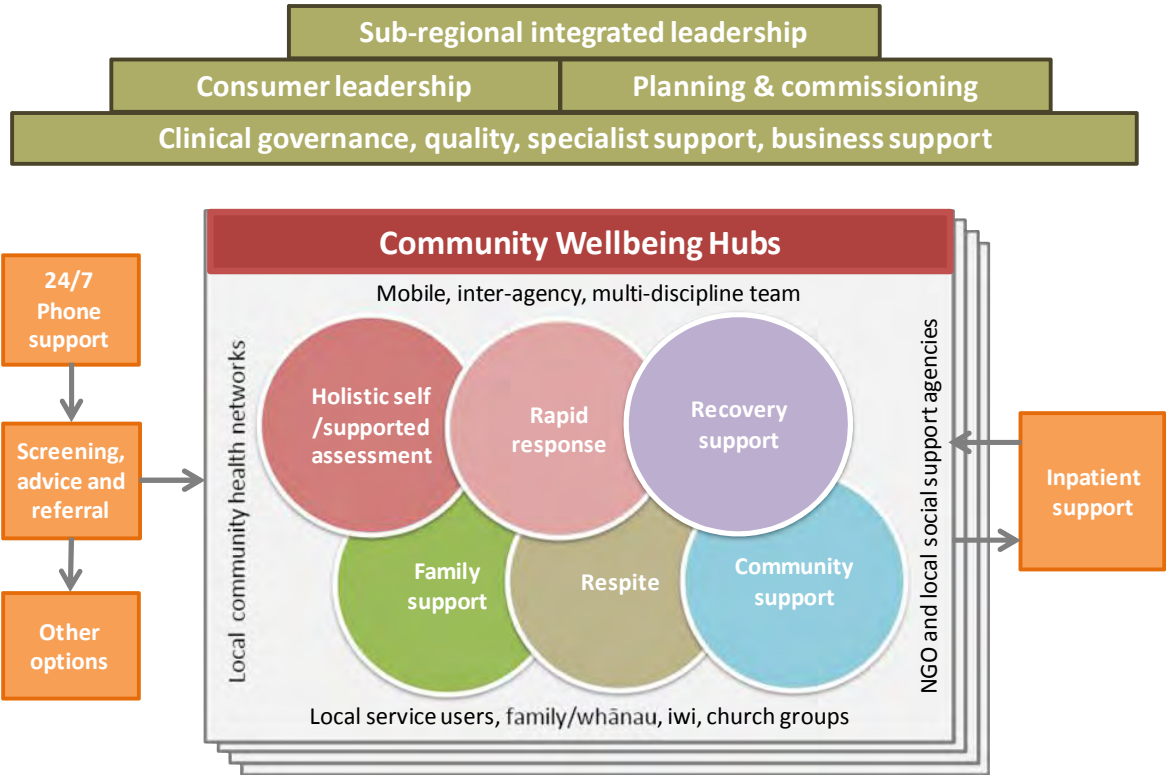
- 1: Providing a good start: Respond earlier to mental health and addiction issues in children and young people to reduce lifetime impact.
- 2: Positively influencing high-risk pathways: Provide earlier and more effective responses for youth and adults who are at risk or involved with social, justice, or forensic mental health and addiction services.
- 3: Supporting people with episodic needs: Support return to health, functioning, and independence for people with episodic mental health and addiction issues.
- 4: Supporting people with severe needs: Support return to health, functioning, and independence for people most severely affected by mental health and addiction issues.
- 5: Supporting people with complex needs: Support people with complex combinations of mental health issues, disabilities, long-term conditions, and/or dementia to achieve the best quality of life.
- 6: Promoting wellbeing and reducing stigma and discrimination: Promote mental health and wellbeing to individuals, families/whānau, and communities and reduce stigma and discrimination against individuals with mental illness and addictions.
- 7: Providing a positive experience of care: Strengthen a culture of partnership and engagement in providing a positive experience of care.
- 8: Improving system performance: Lift system performance and reduce the average cost per person treated while at the same time improving outcomes.



Appendix 4: Community hub example

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

Figure 33: Local community wellbeing hub functional model



Appendix 5: Glossary of terms

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

Addiction	The continued use of a mood-altering substance or behaviour despite adverse consequences.
AOD	Alcohol and other drug services.
Behavioural health	Sometimes used interchangeably with the term 'mental health'. It includes not only ways of promoting wellbeing by preventing or intervening in mental illness such as depression or anxiety but also has as an aim of preventing or intervening in substance abuse or other addictions.
Benchmarking	To evaluate or check something by comparing it with the performance of others or with best practices.
CAMHS	Child and adolescent mental health services.
CBT	Cognitive behavioural therapy. A form of psychotherapy in which the therapist and the client work together as a team to identify and solve problems. Therapists use the Cognitive Model to help clients overcome their difficulties by changing their thinking, behaviour, and emotional responses.
Co-design	An approach to design attempting to actively involve all stakeholders (e.g. employees, partners, customers, citizens, end users) in the design process to help ensure the result meets their needs and is usable. Often also called Participatory design.
Commissioning	A process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers.
Conduct disorder	A childhood and adolescent behavioural disorder characterised by aggressive and destructive activities that cause disruption in the child's environment.
Dementia	Loss of brain function that affects memory, thinking, language, judgement, and behaviour.

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

HWNZ	Health Workforce New Zealand. The organisation responsible for the planning and development of the health workforce, ensuring that staffing issues are aligned with planning and delivery of services and that our health workforce is fit for purpose.
Indicators	Measurable characteristics or variables that represent progress and are used to measure changes or trends over a period of time.
Integration	Coordination of services resulting in support that is seamless, smooth, and easy to navigate.
Interventions	An effort/activity to promote good health behaviour and/or prevent/improve or stabilise a medical condition.
IT	Information technology. The use of electronic devices and processes, such as computers, to create, process, store, secure, and exchange electronic data. Sometimes considered part of the broader category information and communications technology (ICT).
Kessler 10-item scale	A 10-item self-report questionnaire intended to obtain a global measure of psychological distress.
Let's Get Real	A workforce development framework that describes the essential knowledge, skills, and attitudes required to deliver effective mental health and addiction services.
Life course	All stages of life, from prenatal to old age.
Mental health and addiction ringfence	Government mechanism to ensure that funding intended for specialist mental health and addiction services is used solely for those purposes.
MHA	Mental health and addiction.

MHAIDS	Mental Health, Addictions and Intellectual Disability Services / Te Upoko me Te Karu o Te Ika. A MHA service for all ethnicities across Wellington, Porirua, Kāpiti, Hutt Valley, and the Wairarapa, as well as some central region and national services.
Ministry of Health	Government agency whose functions are to provide strategic policy advice and ministerial services to the Minister of Health, monitor DHB performance, and administer legislation and regulations.
Morbidity	The incidence of ill health in a population.
Mortality	The incidence of death in a population.
Nationwide Service Framework	A collection of definitions, processes, and guidelines that provides a nationwide, consistent approach to the funding, monitoring, and analysis of services.
New Zealand Triple Aim	An approach designed to simultaneously achieve improved quality, safety, and experience of care; improved health and equity for all populations; and best value from public health system resources.
NGO	Non-governmental organisation. Independent community and iwi/Māori organisation operating on a not-for-profit basis, which brings a value to society that is distinct from both government and the market.
OECD	Organisation for Economic Co-operation and Development. An international intergovernmental organisation, involving 36 member countries, that aims to promote policies to improve the economic and social wellbeing of people around the world.
Peer support services	Services that enable wellbeing, delivered by people who themselves have experienced mental health or addiction issues, and that are based on principles of respect, shared responsibility, and mutual agreement/choice.

Perinatal	Of or relating to the time, usually several weeks, immediately before or after birth.
PHO	Primary health organisation. Funded by DHBs to ensure the provision of essential primary health care services – mostly through general practices – to enrolled clients.
PHU	Public health unit. 12 DHB-owned units providing regional public health services focused on environmental health, communicable disease control, tobacco control, and health promotion programmes.
Prevalence	The total number of cases of a disease in a given population at a specific time.
Primary care	Essential health care that is universally accessible to people in their communities; the first level of contact with the health system.
PRIMHD	Pronounced 'primed'. The Ministry of Health collection of mental health and addiction activity and outcome data.
Psychological therapies	A group of therapies designed to improve mental health through talk and other means of communication.
Recovery	Living well in the community with natural supports.
Relapse prevention plan	A plan that identifies early relapse warning signs in clients. The plan identifies what a client can do for themselves and what the service will do to support the client. Ideally, each plan will be developed with involvement from clinicians, clients and their significant others. The plan represents an agreement and ownership between parties. Each plan will have varying degrees of complexity, depending on the client. Each client will know, and ideally have a copy of, their plan.
Resilience	The capacity of individuals to cope well under adversity.
Ringfence	See 'Mental health and addiction ringfence'.

Self-management	Actions and decisions that people take to regain, maintain, and improve their own health and wellbeing.
Serious mental health and/or addictions	People who have serious ongoing and disabling mental illness and addiction issues, who require treatment from specialist mental health, alcohol and drug, or other addiction services.
Service user	A person who uses mental health or addiction services. This term is often used interchangeably with 'consumer' and/or 'tangata whai ora'.
Shared care	Integrated health care delivery in which practitioners from more than one health service work in partnership to provide services to a client and their family and whānau.
Social inclusion	The absence of barriers to full participation within a chosen community by a person or group.
Specialist services	Those mental health and alcohol and other drug services described in the National Service Framework (see above) and funded through the mental health and addiction ringfence (see above). This includes both DHB and NGO services.
Staged care	An approach that uses the least intrusive care to meet presenting needs and enables people to access and/or move to a different level of care to suit their identified needs.
Talking therapies	Various forms of psychotherapy that emphasise the importance of the client speaking to the therapist as the main means of expressing and resolving issues.
Targets	A set of national performance measures specifically designed to improve performance and to provide a focus for action.

Trauma informed therapies	Therapies specifically designed to address the consequences of trauma in an individual and to facilitate healing. This can include physical, sexual, and psychological trauma.
Triple Aim	See 'New Zealand Triple Aim'.
Value for money	A term used to assess if an organisation has obtained the maximum benefit from the goods and services that it both acquires and provides, within the resources available to it.
Well Child	A screening, surveillance, education, and support service offered to all New Zealand children and their family and whānau from birth to 5 years of age.
Whānau	Kuia, koroua, pakeke, rangatahi, tamariki. The use of the term whānau in this document is not limited to traditional definitions but recognises the wide diversity of families represented within Māori communities. It is up to each whānau and individual to define for themselves who comprises their whānau.
Whānau Ora	In this document, the government-funded services or initiatives designed to place whānau at the centre and build on the strengths and capabilities already present within the whānau.
Whole of health	Includes all parts of the health and disability system, including physical health services, disability services, mental health and addiction services, and at all levels, including self-care, primary health care, community health care, specialist health care, and so on.
Whole of person	An approach that looks at all the needs of a person, including mental health and addiction needs, physical health, housing, employment, social supports, and so on. It can also be called a holistic approach.

Whole-of-system model of care	A model for conceptualising and organising services across the health system, including links to cross-sectoral partners, such as housing, education, and justice. It provides client pathways to and through services, including decision rules about what treatments to offer to whom, when, and by whom and a high-level model for allocating service resources at the population level.
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 Wairarapa DHB Wairarapa District Health Board Te Pori Hauora a-rohe o Wairarapa  HUTT VALLEY DHB  Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA		3DHB DISABILITY SERVICES ADVISORY COMMITTEE INFORMATION PAPER
		25 January 2019
Author	Noel Hensman, Senior System Development Leader, Mental Health and Addictions, Strategy, Improvement and Performance	
Endorsed by	Rawinia Mariner, General Manager, Mental Health and Addictions, Strategy, Improvement and Performance	
Subject	3DHB Suicide Prevention and Postvention service - UPDATE	
RECOMMENDATION It is recommended that the Committee: a) NOTES the progress and changes underway to improve the system, process and services.		

1. PURPOSE

The purpose of this paper is to provide DSAC an update on:

- a) Key changes following the 3DHBs' decision to exit the contract agreement with Presbyterian Support (Northern) who, through Lifeline (their subsidiary) provide Suicide Prevention for both Capital & Coast DHB (CCDHB) and Hutt Valley DHB (HVDHB) and both Suicide Prevention and Postvention for Wairarapa DHB (WrDHB).
- b) The Suicide Prevention and Postvention Project.

1.1 Introduction

Internationally, and within New Zealand, suicide rates continue to rise and efforts must be matched to the increasing need for effective responses. There is much we can and should do to prevent suicide.

Suicide prevention is complex, and there is no quick fix. People generally take their own lives as a result of a combination of factors. For this reason, actions to prevent suicide require multiple components working together to be effective. While the health sector plays an important role, suicide prevention needs to take a whole of system approach, and requires sustained activity across a number of related areas to make a difference. It also requires that communities take a lead in identifying their own needs and advising what will work for them.

The 3DHBs are well placed to facilitate and lead a comprehensive and inter-sectorial response to address the spectrum of suicidal behaviour.

1.1.1 Previous Board Discussions/Decisions

DSAC received a brief update in paragraph 3.9 of 'Mental Health and Addictions Improvement Programme' discussion paper presented in December 2018.

2. BACKGROUND

2.1 Suicide Prevention and Postvention Services and Project

Every suicide is a tragedy, for families and the communities of Aotearoa/New Zealand. Suicide, self-harm and distress calls to New Zealand Police for suicide risk are all indicators of distress in our community. Coronial Services (NZ) publish provisional suicide numbers quarterly. These provisional numbers are validated by the findings of coroner court proceedings. The Ministry of Health requires the validated numbers for use in its official statistics resulting in a three year delay in published statistics.

Provisional figures published by the Coronial Services show NZ has had the highest number of people ever (668) died by suicide in 2017/18. Sadly, it is also the highest rate ever at 13.67 per 100,000 of population.

The table below reflects the numbers for the past 10 years, for this region.

DHB Region	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018
Capital and Coast	32	24	26	25	28	34	30	30	36	30	40
Hutt	25	9	20	22	12	14	25	16	17	19	13
Wairarapa	6	5	11	5	7	10	8	9	6	12	8
Total	63	38	57	52	47	58	63	55	59	61	61

2.1.1 Services: The 3DHBs have agreed the current model of delivery for prevention and postvention is not working effectively. It was jointly agreed that the contract with Lifeline would not be renewed when the contract ends on 30th April 2019. Lifeline have been given formal notice about this. It has also been agreed to take back the Postvention Coordination service currently provided by Regional Public Health (RPH). This service consisted of a 0.6FTE and has historically been provided to HVDHB and CCDHB only.

2.1.2 Suicide Prevention and Postvention Project: The project aims to reduce suicides and suicidal behaviour across the 3DHBs by creating more effective responses to people who access the various “touchpoints” within and across the health system (such as Emergency Departments). The report will provide recommendations which may include reconfiguring existing services or purchasing new services where there are gaps.

3. DISCUSSION

3.1 Details

3.1.1 Services:

Over the past few years the number of suspected suicides and suicidal behaviour has not decreased in the sub-region. This concerning trend prompted the 3DHBs to reconsider our current suicide prevention and postvention strategy and the effectiveness of how these services are being delivered.

The current model of delivering the Prevention and Postvention Services separately by two different service providers has not been working as effectively as we would like. In line with the other DHBs across the country, the 3DHBs have agreed to bring these services together and centrally manage these services.

The agreed Suicide Prevention and Postvention strategic approach is being led by CCDHB, in partnership with HVDHB and WrDHB. The two Suicide Prevention and Postvention co-ordinator FTEs (currently within the Lifeline contract) will be based within the CCDHB, Mental Health and Addictions team within SIP. They

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will provide prevention and postvention service to CCDHB and HVDHB. Wairarapa DHB will be engaging their own coordinator to deliver these services locally. Both teams will work closely together to provide support and cover when required.

The SIP, Mental Health and Addictions team have successfully recruited two coordinators who will join the team on 4th of February and 1st of May 2019 respectively.

The 3DHBs have an interim plan in place which will be updated to align with the National Suicide Prevention Strategy once it is finalised and published by the Ministry of Health.

Working closely with the current service provider, a refreshed inter-agency Governance Group has been established and the first meeting was held on 23rd January 2019.

3.1.2 Suicide Prevention and Postvention Project:

A Strategic Advisory Group has been established with clinical and subject matter experts. This group has helped to shape the project scope and deliverables. These include:

- analysis of data that will be provided by the 3DHBs on deaths due to suspected suicide and self-harm data in the respective regions
- completion of a literature review of relevant international and national evidence
- a brief review of suicide prevention programmes
- contact/site visits to the 3DHB emergency departments, key mental health and addiction services including Te Haika, MHAIDS NASC, Crisis Resolution and Community Mental Health teams and NGOs
- review of the use of “Preventing Suicide Guidance for Emergency Departments 2016” in the 3DHB Emergency departments services
- review of the use of any other relevant guidelines i.e. NZ Guidelines Group: “The assessment and management of people at risk of suicide”
- broad analysis of what the key issues are and where these lie within the health system

Following a procurement process a contractor was appointed in January 2019 and is in the process of meeting with key stakeholders across the 3 DHBs.

4. NEXT STEPS

- a) **Services:** The Mental Health and Addictions team at SIP are working closely with both the current providers (Lifeline and RPH) to ensure a smooth and seamless transition of services.
- b) **Project:** The project report is expected in March.

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 Wairarapa DHB Wairarapa District Health Board Te Pori Hauora a-rohe o Wairarapa  HUTT VALLEY DHB  Capital & Coast District Health Board Ōfokō ki te ūru hauora		3DHB DISABILITY SERVICES ADVISORY COMMITTEE INFORMATION PAPER 29 January 2019
Author	David Darling, System Development Lead, Disability Strategy and Performance	
Endorsed by	Bob Francis, Chair Sub-Regional Disability Advisory Group Rachel Haggerty, Director Strategy Innovation and Performance, Capital & Coast District Health Board	
Subject	Summary and update of activities supported by the CCDHB Disability Strategy and Performance team post the SR-DAG meeting 25 January 2019.	
RECOMMENDATION It is recommended that the DSAC Committee a. NOTES the Alerts review (3.3) b. NOTES the Accessibility Project-Environments (3.6) c. NOTES the Forum update (May 3rd) (3.7) d. ENDORSES the Terms of Reference for Sub-Regional Disability Advisory Group (SRDAG) e. NOTES the Accessibility Charter (4.3)		
APPENDICES 1. TERMS OF REFERENCE		

1 PURPOSE

This paper updates you on the status of the 3DHB Disability Strategy and Performance team and provides information about the team's work programme given the substantive changes in the team with new members appointed.

This update intends to assure you that the objectives of the team remain in scope, and that the team remains committed to meeting the goals of the work programme.

2 BACKGROUND

The Disability Strategy and Performance team supports the 3DHB initiatives to help disabled people and whānau in maximising their independence, assisting in identifying and addressing inequities resulting in a fully inclusive experience for all people.

The team provides support through training, helps stakeholders address barriers to an equitable experience, while supporting the development of practical, more effective solutions for people who access disability supports.

3 STATUS OF TEAM APPOINTMENTS

General Manager - the successful candidate is yet to be confirmed. A recruitment process is underway and the team await the outcome

Sarah Murtha - Programme Coordinator

David Darling - Senior Development Lead-Disability

Educator role - this role is currently advertised

Robyn Armour- Hutt Valley DHB colleague, has been confirmed as the Disability Educator for the Hutt Valley DHB three days per week, Monday, Tuesday and Wednesday. The role will sit in the Hutt Learning and Capability team, and be linked to the 3DHB team.

4 WORK PLAN UPDATE

4.1 Alerts review

The Disability team is reviewing the 3DHB Disability Alerts as part of the HQSC co-design programme. The team is working with a small group of people with disabilities to clarify the purpose of the disability alerts, improve the alert quality and make recommendations to improve staff and patient use of the disability alerts.

The review is timely, as we understand that the quality of information capture is variable, and in some instances not fit for purpose. .

4.2 Disability information available on 3DHB websites

During 2018 discussions were had about DHB website content covering disability support and information. There is commitment in 2019 to design pages for use across the three DHBs providing disabled people and their whānau consistent messaging leading to more choices and control for people using our services.

Issues with current content include:

- The current pages are all different
- some of the content is outdated
- they do not demonstrate a collaborative approach across the DHBs.

We are collaborating with colleagues across the 3DHBs to ensure that we have a joined up approach that will ensure information is standardised as much as possible while allowing for regional nuances.

4.3 Policy Review

The Consumer Payment and Reimbursement' policy is currently being reviewed. We will be focusing on usability for all stakeholders, making sure it contains limited jargon and that all people can access and use the documents with ease. As the work progresses there will be consultation with the sector.

4.4 Accessibility Project-Environments

The DHBs have an obligation to ensure that services, buildings and exterior spaces are accessible to everyone. Statutory requirements including Human Rights address instances where people have been excluded from services or physical spaces due to demographic factors that limit their independence, such as age, ethnicity and/or disability.

It is our obligation that where inequality is seen, DHBs address and overcome these barriers. We are obligated to our communities to address the disparities that limit full participation by marginalised people. We recommend completing a review of DHB environments to identify shortcomings.

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We propose initiating a review shortly so that we receive a final report and make recommendations before the end of the 18/19 financial year. The report will identify where DHBs need to concentrate development and investment to ensure all products, buildings and exterior spaces are able to be used by all people to the greatest extent possible.

Solutions will include, but not be limited to, modified planning of environments/infrastructure, advice on fit-for-use products/equipment, and how to communicate effectively with all service users. Signage can be a significant barrier so we need to incorporate visual, tactile, and audible functionality. This will help people who are blind or partially sighted, deaf or with hearing loss, and people with learning disabilities to navigate the service environment as independently as possible.

The intent of the Environments Project is to achieve equity of access through actively considering mobility, sensory and cognitive requirements for people to move through our services independently.

4.5 Disability Forum Planning

- The Forum is planned for 3 May 2019, for approximately four and a half hours
- Registration is 9.30am with main business beginning at 10am
- End time is tentatively 2.30pm so that people can have travel needs considered
- We propose a member of the Executive such as the Executive Director, SIP, opens the event/welcomes participants
- The theme and content of the forum is being developed. Current suggestions include looking at the commonalities between 3DHB Disability Strategy/ CCDHB Health System plan/Disability Action Plan (under review) which would result in workshops looking at key actions to support equitable access
 - Equity
 - Accessibility
 - Communication/Information

The intention is for the forum to be co-designed and co-facilitated including having people who use the services to lead the workshops. The facilitation role (usually undertaken or coordinated by officials) is an essential component of a successful co-design project.

The immediate benefits of employing a co-design approach include:

- Generation of better ideas with a high degree of originality and user value
- Improved knowledge of user needs
- Immediate validation of ideas or concepts
- More efficient decision making
- Better cooperation between different people or organisations, as users are leading the discussion

The longer-term benefits include:

- Higher level of satisfaction of users
- Increased levels of support for innovative actions
- Relationships develop between users and the provider

4.6 Health Passport update

A meeting was held on 25th of January 2019, which included the chair of Sub-Regional Disability Advisory Group (SRDAG), representation by CIT, Rose Wall from the Office of the Health and Disability Commissioner and David Darling of the Disability team in CCDHB. The purpose was to discuss progress with E-Health Passport development. There was shared commitment to progressing both the soft version of the passport and the hard copy should the latter need a refresh.

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The group recommended a review be completed, with input from ICT. There is a plan for developing the Health Passport in a soft format, accessible by various parties (GPs, PHOs and hospital services) and where the disabled person has full control of the information that is collected.

Planning will occur over the remainder of this financial year, with development of an electronic format coming into fruition in the 19/20 period.

Resourcing will need to be better understood, as development costs may be significant. Strong advocates of the Health Passport have recently been appointed to senior leadership positions at the Ministry of Health and may be prepared to support development into the future.

A plan to support development of a soft version, and the management of integration of a hard version of the passport is a specialised area. It will be prudent to engage a person with skills in the area of consultation and development to get the development to the build phase. Significant information is available, however it needs to be incorporated in a final design plan to support the application through to production.

A workshop approach will be applied to ensure there will be input from those who will be using the health passport, and to test that any development is fit for purpose. This process will include SR DAG and people in the community. It was agreed that wide engagement should be undertaken to ensure the Health Passport will be useful and accessible.

5 OTHER MATTERS

5.1 SRDAG: Terms of Reference

The Terms of Reference (TOR) dated 10th of December, the last shared version for comment was discussed in-depth at the SRDAG meeting on 25th January.

Points discussed were the suggested amendments to the November version:

- A clear commitment to co-design being equals at the table and all having a say was reinforced as an essential addition to the TOR
- We need to have a living Terms of Reference.
- Discussions around SRDAG membership; the current requirement is no more than 15 members; at present we have 11 members, which is considered acceptable.

Attendees agreed to endorse the TOR with the amendments added. The TOR will be emailed to members for final confirmation by reply email.

We are seeking endorsement of the draft Terms of Reference from DSAC so that the process of finalising the TOR can be completed.

5.2 SRDAG meeting locations

The quarterly SRDAG meetings have historically been at the Silverstream retreat. This is a good venue for larger forums but presents access challenges for smaller regular meetings.

After discussion it was agreed that future SRDAG meetings will be held at the HVDHB. A regular meeting room can be booked, and accessibility issues overcome. The location of the venue is more accessible, and it can be reached by some public transport options (which is useful if new members join).

5.3 Accessibility Charter

Minister Sepuloni has last year announced a new guide on accessible information across government agencies that have signed up to the Governments Accessibility Charter. The purpose of the charter is to ensure that communication, services and information provided by state sector agencies is available to everyone.

Information will be accessible through the use of accessible language, design and alternate formats such as New Zealand Sign Language, Easy Read and Braille. The aim is to get services to be accessible within the next five years.

SRDAG and the disability team are eager to get the DHBs involved in this initiative and there is an endorsement by SRDAG for the DHBs to work toward full accessibility.

Should the DHBs agree to adopt the charter and implement plans to support the projects across all DHB managed environments and services, significant resource and time commitment will be required.

6 CONCLUSION

To ensure success we need a 3DHB wide approach for many of the identified initiatives, including an integrated approach with our colleagues at all points of the health and social continuum of care and assistance. The team is focusing on evidentially based analysis of primary issues and concerns as a first step.

Looking ahead, robust project planning involving determining and documenting a list of specific project goals, deliverables, features, functions, tasks, deadlines, and ultimately costs will be needed to ensure projects are sustainable and can be supported with confidence. To do this effectively, we first need to understand the full scope of issues at all levels as without this delivery schedules and/or costs can be adversely impacted. This will be an ongoing challenge for the team to manage.



Sub-Regional Disability Advisory Group (SRDAG)

Terms of Reference

1. CONTEXT

The Capital and Coast, Hutt Valley and Wairarapa District Health Boards are committed to improving the responsiveness of their health services to people within their resident populations who experience disability. To achieve this goal, Boards and DHB staff need advice from and to work in partnership with people with a lived experience of disability who use health and disability support services.

The commitment of these DHBs is reflected in the 3DHB Sub-Regional Disability Strategy 2017-2022 ***Enabling Partnerships: Collaboration for Effective Access to Health Services.***

It is recognised that most people with disabilities experience various barriers when accessing health services, and this can perpetuate health inequities. Examples of such inequities are evident in the poor health outcomes within Māori and Pacific communities and for people with learning disabilities.

2. PURPOSE

The **overarching mission** of SRDAG is to provide expert advice and leadership from a disability perspective, on health services policies and on the design, planning and delivery of health services for people with disabilities within the three DHBs, based on the lived experience of disability. This includes the implementation of the *3DHB Sub-Regional Disability Strategy 2017-2022*.

The three DHBs commit to working in partnership with SRDAG in a process of co-design. Co-design is the process of deliberately engaging users of a system, including both those who receive and deliver services, being led by process experts to actively understand, explore and ultimately change a system together.

This co-design process shall also embody the following principles:

- *Participation** - Co-design is a collaboration*
- *Development** – Co-design is a developmental process*
- *Ownership and power** – Co-design requires a necessary balance of rights and freedoms between participants*

The purpose of SRDAG is to:

- *Provide advice and leadership from a disability perspective, including that gained from a lived experience and from practical community engagement, and to act as co-design partners with the three DHBs on:*
 - current issues faced by people with disabilities within the health care system
 - system solutions to remove barriers, to increase access and participation, and to meet the health needs of people with disabilities in an integrated way
 - actions required to address health inequities for people with disabilities
 - actions required to ensure all people with disabilities, including receiving support services funded by the DHBs or Ministry of Health (Disability Support Services), have equitable access to all health services in all settings¹
 - the impact and effectiveness of health services for people with disabilities
- *Provide advice from a disability perspective on the priorities, the work programme, and monitoring the implementation of the 3DHB Sub-Regional Disability Strategy*
- *Provide a mechanism for the 3DHB Disability Responsiveness Team and other staff within the three DHBs to seek the input of SRDAG members and the disability community on health services' policies, and the design, planning and delivery of health services for people with disabilities. DHB staff will also engage with SRDAG members as co-design partners*
- *Inform and encourage best practice and innovation*
- *provide representation to the statutory committees for the 3DHBs i.e. Disability Support Advisory Committee (DSAC), Community Public Health Advisory Committee (CPHAC) and Health Advisory Committee (HAC) (CPHAC & HAC have amalgamated for CCDHB into Health System Committee(HSC)) “*
- *Increase the opportunities for and the engagement of people with disabilities in decision-making processes across the 3 DHBs*

¹ Currently there can be inequitable access to health and/or support services for some groups, in many settings, depending on whether they are eligible for DSS or DHB-funded support services.

- *Support the DHBs to collect information and understand the needs of the range of people with disabilities, reflecting ethnicity, age, and locality, so that design, planning and implementation results in health services which better meet needs*
- *Provide a forum and support for members from across the 3DHB localities to support the implementation of the 3DHB Sub-Regional Disability Strategy*

3. ROLE

To give effect to its purpose, SRDAG will:

- *Identify issues and work in partnership with the three DHBs to co-design policy and service recommendations, primarily to the Disability Support Advisory Committee (DSAC) and to other relevant DHB committees and local Boards*
- *Provide advice informed by a range of voices from the communities of people with disabilities, including Maori, Pacific, the Deaf, and those from localities across the 3 DHBs. This advice will also be informed by members' practical community engagement*
- *Ensure that international conventions, best-practice, and disability community expectations are recognised and included in the three DHBs strategy, policies and services.*
- *Work positively with the 3DHB Disability Responsiveness Team and other DHB staff to give effect to SRDAG's purpose*
- *Provide information on how each locality/community engages with health services*
- *Recognise the mana of tāngata whaikaha Māori and include advice and recommendations from the Māori disability community and ensure this group is included in the co-design process.*
- *Include advice from the Pacific disability advisory group from across the region*
- *Include advice from the deaf community reference group*
- *Communicate information and events to local groups and other communities of interest. Members will be available where possible to receive feedback to present to SRDAG members.*

All statements made on behalf of the group will be made by the Chair and/or an appropriate member as selected by the Chair.

The Advisory Group will **NOT**:

- Provide clinical evaluation of health services
- Be involved in DHB contracting processes.

4. ACCOUNTABILITY and REPORTING

Following each SRDAG meeting a report will be provided to the subsequent DSAC and/or relevant statutory committee meetings, and made available to the three DHBs. Consistent with SRDAG's purpose, this will provide advice and information relevant to improving the design, planning and delivery of health and disability support services to people with disabilities resident within the three DHBs. Reports will be provided by the secretariat in consultation with the Chair.

5. REVIEW

The terms of reference of SRDAG will be reviewed every three years, or as required, in conjunction with a person external to the Group.

6. MEMBERSHIP

SRDAG will have a maximum of 15 members.

80% of members will have a lived experience of disability, representing a broad range of backgrounds, experiences, knowledge and skills, including:

- *Lived experience of disability includes physical, mental health, learning disability, sensory and other impairments:* The group may also include members who are parents/family/whānau or provide personal support for a person / people with a disability.
- *Māori representation* from across the sub-region
- *Pacific representation* from across the sub-region
- *Deaf community representation* from across the sub-region
- *Locality:* Members representative of the localities across the sub-region, - including Wairarapa, Hutt Valley, Wellington, Porirua and Kāpiti
- *Disabled peoples' organisations* e.g. key Disabled Peoples' Organisations (DPOs) such as People First and DPA National

- *Age and life stage:* Members from across the life course, including young people (aged under 25).

Ideally each member should meet several of these requirements.

In attendance ex officio:

- Manager, 3DHB Disability Responsiveness Team
- Secretariat member from 3DHB Disability Responsiveness Team
- Members of 3DHB Disability Responsiveness Team as relevant to agenda items
- Chair, Disability Support Advisory Committee (on invitation).

Ability to co-opt: Others having specific knowledge, skills or experience may be invited to attend and /or be co-opted, as required.

Appointment process:

The secretariat will manage the appointment process. Vacancies will be publicly advertised. Candidates will be interviewed by a disability-led panel which will comprise two SRDAG members and one member of the 3DHB Disability Responsiveness Team. Membership will then be endorsed by DSAC.

Term of appointment:

The membership term is up to three years. Members may seek re-appointment, using the same process as applies to other applicants.

Non-attendance:

- If a member is unable to attend they must advise the secretariat prior to the meeting
- If a member misses three meetings in a row (with an apology) or two (without an apology) they may be asked to step down by the Chair.

7. CHAIR AND DEPUTY CHAIR

Chair

- *Selection:* The Chair will be selected by the Group and then endorsed by DSAC
- *Term:* Up to 3 years, aligned with appointments to DSAC.

Deputy Chair: A Deputy Chair will also be selected by the Group. The Deputy Chair may act as a proxy for the Chair, e.g. attending meetings.

8. MEMBER RESPONSIBILITIES

Members of SRDAG will:

- Assist the 3 DHBs in their aim to improve the health status of people with disabilities
- Participate in an open, honest and mature manner, respecting the views of others
- Abide by the decisions of the Group
- Maintain the confidentiality of all information gained as a Group member
- Members will be actively involved in their own community and in consultation with the wider community
 - seeking the views of their communities on relevant issues and contributing these for the consideration of the Group
 - feeding back information to their communities.
- Attend meetings prepared to contribute, including having read all papers prior to the meeting and contributing to agenda items in a timely way
- Ensure the Chair and the Manager, 3DHB Disability Responsiveness Team are informed of any activities members are undertaking which are relevant to their roles on SRDAG.

Expectations on members' time

- Total time commitment from members is approximately 4-6 hours every 3 months which includes meeting attendance, any required reading, providing information, and engaging with their networks to support a two way flow of information
- Attending workshops or additional meetings on behalf of SRDAG, or carrying out specific items of work, will be negotiated and agreed in advance, and will be in addition to the meeting-related commitment. (See **Payment.**)

9. SECRETARIAT

Secretariat support will be provided by the 3DHB Disability Responsiveness Team.

10. MEETINGS

Frequency: SRDAG will meet every 3 months (with flexibility for additional meetings), and timed to align with advice being provided to the next available meeting of DSAC.

Quorum: The quorum is a minimum of one third of group members, plus the Chair or Deputy Chair, and a secretary in attendance from the 3DHB Disability Responsiveness Team.

Agenda, minutes and meeting papers

- Two weeks before the meeting members will be asked to submit items for the agenda to the secretariat

- Minutes and agenda will be circulated in appropriate formats at least one week prior to each meeting with any related papers attached
- The final agenda will be agreed between the Chair and the manager of the 3DHB Disability Responsiveness Team
- Minutes of all meetings will be circulated to the Group and posted on the web sites of each DHB
- Provision can be made for Committee-Only time.

11. ENABLING MEMBERS' PARTICIPATION

The three DHBs are committed to ensuring that costs, including those that may be incurred as a direct result of a members' disability, are not a barrier to participation in SRDAG activities.

SRDAG members' actual and reasonable expenses incurred while on authorised SRDAG business, including SRDAG and sub-committee meetings are therefore paid or reimbursed consistent with the CCDHB policy on Consumer Committee Payment and Reimbursement of Expenses.

The reasonable needs of members to attend and participate in meetings will be met, e.g. interpreters, spoken minutes, accessible transportation. Members should advise the secretariat as early as possible of changes to their needs, to ensure full participation.

Consultation with the Disability Community shall be conducted in accordance with the Ministry of Health's *Guide to Community Engagement with People with Disabilities*.²

12. PAYMENT

Payment will be made to members consistent with the CCDHB policy on *Consumer Committee Payment and Reimbursement of Expenses*.

Carrying out specific additional items of work (e.g. reports, attending additional meetings, co-design activity), will be negotiated separately from regular meeting attendance, and must receive prior approval from the budget holder. Reimbursement will be consistent with the CCDHB policy on *Consumer Committee Payment and Reimbursement of Expenses*.

² Ministry of Health. 2017. *A Guide to Community Engagement with People with Disabilities* (2nd edn). Wellington: Ministry of Health. <https://www.health.govt.nz/publication/guide-community-engagement-people-disabilities>

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  		3DHB DISABILITY SERVICES ADVISORY COMMITTEE DECISION PAPER
		22 November 2018
Author	Fran Wilde, Health System Committee Chair	
Subject	RESOLUTION TO EXCLUDE THE PUBLIC	
RECOMMENDATION It is recommended that the Health System Committee: a) Agrees that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:		

SUBJECT	REASON	REFERENCE
Home and Community Support Services (HCSS) Request for Proposal (RFP) 2018 Evaluation conclusion and preferred providers	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	9(2)(b)(i)(j)

* Official Information Act 1982.