Wairarapa, Hutt Valley and Capital & Coast District Health Boards

Living Life Well

A strategy for mental health and addiction

2019–2025

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

HUTT VALLEY DHB

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

Contents

Contents iii

Foreword 1

Introduction 3
  About *Living Life Well* 4

Contributors to this document 6

Strategic context 7

Living Life Well 2019–2025: A summary 11

Setting the foundation 12
  Rangatiratanga 12
  Getting the basics right – addressing inequity 12
  Health needs assessment 15
  Emerging trends 16
  Priority populations 19

Determinants of health 27

Integration of mental health with other health and social services 28

Workforce capacity and capability 30
  Workforce planning 30
  Workforce practice 30

New approaches 32
  Utilising cultural partnerships in approaches 33

Whole-of-system model of care 34

Strategic directions 36
  Life-course care 38
  People-based care 41
  Information intelligence 43
  Quality and safety 45
  Commissioning 47

Investment approach 50
  Principles for investment 50
  Next steps 51

Appendices 52
  Appendix 1: *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* recommendations mapped to this strategy 52
  Appendix 2: Bibliography 60
  Appendix 3: Other plans informing this strategy 64
  Appendix 4: Community hub example 67
  Appendix 5: Glossary of terms 68

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. Our committed intention is to truly partner with Māori in the design, planning, and implementation of this strategy.

This strategy 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.

We intend to review this strategy at the end of 2019, and annually after that, to ensure it continues to meet our communities' needs.

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 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 greater Wellington region (Wairarapa, Hutt Valley, and Capital & Coast DHBs – the 3DHBs or sub-regions) 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-regions are 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 (Capital & Coast DHB), 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 MHA services with their families and whānau, the communities they live in, and the services and groups that respond to their needs. It is based on a people-centred[1] approach in which individuals, families and 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 and whānau and communities to collaborate with health practitioners, health care service providers, and cultural specialists.

---

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

Contributors to this document

This MHA 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

NGOs, including the following

Atareira, CareNZ, Earthlink Inc, Emerge Aotearoa, Mix, Oasis Network Inc, Pathways, Pact Central Region, Refugee Trauma Recovery services, The Salvation Army (including Bridge and Oasis services), Te Waka Whaiora Trust, Wellbeing Wellington

Primary health care

Compass Health, Te Awaikairangi Health Network, Kokiri Hauora Whānau Ora collective, Ora Toa Mauriora – Te Rūnanga 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 – Māori Health Strategy, ‘Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2014–2018, and the New Zealand Disability Strategy 2016–2026. The 3DHBs are also guided by the Government’s commitment to the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

This 2019 to 2025 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*: *Report of the Government Inquiry into Mental Health and Addictions*, completed in November 2018 (Government Inquiry into Mental Health and Addictions, 2018). The 40 recommendations from the report specify changes aimed at improving New Zealand’s approach to MHAs, 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, the national Māori Health Strategy (Ministry of Health, 2014b) 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

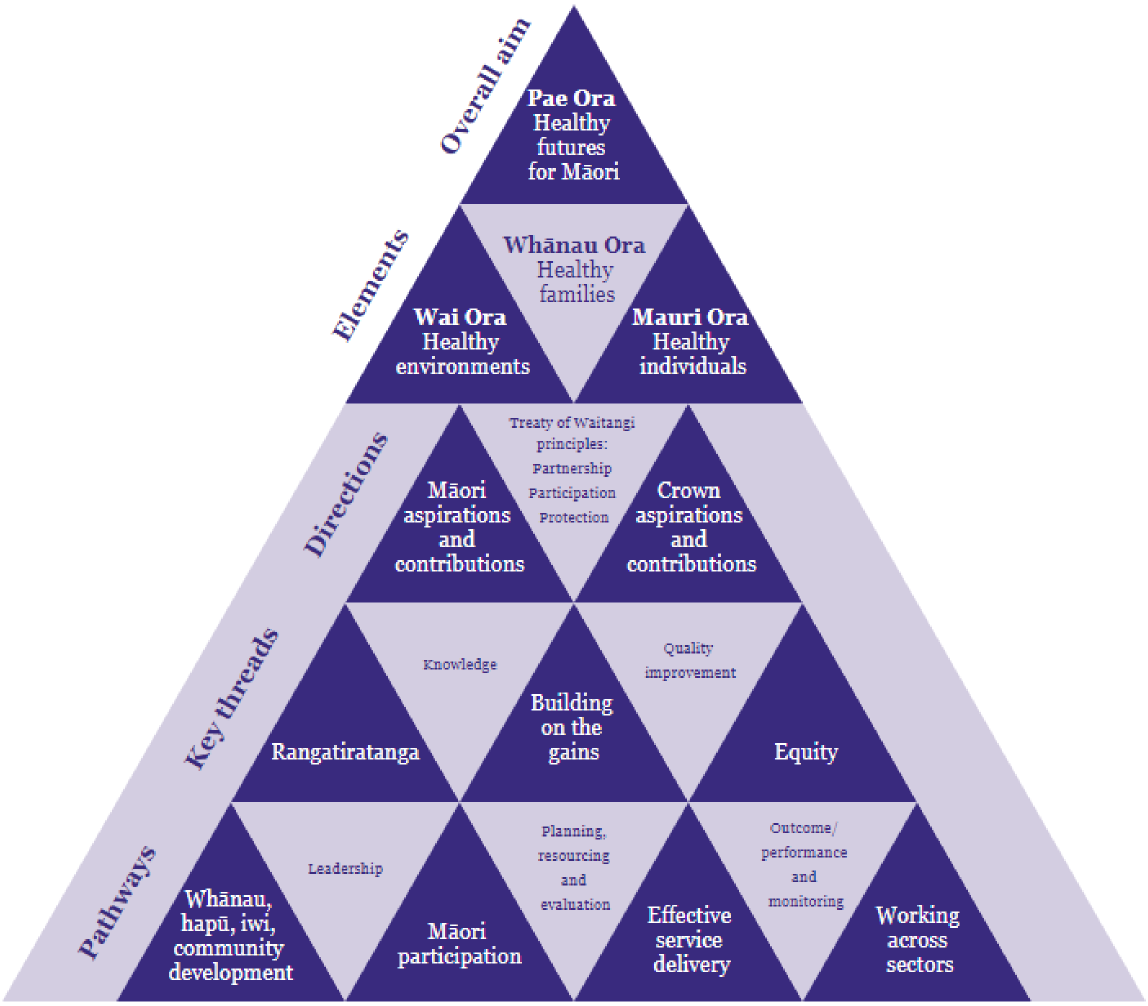


Figure 1 illustrates Māori aspirations on the left and Crown aspirations and obligations on the right. A key thread of He Korowai Oranga is rangatiratanga, enabling whānau, hapū, iwi and all Māori to exercise control over their own health and wellbeing. In alignment with that, this 3DHB strategy recognises 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 (Mental Health Commission, 2012a and b). 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, 2014a) is the current health strategy document for Pacific peoples in New Zealand. At the time of publication of this 3DHB MHA 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 Kāiga Tapu*, (Ministry of Social Development, 2012, p. 4) acknowledges that although there are aspects of concepts and principles that are shared, the origins and traditional and contemporary practices are unique to each ethnic community. Culture is reflected in the following terms: akono'ang Māori (Cook Islands), tovo vaka Viti (Fiji), aga fakaNiue (Niue), aganu'u Sāmoa (Sāmoa), 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).

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 38. 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 directions.

Figure 2: Living Life Well 2019-2025 – strategy summary

LIFE-COURSE CARE

Treatment and support available throughout life, particularly early in life and illness

In 2025, we expect to see…

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

What will we do…

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

PEOPLE-BASED CARE

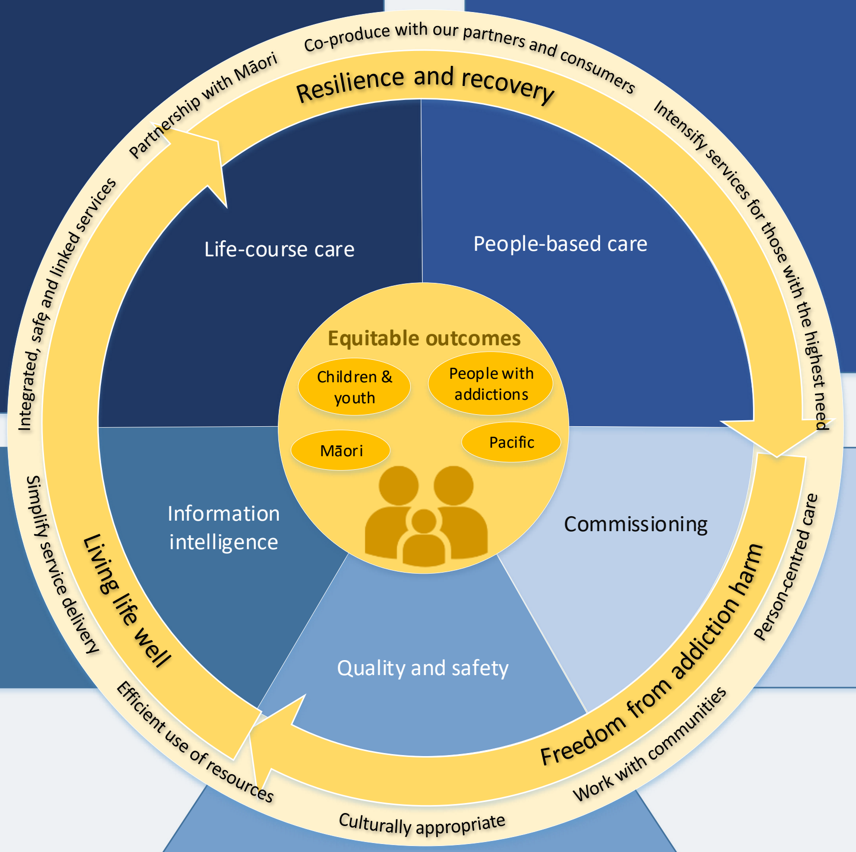
Accessible, integrated, and convenient services delivered close to home

In 2025, we expect to see…

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

What will we do…

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



INFORMATION INTELLIGENCE

Smart systems and intelligent use of information

In 2025, we expect to see…

1. **Data integration** informs service design and commissioning.
2. Data analytics **faithful to cultural world views**, enabling tailored responses.
3. Consumer **records are linked** between services.
4. **Smart technology** Smart technology is used widely to great effect.
5. **System-wide governance**, quality framework and monitoring processes with transparency of service delivery and outcomes.

What will we do…

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

COMMISSIONING

Services are designed and purchased to match identified need

In 2025, we expect to see…

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

What will we do…

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

QUALITY AND SAFETY

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

In 2025, we expect to see…

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

What will we do…

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

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, 2014b). Enabling Māori to exercise power in relation to the commissioning and provision of MHA 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, 2014b). 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 that relationship [between the government and Māori under the Treaty of Waitangi]...*
>
> - *Partnership: Working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services*
> - *Participation: Involving Māori at all level of the [health and disability] sector, in decision-making, planning, development and delivery of health and disability services*
> - *Protection: 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, 2014b, p. 2)

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-person[2] approach to their treatment and recovery.

Across the New Zealand health sector, there is general agreement to the use of the World Health Organization (WHO) 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.*

(WHO, 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, 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, 2014b).

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

In addition to Māori, these other groups also experience inequity of MHA services access and outcomes: Pacific peoples, children, and youth (HDC, 2018). The rainbow community[3] has also been identified as experiencing significant inequalities.

The significance of system deficiencies for achieving equity

Māori and Pacific peoples 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, 2014b)

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

---

[3] The term ‘rainbow community’ is an umbrella term for sex characteristic and sexuality- and gender-diverse communities, also known as ‘LGBTIQA+’.

Health and Disability Commissioner Act 1994. 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.*

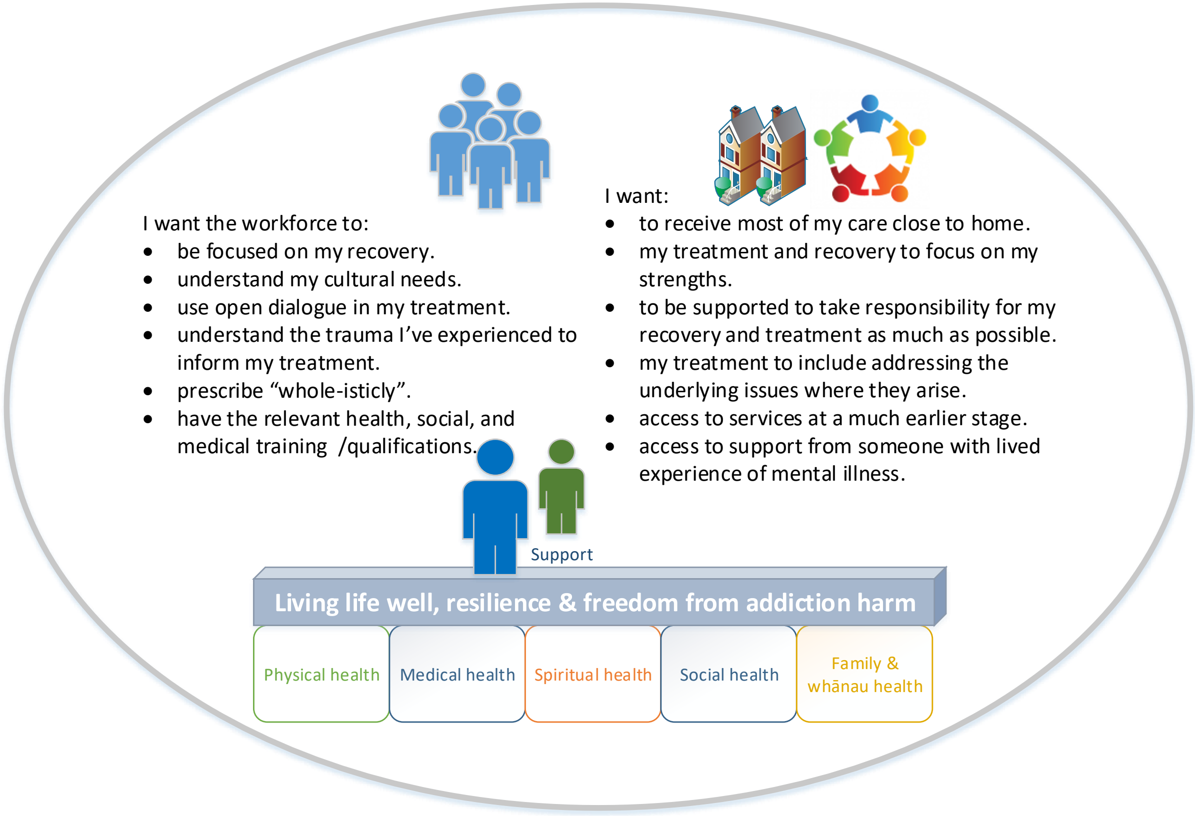
(HDC, 1996)

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



I want the workforce to:

- be focused on my recovery.
- understand my cultural needs.
- use open dialogue in my treatment.
- understand the trauma I've experienced to inform my treatment.
- prescribe "whole-isticly".
- have the relevant health, social, and medical training /qualifications.

I want:

- to receive most of my care close to home.
- my treatment and recovery to focus on my strengths.
- to be supported to take responsibility for my recovery and treatment as much as possible.
- my treatment to include addressing the underlying issues where they arise.
- access to services at a much earlier stage.
- access to support from someone with lived experience of mental illness.

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

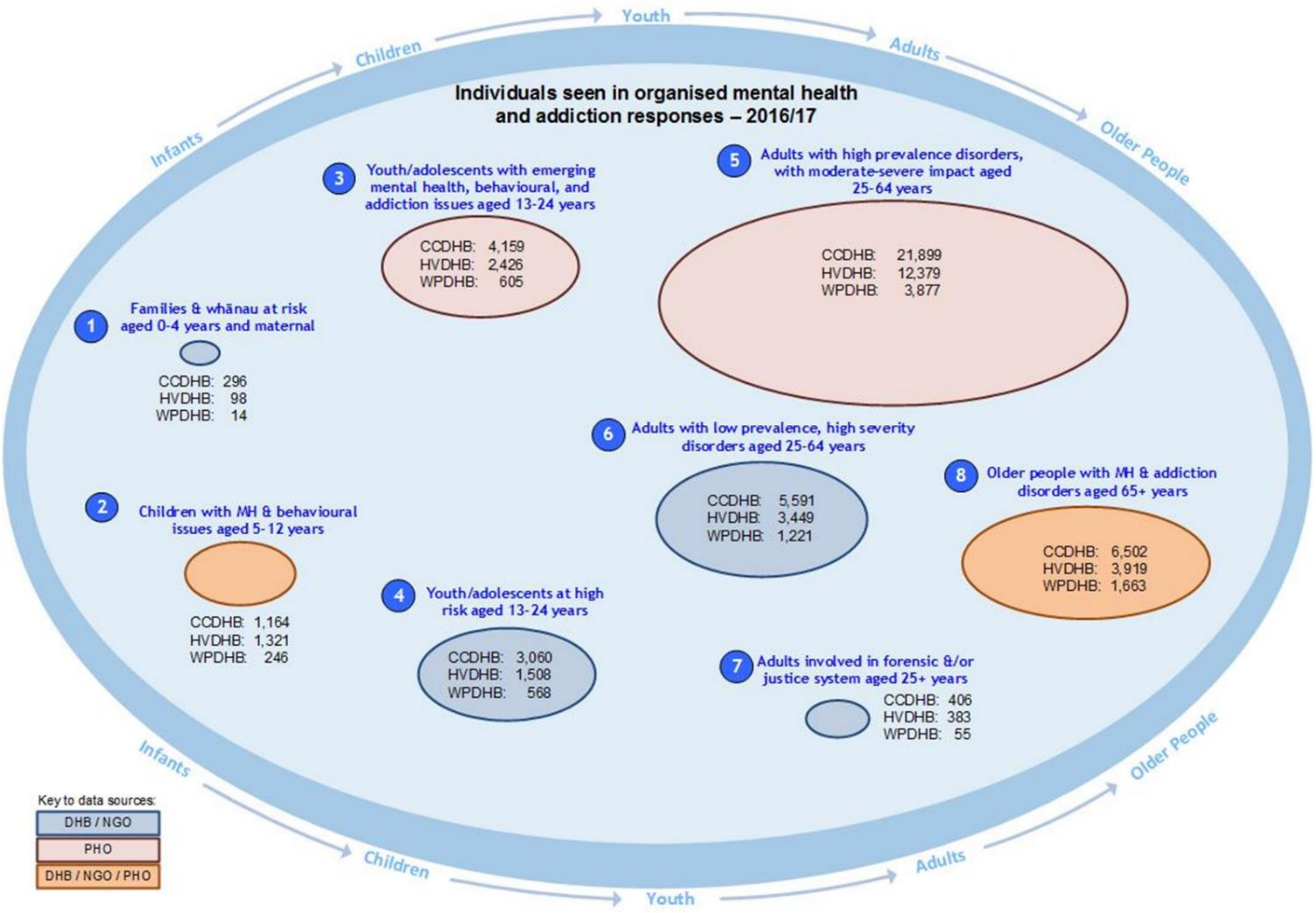
Such a holistic approach proposed by consumers asks those involved in their care to be aware of the trauma that has lead them to where they are now and to be respectful in ensuring any treatment avoids exposing the consumer to further trauma, while supporting and encouraging them to self-manage wherever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

Health needs assessment

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

Eight critical points in the development of MHA issues are identified in the *Blueprint II* life-course model (Mental Health Commission, 2012a and b). Using *Blueprint II,* we can provide a snapshot of the number of people who used primary and secondary mental health services in the sub-region during the 2016/17 year, mapped against the life-course clusters.
Figure 4 shows the number of people provided with MHA responses in 2016/17, mapped against the *Blueprint II* life course model.

Figure 4: MHA services in 2016/17, mapped against the *Blueprint II* life-course model



Emerging trends

Of all adults aged 20 years or over accessing MHA services across the 3DHBs in 2015/16, approximately 23 percent were considered to meet the Ministry of Health criteria for a long-term client.[4] 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 could 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 5 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.

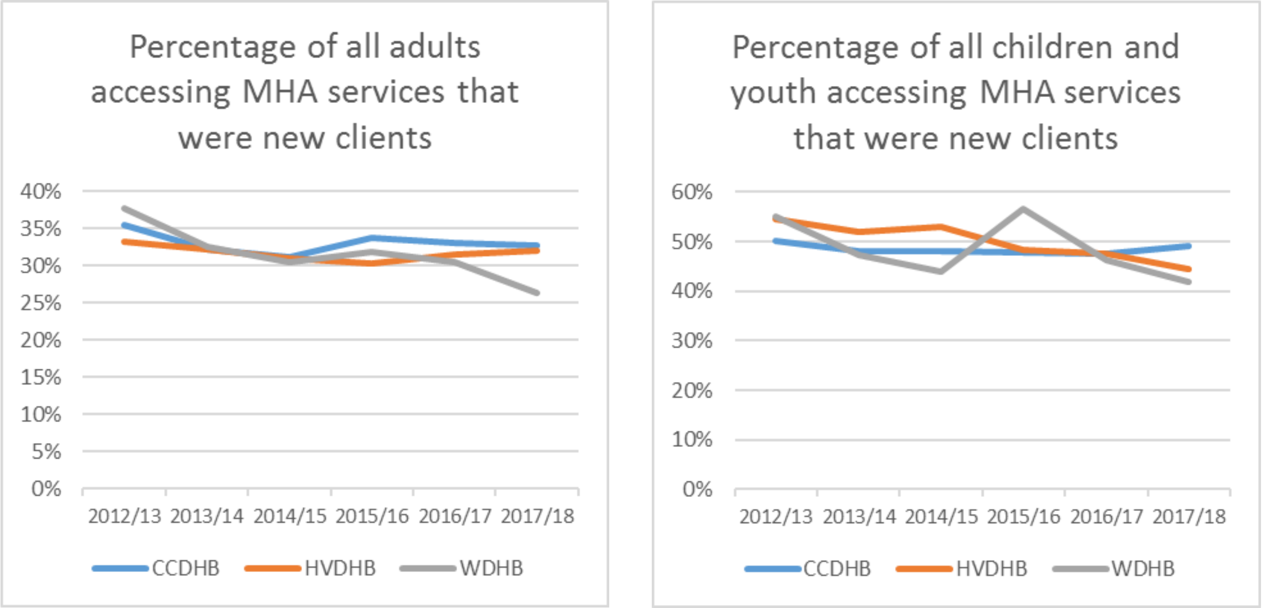
Investigations from a New Zealand longitudinal research study (Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, Poulton R., 2003) have found that of those adults now receiving intensive

---

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

mental health services, around 78 percent had received a diagnosis before 18 years of age and around 60 percent received one before the age of 15 years.

Figure 5: People accessing services for the first time[5]



The populations we serve

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

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

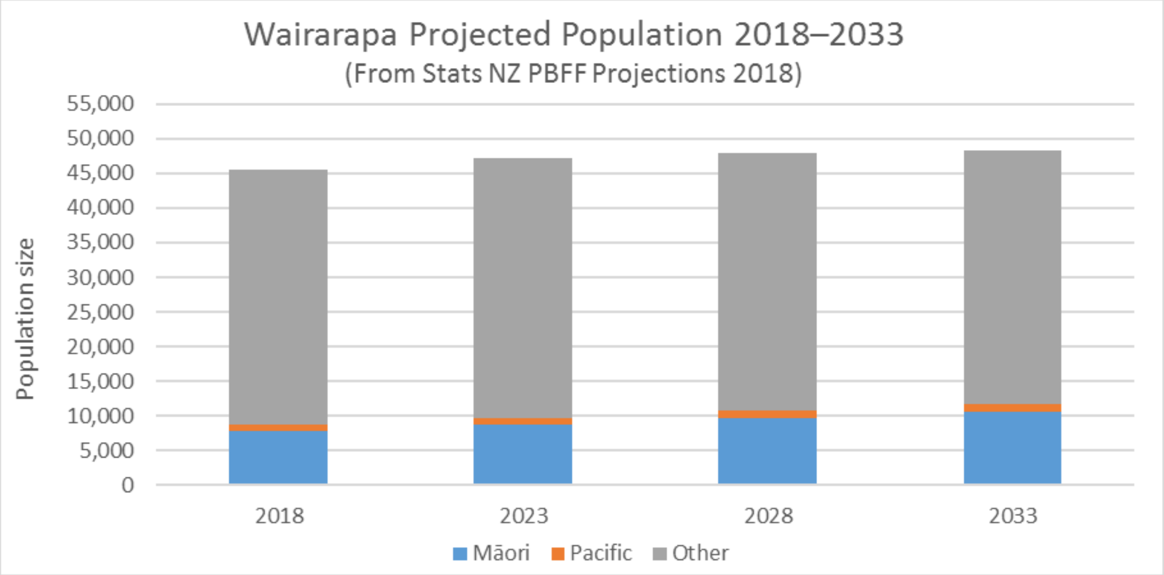
---

[5] Data taken from PRIMHD. A new client is a person who has not had any type of contact with MHA services in the previous five years in the case of adults or three years in the case of children and youths.

Wairarapa: population summary

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

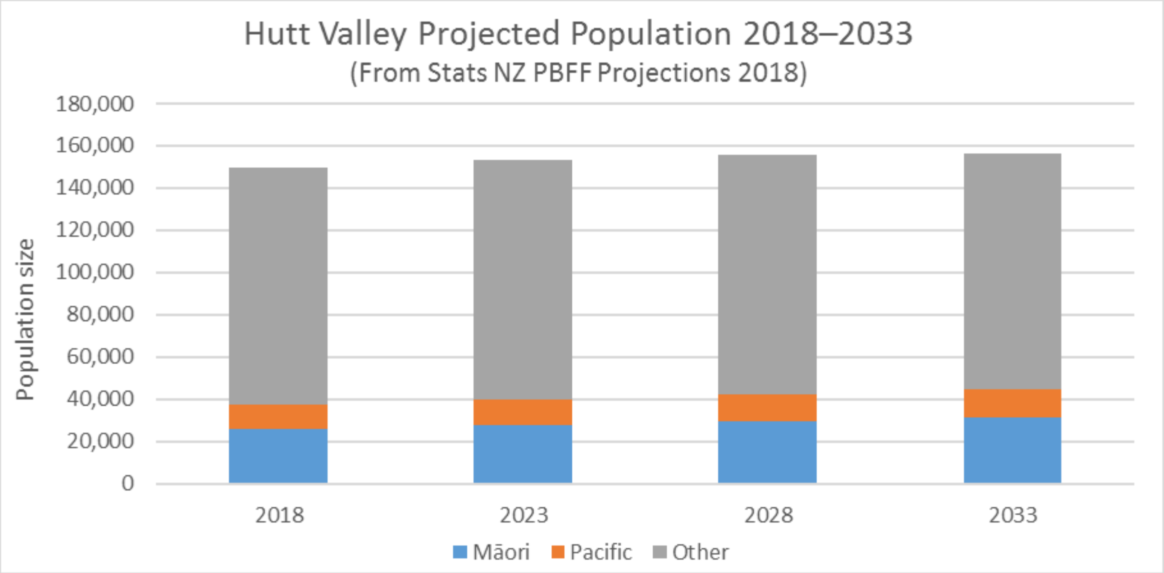
Figure 6: Wairarapa projected population (2018 to 2033)



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.

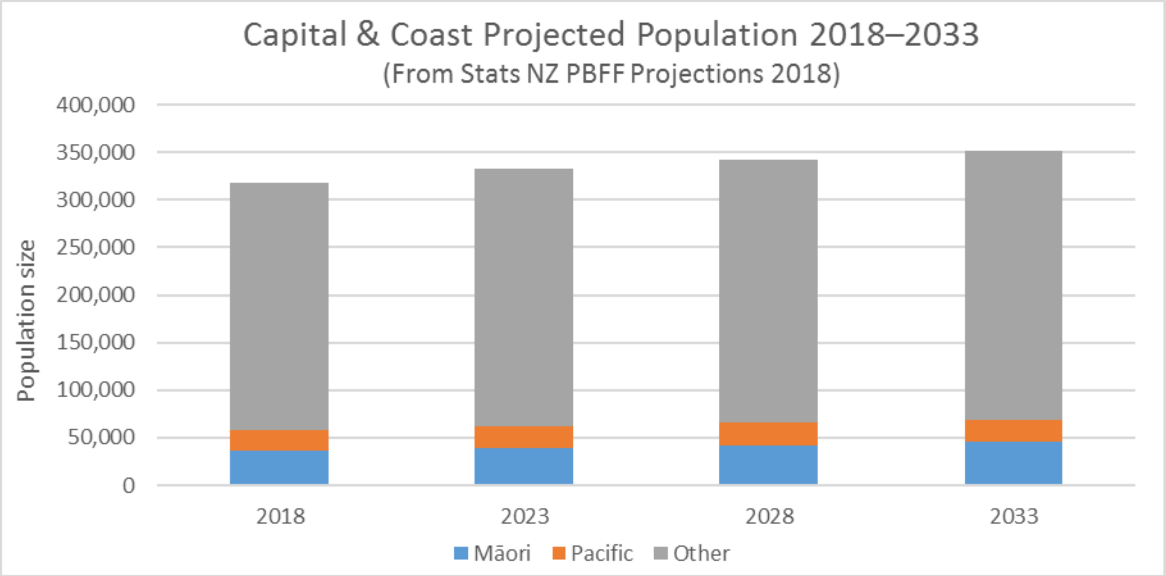
Figure 7: Hutt Valley projected population (2018 to 2033)



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 8: Capital & Coast projected population (2018 to 2033)



Priority populations

Consumers and their families and 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, Pacific peoples and 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 Office of the Health and Disability Commissioner acknowledged that it was not able to 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 these groups as well; we particularly acknowledge the rainbow community 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 percent of all MHAs service users in New Zealand (Ministry of Health, 2018). Sixteen percent of the total New Zealand population is Māori (Stats NZ, 2017). The overall population rate for access to MHA services in New Zealand is 3.6 percent, with the rate for Māori being almost double that at 6.3 percent (Ministry of Health, 2018).

Pacific peoples

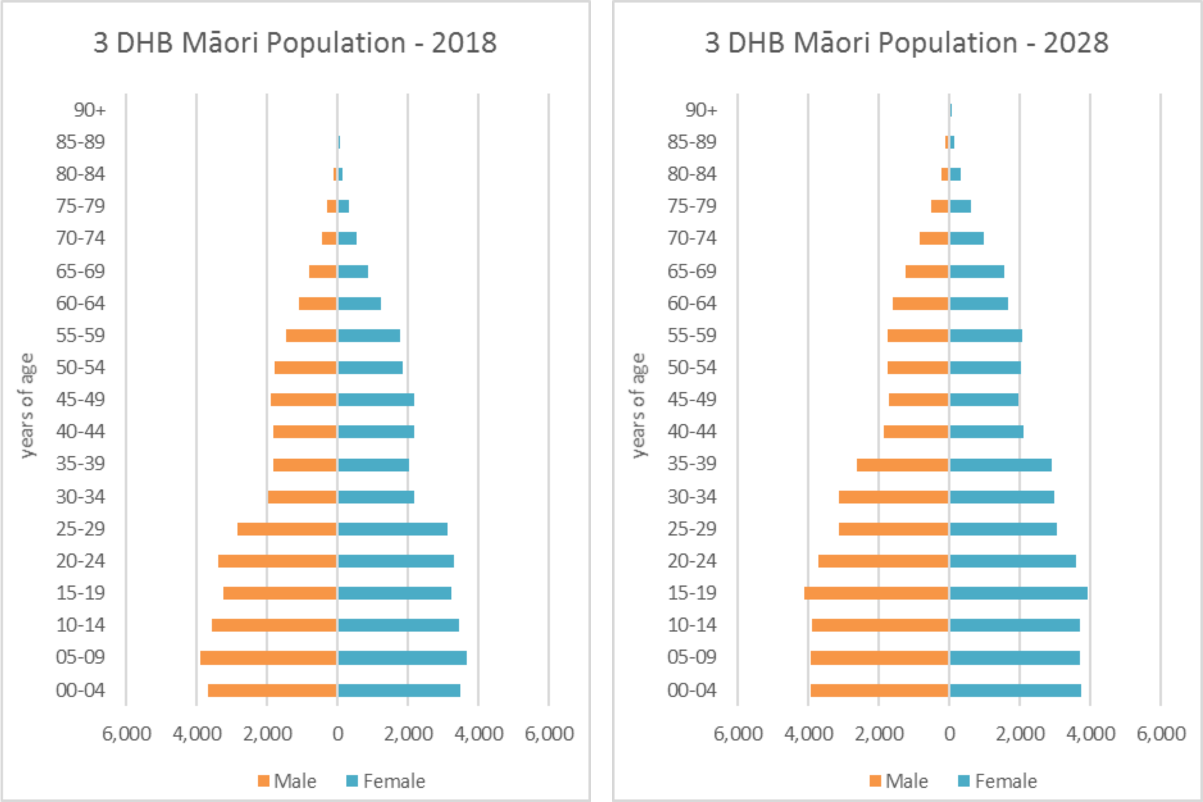
Pacific peoples also experience mental illness and/or addiction at higher rates than others, with 25 percent experiencing a disorder within the previous 12 months (compared with 21 percent overall). The prevalence of medium to high levels of psychological distress reported over the previous four weeks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

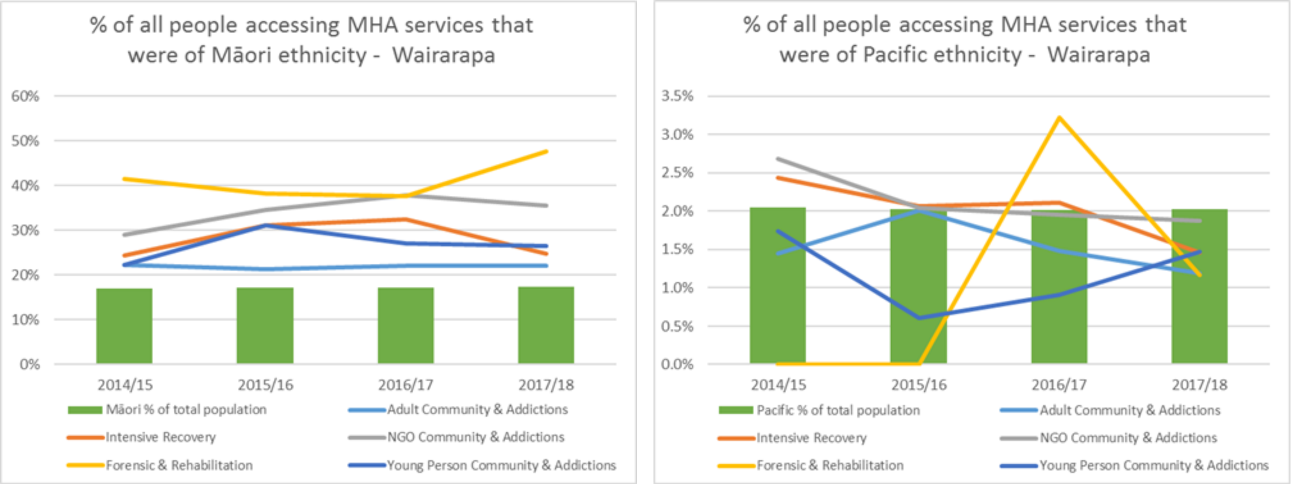
The 3DHB Māori and Pacific populations are younger than the populations for other ethnicity groups, and our Asian population is growing.

Figures 9 and 10: 3DHB Māori population 2018 and 2028 (taken from Stats NZ PBFF projections)

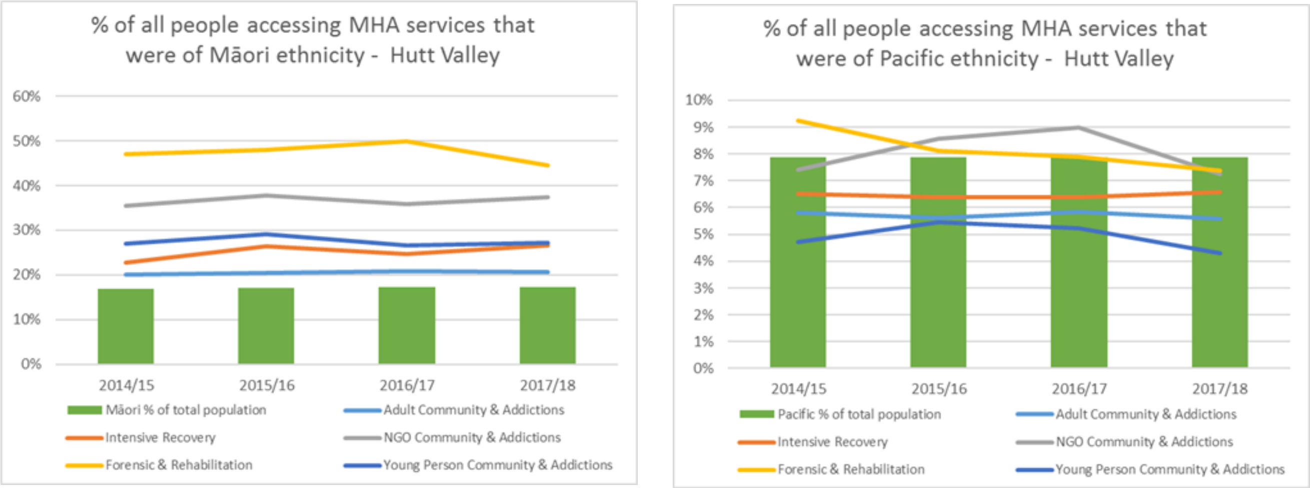


The following graphs illustrate the access rates for Māori and Pacific into 3DHB MHA services (both provider arm services; Mental Health, Addictions and Intellectual Disability Services / Te Upoko me Te Karu o Te Ika – MHAIDS; and non-governmental organisations – NGOs), over the last four years. Clearly the Māori population is 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.

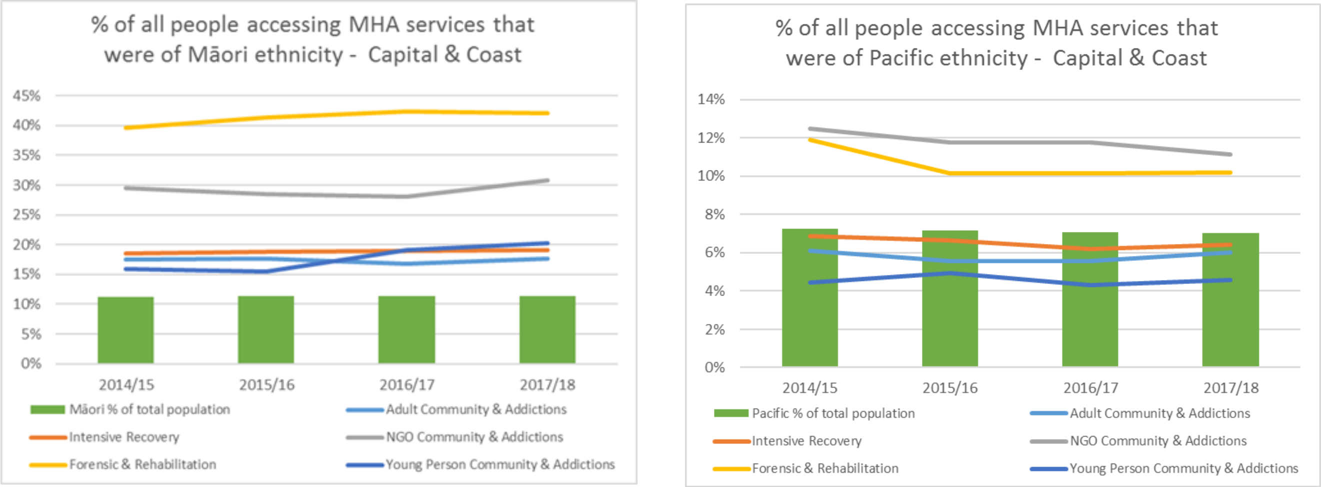
Figures 11 and 12: WDHB, percentage of consumers of Māori and Pacific ethnicity accessing MHA services (taken from PRIMHD)



Figures 13 and 14: HVDHB, percentage of consumers of Māori and Pacific ethnicity accessing MHA services



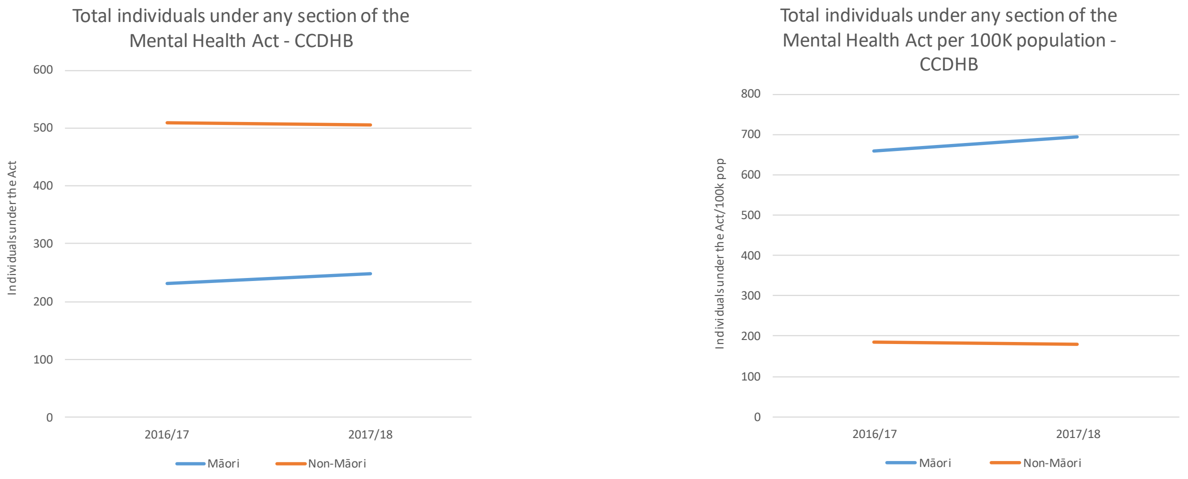
Figures 15 and 16: CCDHB, percentage of consumers of Māori and Pacific ethnicity accessing MHA services



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 (Compulsory Assessment and Treatment) Act 1992 (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 percent since 2016/17; the rate for non-Māori fell slightly over the same period.

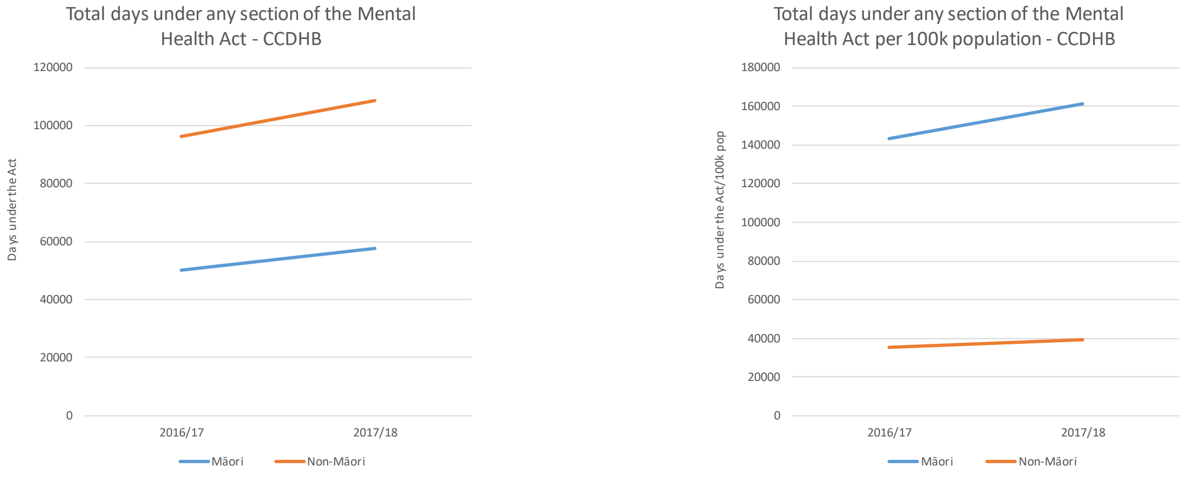
Figures 17 and 18: Total individuals under any section of the Mental Health Act and per 100k population (CCDHB only)



*From MHAIDS legal status data

The total number of days that Māori spent under a section of the Mental Health Act increased by 14.6 percent between 2016/17 and 2017/18. The rate of days under the Mental Health Act per 100,000 population was four times higher for Māori in 2017/18.

Figures 19 and 20: 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 with non-Māori

Because of the small number of suicides in each DHB, it is helpful to look at national data. Tables 1 and 2 below uses data from the 2015 Ministry of Health 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 suicides per total deaths is more than double for Māori compared with non-Māori, and suicide is the leading cause of death for Māori and non-Māori aged 15 to 24 years.

Table 1: 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%	712,200	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%	3,887,100	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

Table 2: Suicide rates for 15–24 years, with a Māori/non-Māori ethnicity split

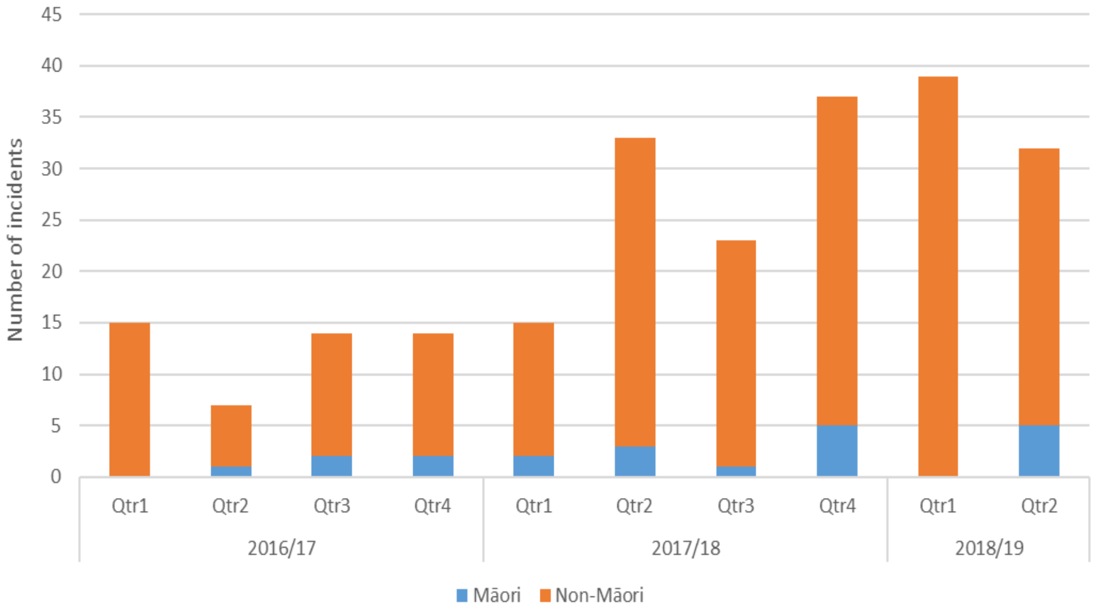
15–24 years						
		Total Deaths in NZ	Total Suicides	% suicides of total deaths	NZ Population	Suicides per 100k population
Māori	*Male:*	64	19	29.7%	66,890	28.4
	Female:	40	23	57.5%	65,190	35.3
	Total:	104	42	40.4%	132,080	31.8
Non-Māori	*Male:*	173	50	28.9%	272,430	18.4
	Female:	62	19	30.6%	252,050	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 percent) than for non-Māori, non-Pacific people (4.1 percent). 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 two and a half years, 9.2 percent of all restraint incidents reported by MHAIDS in CCDHB involved a Māori service user. This data has been sourced from CCDHB reportable events data (SQUARE).

Figure 21: 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).

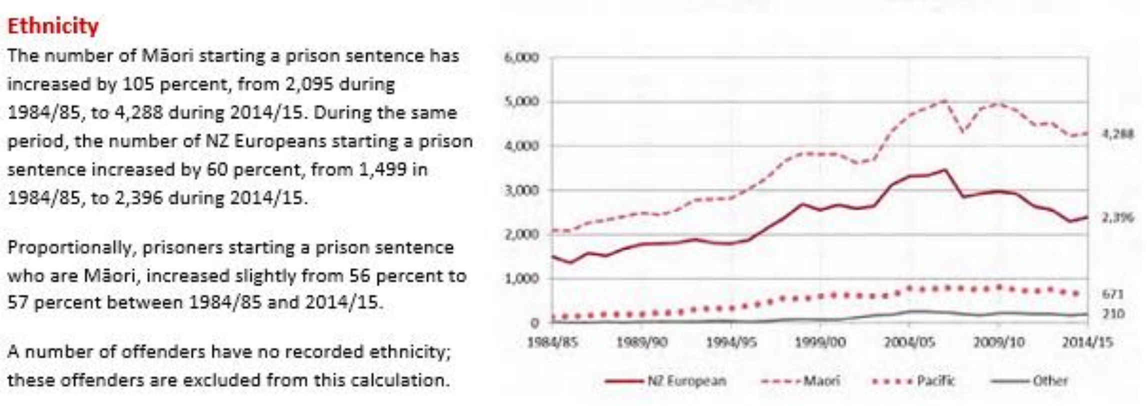
Coupled with this, there is a much larger group of people who are not necessarily dependent (or severely addicted) but who are experiencing harm related to their problematic use of substances. For example, one in five (19 percent) New Zealanders aged 15 years or more who drank alcohol in the past year has a potentially hazardous drinking pattern that could result in significant harm to them and their families and 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 22 and 23: Department of Corrections, Trends in offender population, 2014 to 2015

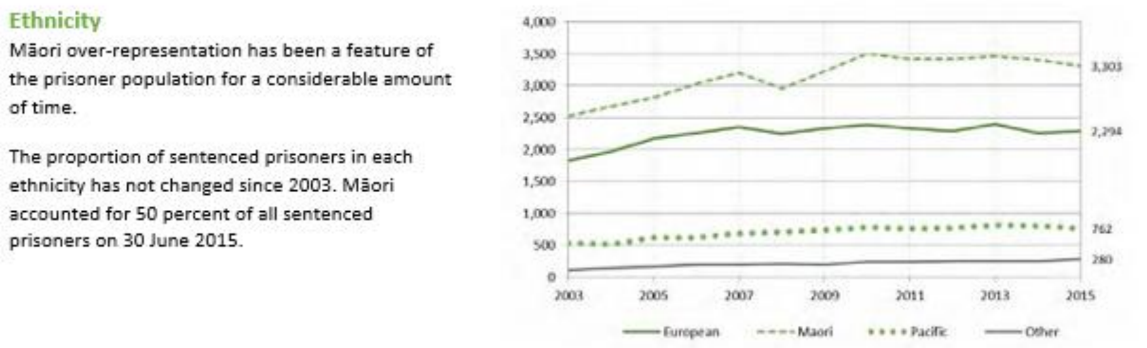


Ethnicity

The number of Māori 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 Māori, increased 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

Māori 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. Māori accounted for 50 percent of all sentenced prisoners on 30 June 2015.

The presentation of more serious conditions is also more prevalent among people in prison, including conditions such as post-traumatic stress disorder and bipolar disorder associated with high levels of distress and disability, especially in acute phases.

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

Determinants of health

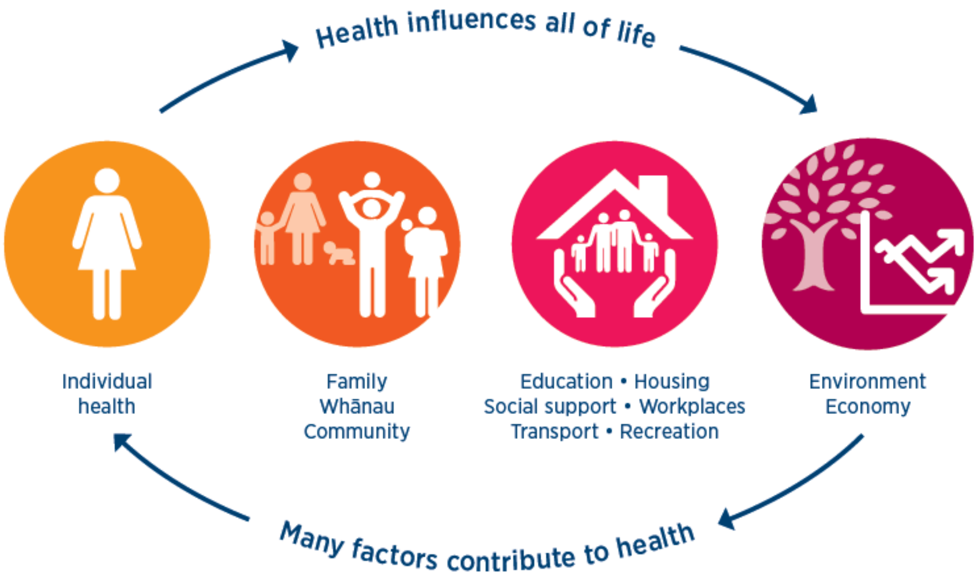
Positive mental wellbeing and freedom from addiction rely on many factors at an individual, family and whānau, community, and society level. Socially cohesive societies tend to produce healthier members.

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

’Ala Mo’ui (Ministry of Health, 2014a) provides a similar framework for Pacific peoples, recognising that ‘āiga, kāiga, magafaoa, kōpū tangata, vuvale, or 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 24: 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., Gilburt, H., 2016). The aim of integrating services and MHA responses is to enable people to experience 'seamless' health care.

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

Mental health, like other aspects of health, can be affected by a range of socio-economic factors (such as relationships with friends, family and whānau, and others; connection to or disconnection from tūrangawaewae 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 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 and 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).

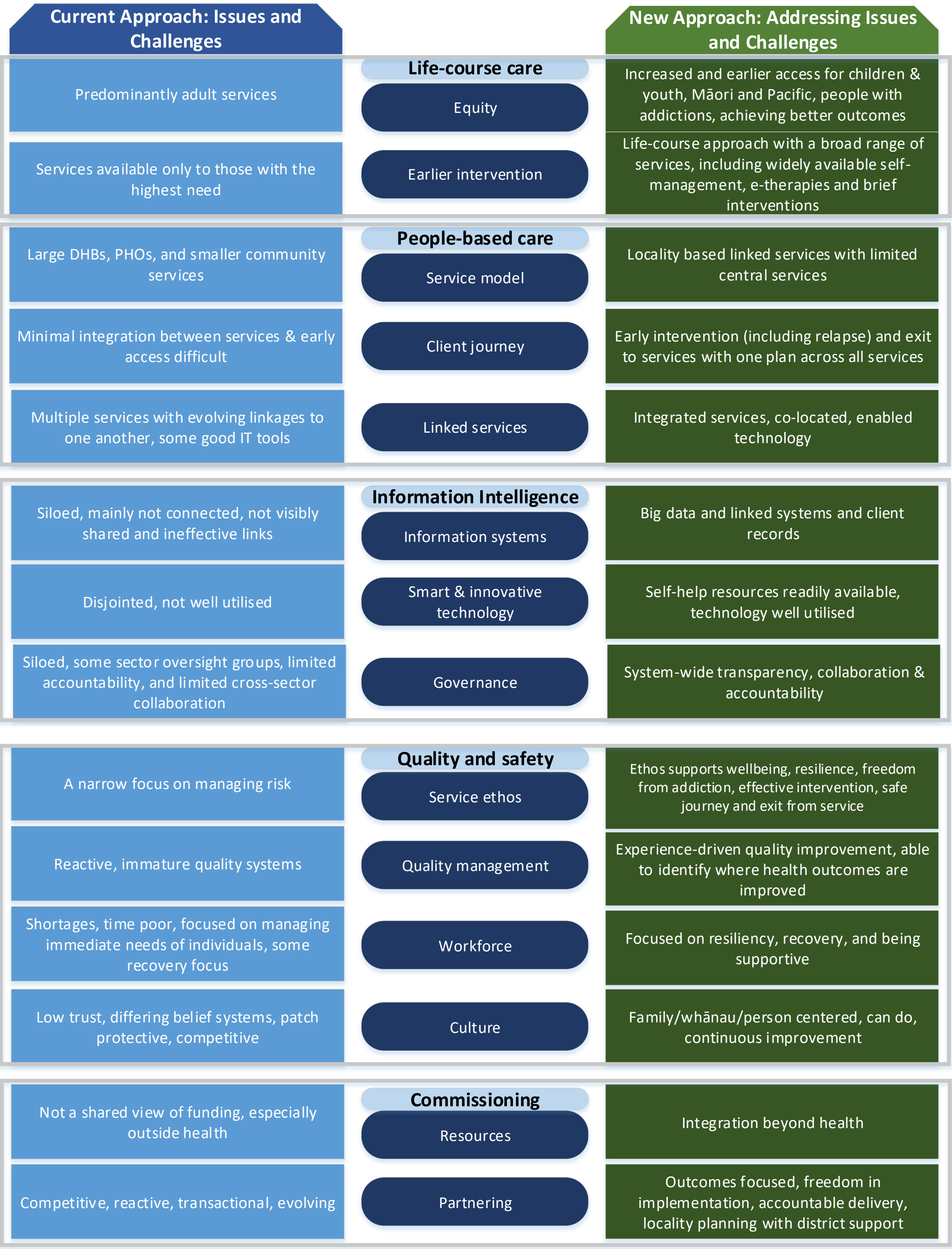
People working in MHA services, including primary health care and community services, will work closely with individuals and their families and whānau to provide wellbeing within a wider community context.

Our workforce will be characterised by:

- having compassionate care skills
- fostering recovery in and support for consumers
- utilising open dialogue and trauma-informed practices
- being 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 25: Current and future approach to MHA care of the community (built from information collected at workshops across the 3DHBs)



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

Figure 25 describes our current approach and its associated issues and challenges, alongside the new approach we expect future workforces and services to embrace and implement. We envisage a service-level alliance structure[6] made up of a range of stakeholders with oversight of the needs in the region and how current services and resources deliver the required outcomes.

Utilising cultural partnerships in approaches

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

The Pacific models of health care share common elements with Māori understanding of health, in that they are collective and relational. Six core values have been identified as being common across different Pacific peoples: tapu (sacred bonds), alofa (love and compassion), fa'aaloalo (respect and deference), fa'amaualalo (humility), tautua (reciprocal service), and āiga (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 and 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 (Ministry of Health, 2008)

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.

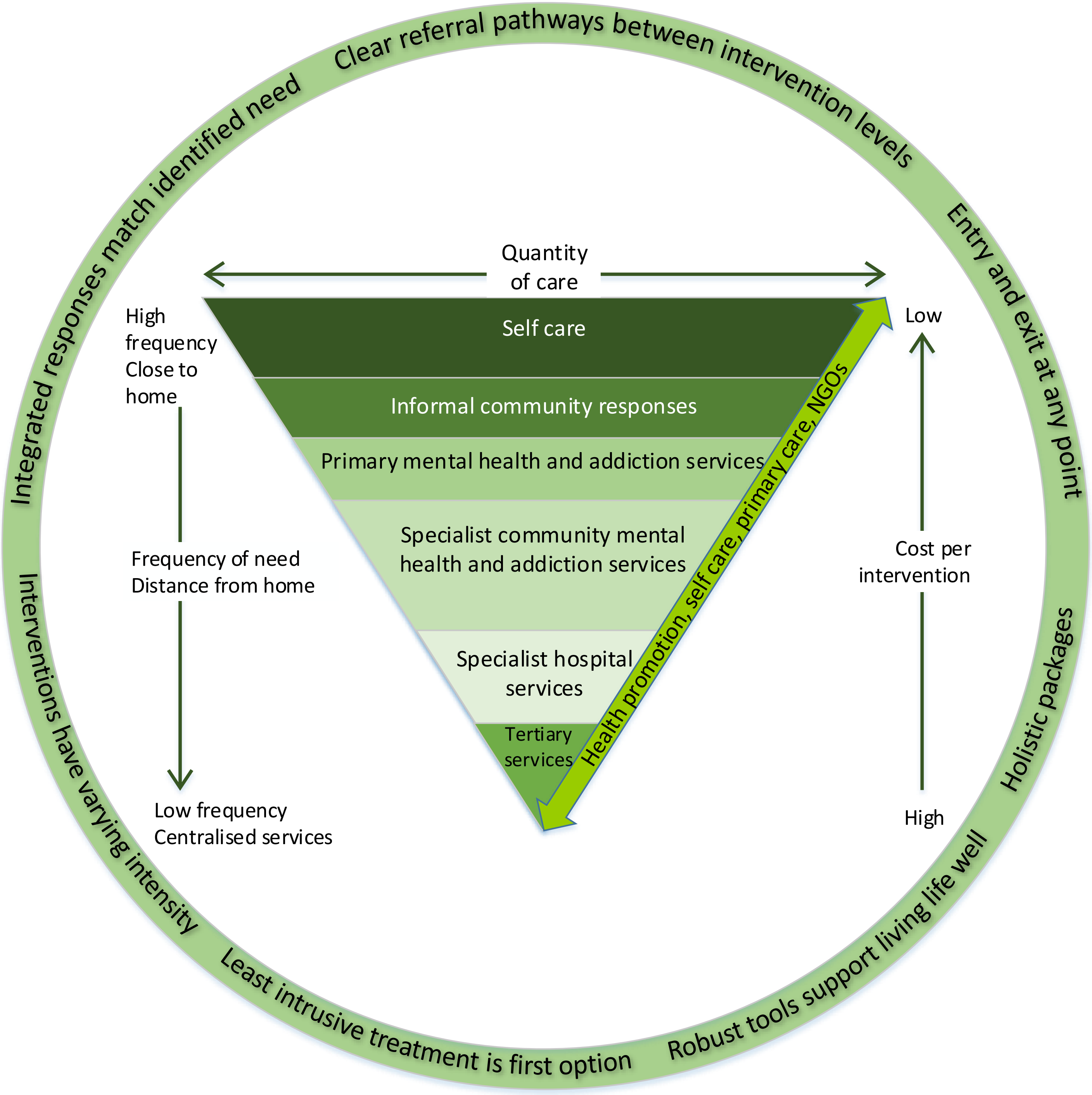
Our model of care will guide us so that people experiencing mental distress and/or substance-use harm, as well as their families and whānau, will be able to access care appropriate to their needs when they require it. Health professionals will recognise when they need to intervene and be able to offer 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 and whānau can access the right support will mean implementing a transparent staged care[7] approach. This will involve health professionals working at the top of their scope, a greater role for primary health care, and people receiving most of their health care close to home from health specialist and other services.

As illustrated in Figure 26 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 26: **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). This is summarised in Figure 2, earlier in the document on page 11.

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-design[8] 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.

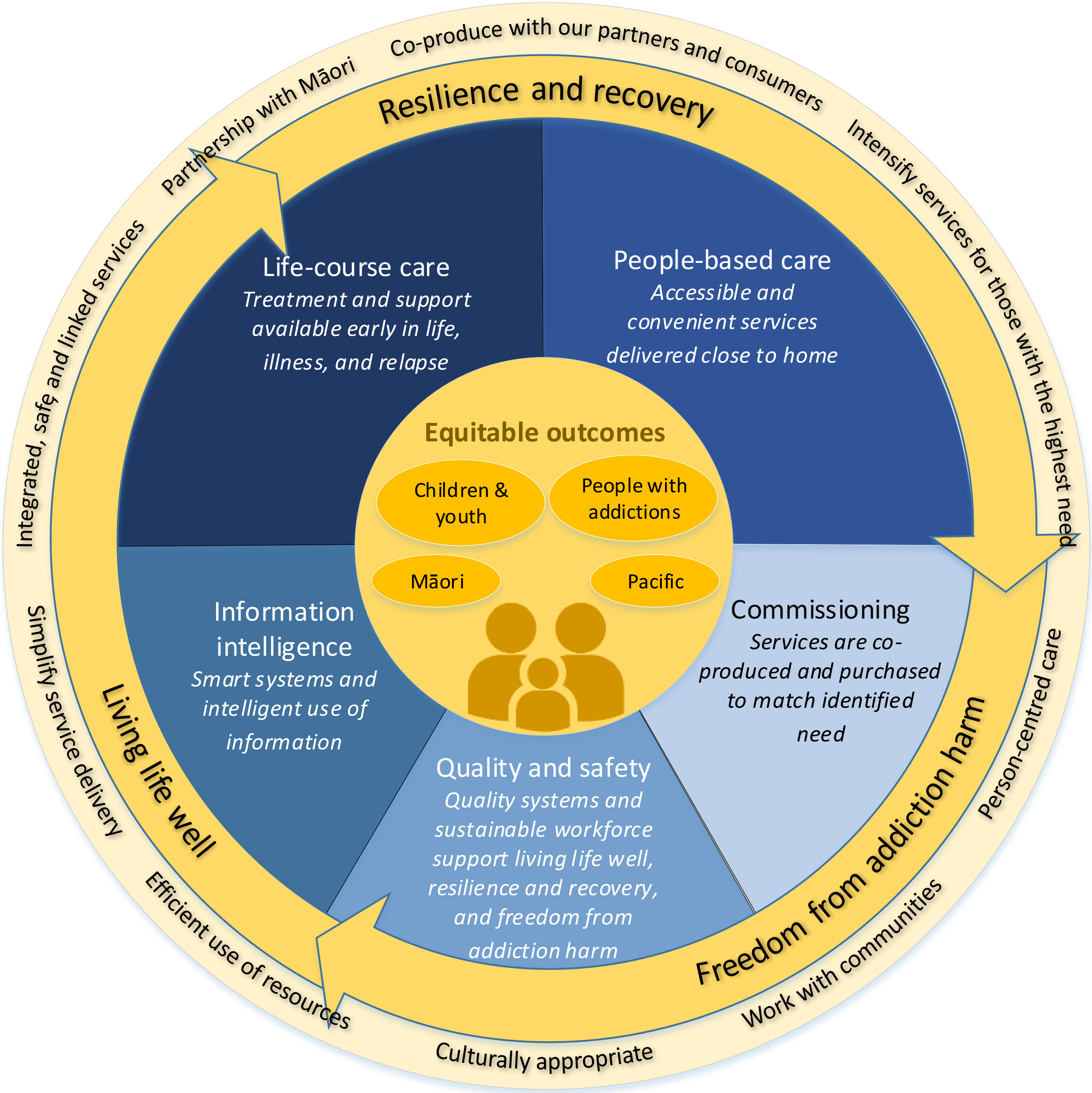
The World Health Organization (WHO) has five interwoven strategies for moving towards integrated, people-centred health care (WHO, 2016). As can be seen in Figure 27 on the next page, our strategic plan is consistent with these five WHO strategies to:

- 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 the Health Quality & Safety Commission New Zealand's (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. (see Maher, Dr. L. (2017). *Co-designing Health and Care Services for the Partners in Care Programme.* Wellington: Health Quality & Safety Commission New Zealand. Accessed via www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/Dr_Lynne_Maher_-_Co-designing_Health_and_Care_Services_May_2017.pdf)

Figure 27: Strategies for integrated, people-centred care



Life-course care

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

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

What does this look like?

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

Strengthening prevention and supporting destigmatisation are key factors in healthy communities. There must be safe environments where people in distress feel free to discuss what they are experiencing. Early intervention is particularly important for children and young people, for whom mental illness and addiction can have profound, long-term consequences. 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 (WHO, 2017). 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.

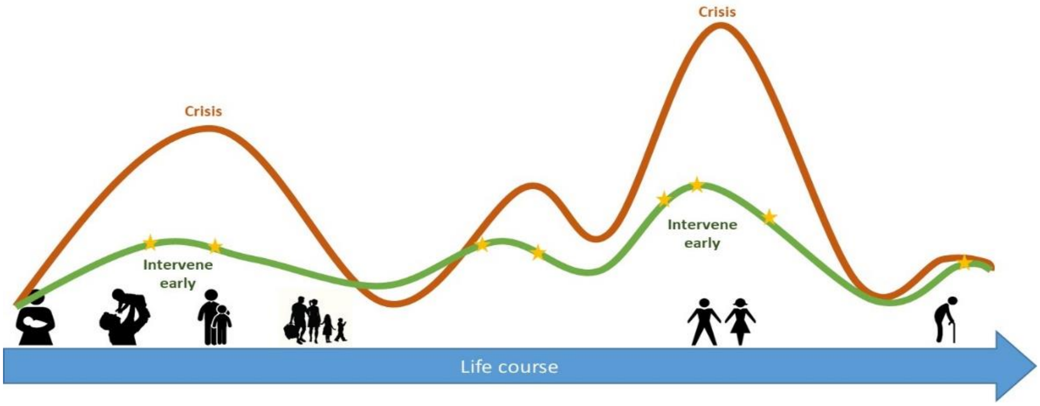
5: Promote the health navigator **website** as the basis for information to support patients and their families and whānau throughout their journey.

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 28: 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: **Māori and Pacific peoples** will have **reduced inequities of access** to services, quality care, and better health outcomes.

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

Current Approach: Issues and Challenges	People-based care	New Approach: Addressing Issues and Challenges
Large DHBs, PHOs, and smaller community services	Service model	Locality-based linked services with limited central services
Minimal integration between services & early access difficult	Client journey	Early intervention (including relapse) and exit to services with one plan across all services
Multiple services with evolving linkages to one another, some good IT tools	Linked services	Integrated services, co-located, enabled technology

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 responses 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.

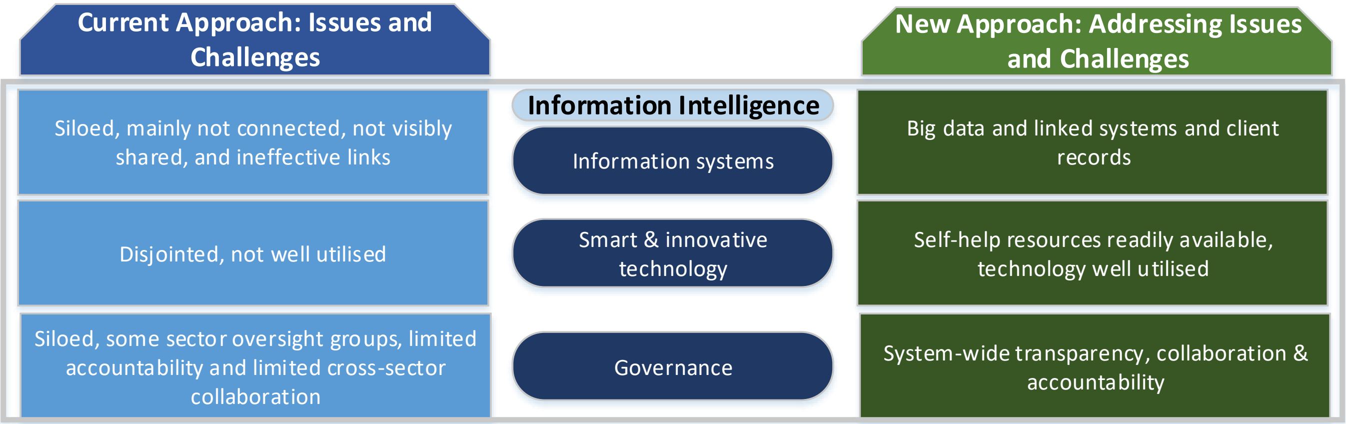
Person-centred care does not mean giving people whatever they want or just providing information; it means putting people and their families and whānau at the centre of everything we do. When decisions are made, we see consumer and their families and whānau as experts, working alongside professionals 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 MHA care **close to home**, with **centralised specialist services** and specialist Māori practices.
2: **Closer-to-home initiatives** led by Māori and Pacific providers will be well established in Māori and Pacific communities, and there will be 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



Current Approach: Issues and Challenges	Information Intelligence	New Approach: Addressing Issues and Challenges
Siloed, mainly not connected, not visibly shared, and ineffective links	Information systems	Big data and linked systems and client records
Disjointed, not well utilised	Smart & innovative technology	Self-help resources readily available, technology well utilised
Siloed, some sector oversight groups, limited accountability and limited cross-sector collaboration	Governance	System-wide transparency, collaboration & accountability

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 activities. It can be shared with others to unlock benefits for both consumers and their families and 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 frameworks 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 will be faithful to cultural world views**, 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, enabling more effective use of the technology, and data will be matched to achieved outcomes.
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

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

What does this mean?

Transformational improvements in MHA will require new, less medicalised models focused on working with communities, reducing the pressures on acute care, and having a workforce aligned with the new models of care and ways of working. Our quality systems must draw more on utilising experience and quality systems to drive quality improvement. The organisational cultures must move from competitive patch protection to person-centred solutions with a can-do attitude focused on continuous improvement. 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
- using co-design and co-production to drive a system-wide quality culture
- developing the workforce, particularly the health care practitioners who are best placed to deliver talking therapies to our population
- providing all frontline staff with 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)
- providing workforce training that better prepares and educates our staff so they can learn how to work effectively with children and families and whānau and use kaupapa Māori frameworks and other cultural lenses for viewing mental health and wellbeing
- having relevant tertiary education providers deliver 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 that supports inclusion from consumers, family and whānau.

Consumers, family and 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 issues are also many and varied, with the MHA sector having an aging workforce and a significant gender and cultural imbalance. MHA is a challenging 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, families and 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. A **measurement framework** will be embedded that 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

Current Approach: Issues and Challenges	Commissioning	New Approach: Addressing Issues and Challenges
Not a shared view of funding, especially outside health	Resources	Integration beyond health
Competitive, reactive, transactional, evolving	Commissioning	Outcomes focused, freedom in implementation, accountable delivery, locality planning with district support

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.

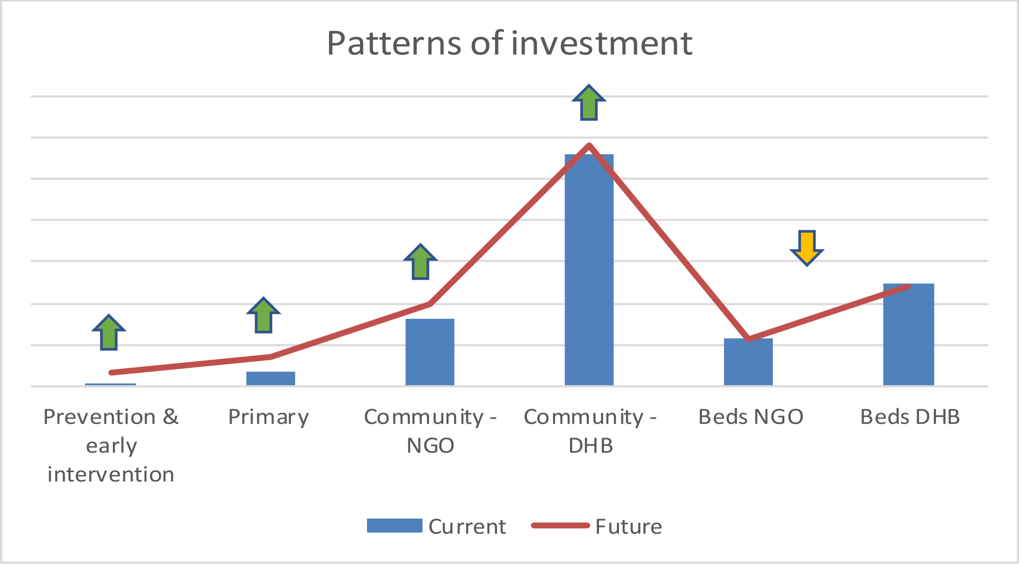
Principles for investment

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 29 on the next page. 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 29: **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* (Government Inquiry into Mental Health and Addictions, 2018) will influence and inform the implementation of this strategy. The recommendations from the inquiry's report have been mapped to this strategy as part of Appendix 1. The strategy is a living document that will be updated, particularly as the DHBs integrate the Government's formal response to the 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: Report of the Government Inquiry into Mental Health and Addiction* recommendations mapped to this strategy

In November 2018, the Government Inquiry into Mental Health and Addiction published *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (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' MHAs 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 health care: the 3DHBs' strategy recognises a shift of substantial magnitude is required in how primary health 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 in the design and delivery of services
- recognising the obligations under the Treaty of Waitangi to Māori as tangata whenua and citizens, 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's recommendations and believe the strategy's approval will enable us to move quickly to prepare the ground for the Government's formal response to those recommendations as they apply to our populations.

***He Ara Oranga* recommendations**	**3DHB *Living Life Well* links**
Expand access and choice **Expand access** 1. Agree to significantly increase access to publicly funded MHA services for people with mild to moderate and moderate to severe MHA needs. 2. Set a new target for access to MHA 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 MHA services. 4. Agree that access to MHA services should be based on need so: ○ access to all services is broad based and prioritised according to need, as occurs with other core health services ○ 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 (p. 42). **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 (p. 48).
Increase choice of services 5. Commit to increased choice by broadening the types of MHA 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** (p. 40).
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: ○ facilitate a national co-designed service transformation process with people with lived experience of MHA challenges, DHBs, primary health care, NGOs, kaupapa Māori services, Pacific health services, Whānau Ora services, other	**Life-course care** strategic direction: • Embed **consumer co-design** into all aspects of service design and delivery (p. 40). **Commissioning** enabling direction: • Services are **co-designed** and purchased to match identified need (p. 48).

He Ara Oranga recommendations	3DHB *Living Life Well* links
providers, advocacy and representative organisations, professional bodies, families, whānau, employers, and key government agencies ○ produce a cross-government investment strategy for MHA services. 8. Commit to adequately funding 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 MHA services.	
Enablers to support expanded access and choice 10. Agree that the work to support expanded access and choice will include reviewing and establishing: ○ workforce development and worker wellbeing priorities ○ information, evaluation, and monitoring priorities (including monitoring outcomes) ○ funding rules and expectations, including DHB and primary mental health service specifications and the MHA ringfence, to align them with and support the strategic direction of transforming MHA services. 11. Agree to undertake and regularly update a comprehensive MHA survey. 12. Commit to a staged funding path to give effect to the recommendations to improve access and choice, including: ○ expanding access to services for significantly more people with mild to moderate and moderate to severe MHA needs ○ more options for talk therapies, alcohol and other drug services, and culturally aligned services ○ designing and implementing improvements to create more people-centred and integrated services, with significantly increased access and choice.	**Information intelligence** enabling direction: • **Data integration** will inform service design and commissioning (p. 45). **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 (p. 47). **Commissioning** enabling direction: • Develop a **co-designed investment plan** for each DHB that reflects investment in: • **priority populations** and areas of greatest need • **early intervention** • **services closer to home** (p. 49).

He Ara Oranga recommendations	3DHB *Living Life Well* links

Transform primary health care
13. Note that this inquiry fully supports the focus on primary health care in the health and disability sector review, seeing it as a critical foundation for the development of MHA 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 MHA needs in primary health care 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:
	  • **specialist** mental health professionals
	  • **long-term condition planning** for those with enduring mental illness and/or addiction (p. 40.
	• 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 streamlining delivery of high-cost secondary and complex health care services (p. 43).
	• **Closer-to-home initiatives** led by Māori and Pacific providers well established in Māori and Pacific communities and undergoing evaluation (p. 44).

Strengthen the NGO sector 15. **Identify** a lead agency to: ○ provide a stewardship role in relation to the development and sustainability of the NGO sector, including those NGOs and kaupapa Māori services working in MHA ○ take a lead role in improving commissioning of health and social services with NGOs.	*This recommendation is out of scope for the 3DHBs' strategy, however if it were enacted, its application would be supported by the strategy's people-based care strategic direction.*

He Ara Oranga recommendations	3DHB *Living Life Well* links
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: ○ tackling social determinants that impact on multiple outcomes and that lead to inequities within society ○ 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: ○ its form and location (a new social wellbeing agency, a unit within an existing agency, or reconfiguring an existing agency) ○ its functions.	*This recommendation is out of scope for the 3DHBs' strategy, however if it were enacted, its application would be supported by overall implementation of the 3DHBs' MHA strategy.*
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 (p. 40). **Quality and safety** enabling direction: • Workforce training that better prepares and educates our staff so they can learn how to work effectively with children, families and whānau, and use kaupapa Māori frameworks and other cultural lenses for viewing mental health and wellbeing (p. 47).

He Ara Oranga recommendations	3DHB *Living Life Well* links
Place people at the centre **Strengthen consumer voice and experience in MHA 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 MHA 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 New Zealand, and DHBs on how the consumer voice and role can be strengthened in DHBs, primary health care services, 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 MHA services.	**Life-course care** strategic direction: • Embed **consumer co-design** into all aspects of service design and delivery (p. 40).
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: ○ training across the MHA workforce ○ all relevant contracts, standards, specifications, guidelines, quality improvement processes, and accountability arrangements.	**People-based care** strategic direction: • We envisage seeing consumer and their families and whānau as experts, working alongside professionals to get the best outcome (p. 43).
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: ○ lead a review of the support provided to families and whānau of people with MHA needs and where gaps exist	**Commissioning** enabling direction: • **Integrated** health service responses will aim to meet the needs of people and their families and whānau (p. 50).

He Ara Oranga recommendations	3DHB *Living Life Well* links
○ 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.	
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 (e.g., 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.	*This recommendation is out of scope for the 3DHBs' strategy, however if it were enacted, there would be no conflict with the implementation of the 3DHBs' MHA strategy.*
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 percent reduction in suicide rates by 2030. 32. **Establish** a suicide prevention office to provide stronger and sustained leadership on actions 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 (p. 40).
Reform the Mental Health Act 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-	*This recommendation is out of scope for the 3DHBs' strategy, however if it were enacted, its application would be supported by the strategy's people-based care strategic direction.*

***He Ara Oranga* recommendations**	**3DHB *Living Life Well* links**
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.	
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 MHA 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.**	*This recommendation is out of scope for the 3DHBs' strategy, however if it were enacted, there would be no conflict with the implementation of the 3DHBs' MHA strategy.*
Wider issues and collective commitment 39. Ensure the health and disability sector review: ○ assesses how any of its proposed system, structural, or service commissioning changes will improve both MHA services and mental health and wellbeing ○ 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 and enduring political commitment to improved mental health and wellbeing in New Zealand.	*This recommendation is out of scope for the 3DHBs' strategy, however if it were enacted, there would be no conflict with the implementation of the 3DHBs' MHA strategy.*

Appendix 2: Bibliography

Ataera-Minster, J., & Trowland, H. (2018). *Te Kaveinga: Mental health and wellbeing of Pacific peoples. Results from the New Zealand Mental Health Monitor & Health and Lifestyles Survey.* Wellington: Health Promotion Agency.

Best Practice Advocacy Centre NZ. (2008). Maori mental health. *Best Practice Journal*, 31–35.

Brazier, C. (2017). *Building the Future: Children and the sustainable development goals in rich countries. Innocenti Report Card 14.* Florence: United Nations International Children's Emergency Fund (UNICEF).

CCDHB. (2015). *Perinatal, Maternal and Infant Mental Health Strategy (unpublished).* CCDHB.

CCDHB. (2016). *Capital and Coast Health System Plan (draft).* Wellington: Capital and Coast DHB.

CCDHB. (2017). *Toe Timata le Upega: Pacific Action Plan 2017–2020.* Wellington: Capital & Coast DHB.

Clarke, A., Vargas, O., Goddu, A., McCullough, K., DeMeester, R., Cook, S., . . . Chin, M. (2014). *A Roadmap to Reduce Racial and Ethnic Disparities in Health Care.* Chicago: Finding Answers Partnership.

Department of Health. (2006). *Informing Healthier Choices.* London: Department of Health.

Durie, M. H. (1985). A Māori perspective of health. *Social Science Medicine, 20*(5), 483–86.

Government Inquiry into Mental Health and Addictions. (2018). *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction.* Wellington: Government Inquiry into Mental Health and Addictions.

HDC. (1996). *Code of Health and Disability Services Consumers' Rights.* Wellington: Office of the Health and Disability Commissioner. Retrieved from https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/

HDC. (2018). *New Zealand's Mental Health and Addiction Services: The monitoring and advocacy report of the the Mental Health Commissioner.* Wellington: Office of the Health and Disability Commissioner.

He Korowai Oranga, Ministry of Health, New Zealand. (2014). *He Korowai Oranga.* Retrieved from Ministry of Health.

HIN. (2016, December 15). *What is person-centred care and why is it important?* London: Health Innovation Network South London. Retrieved November 6, 2018, from HIN-South London: www.hin-southlondon.org/system/ckeditor_assets/attachments/41/what_is_person-centred_care_and_why_is_it_important.pdf

HPA. (2013). *Early Intervention Addiction Plan 2013–2017.* Wellington: Health Promotion Agency.

HVDHB. (2016). *Hutt Valley District Health Board Health System Plan.* Lower Hutt: Hutt Valley DHB.

HVDHB. (2017). *Our Vision for Change 2017–2027.* Lower Hutt: Hutt Valley DHB.

HVDHB, WDHB. (2015). *Pāolo mo Tagata ole Moana: Pacific Health Action Plan.* Hutt Valley DHB and Wairarapa DHB.

Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, Poulton R. (2003). Juvenile diagnoses in adults with mental disorder developmental follow-back of a prospective longitudinal cohort. *Arch Gen Psychiatr*, 709–17.

King, D., & Welsh, B. (2006). *Knowing the People Planning.* London: The Nuffield Trust.

McCulloch, A. (2009). *Old age and mental health in the context of the life span: What are the key issues in the 21st century. .*

Melissa McLeod, P. K. (28th April 2017,). Ethnic disparities in the use of seclusion for adult psychiatric inpatients in New Zealand. *The New Zealand Medical Journal*, Volume 130 Number 1454.

Mental Health Commission. (2012a). *Blueprint II: How things need to be.* Wellington: Mental Health Commission.

Mental Health Commission. (2012b). *Blueprint II: Making change happen.* Wellington: Mental Health Commission.

Ministry of Health. (2008). *Pacific Peoples and Mental health; A paper for the Pacific Health and Disability Action Plan Review.* Wellington: Ministry of Health.

Ministry of Health. (2012). *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017.* Wellington: Ministry of Health.

Ministry of Health. (2013). *Hazardous Drinking in 2011/12: Findings from the New Zealand Health Survey.* Wellington: Ministry of Health.

Ministry of Health. (2014a). *'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018.* Wellington: Ministry of Health.

Ministry of Health. (2014b). *He Korowai Oranga: Māori Health Strategy.* Wellington: Ministry of Health. Retrieved November 6, 2018, from www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga

Ministry of Health. (2015). *Annual Update of Key Results 2014/15: New Zealand Health Survey.* Wellington: Ministry of Health.

Ministry of Health. (2016a). *Health Loss in New Zealand 1990–2013.* Wellington: Ministry of Health.

Ministry of Health. (2016b). *New Zealand Health Strategy: Future direction.* Wellington: Ministry of Health.

Ministry of Health. (2018). *Ministry of Health Quarterly Reporting Q4.* Wellington: Ministry of Health.

Ministry of Social Development. (2012). *Nga Vaka o Kāiga Tapu: A Pacific conceptual framework to address family violence in New Zealand.* Wellington: Ministry of Social Development.

ModernMedicine Network. (2016). *Why behavioral health is the new frontier in primary care.* Retrieved June 26, 2018, from Medical Economics: www.medicaleconomics.com/medical-economics-blog/why-behavioral-health-new-frontier-primary-care/page/0/1

National Mental Health Workforce Development Co-ordinating Committee. (1999). *Developing the Mental Health Workforce.* Wellington: National Mental Health Workforce Development Co-ordinating Committee.

Naylor, C., Das, P., Ross, S., Honeyman, M., Thompson, J., Gilburt, H. (2016). *Bringing Together Physical and Mental Health.* London: The King's Fund.

Naylor, C., Taggart, H., & Charles, A. (2017). *Mental Health and New Models of Care. Lessons from the vanguards.* London: The King's Fund.

NCAT. (2016). *Shaping the Sector: A briefing from the National Committee for Addiction Treatment for sector leaders, allied health and social services, and decision makers.* Wellington: National Committee for Addiction Treatment. Retrieved August 29, 2018, from NCAT: http://ncat.org.nz/wp-content/uploads/NCAT-shaping-the-sector-single-pages-full.pdf

New Zealand Drug Foundation. (2017). *Briefing to the Incoming Parliament: New Zealand Drug Foundation policy briefing 2017–2020.* Retrieved November 6, 2018, from New Zealand Drug Foundation: www.drugfoundation.org.nz/assets/uploads/2017-uploads/nzdrug-parliamentary-briefing-dec-2017.pdf

NLGN. (2016). *Get Well Soon. Reimagining Place-based Health: The Place-based Health Commission report.* London: New Local Government Network.

Office for Disability Issues. (2016). *New Zealand Disability Strategy 2016-2026.* Wellington: Office for Disability Issues.

Platform Trust & Te Pou o Te Whakaaro Nui. (2015). *On Track: Knowing where we are going.* Auckland: Te Pou o Te Whakaaro Nui.

Procare, Pegasus Health, Compass Health, Midland Health Network PHOs. (2016). *Closing the Loop.* Retrieved November 6, 2018, from www.closingtheloop.net.nz/#latest-news

Pulotu-Endemann, F. K. (2001). *Fonofale Model of Health.* Retrieved November 6, 2018, from www.hauora.co.nz/resources/Fonofalemodelexplanation.pdf

Stats NZ. (2017). *Statistics NZ PBFF projections.* Wellington: Statistics New Zealand.

Te Pou o Te Whakaaro Nui. (2014). *Equally Well.* Wellington: Te Pou.

Te Pou o te Whakaaro Nui. (2018). *Let’s Get Real: Real skills for working with people and whānau with mental health.* Auckland: Te Pou o te Whakaaro Nui.

Te Rau Matatini. (2015). *Kaupapa Māori Mental Health and Addiction Services: Best practice framework.* Wellington: Ministry of Health.

The King's Fund. (2017). *What is Social Prescribing?* Retrieved November 6, 2018, from The King's Fund: www.kingsfund.org.uk/publications/social-prescribing

The Young Foundation. (2010). *Taking the Temperature of Local Communities.* London: The Young Foundation.

WDHB. (2016). *Wairarapa DHB Health System Plan.* Masterton: Wairarapa DHB.

WDHB, HVDHB, CCDHB. (2015). *2015: Health Needs Assessment for Wairarapa, Hutt Valley, and Capital & Coast District Health Boards.* Wellington: Wairarapa, Hutt Valley, and Capital & Coast DHBs.

WDHB, HVDHB, CCDHB. (2017). *Sub-regional Disability Strategy 2017–2022.* Wellington: Wairarapa, Hutt Valley and Capital & Coast DHBs.

WHO. (2016). *Framework on integrated, people-centred health services.* Geneva: World Health Organization.

WHO. (2017). *Mental health*. Retrieved from World Health Organization: www.who.int/mental_health/suicide-prevention/en/

WHO. (2017). *People-Centred Health Care. A Policy Framework.* Geneva: World Health Organization.

WHO. (2018). *Equity*. Retrieved November 6, 2018, from World Health Organization: www.who.int/healthsystems/topics/equity/en/

Appendix 3: Other plans informing this strategy

New Zealand Health Strategy

New Zealand Health Strategy
Future direction

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 30: New Zealand Health Strategy framework

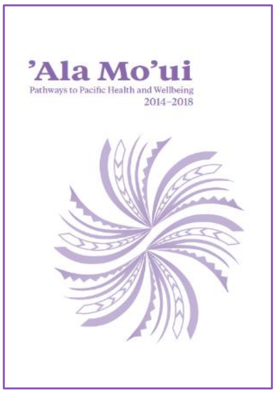
He Korowai Oranga

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 (Ministry of Health, 2014b).

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

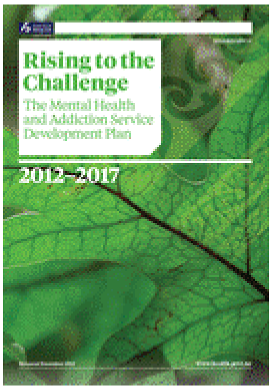
'Ala Mo'ui (Ministry of Health, 2014a) has been developed to facilitate the delivery of high-quality health services that meet the needs of Pacific peoples. It sets out the strategic direction to address the health needs of Pacific peoples, outlines the Government’s priority focus areas for Pacific health, and stipulates new actions. At the time of publication of this 3DHB mental health & addictions strategy, 'Ala Mo'ui was being reviewed in preparation for updating.



Rising to the Challenge

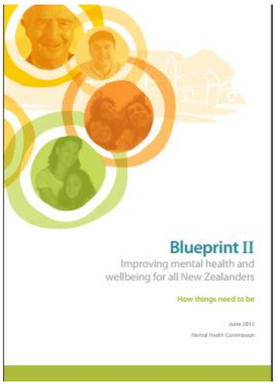
Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 (Ministry of Health, 2012) is the national MHA strategy. It focuses on the four key areas of:

- making better use of resources
- improving integration between primary and secondary health 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 MHA 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 approaches.



Blueprint II
Improving mental health and
wellbeing for all New Zealanders

How things need to be

June 2012
Mental Health Commission

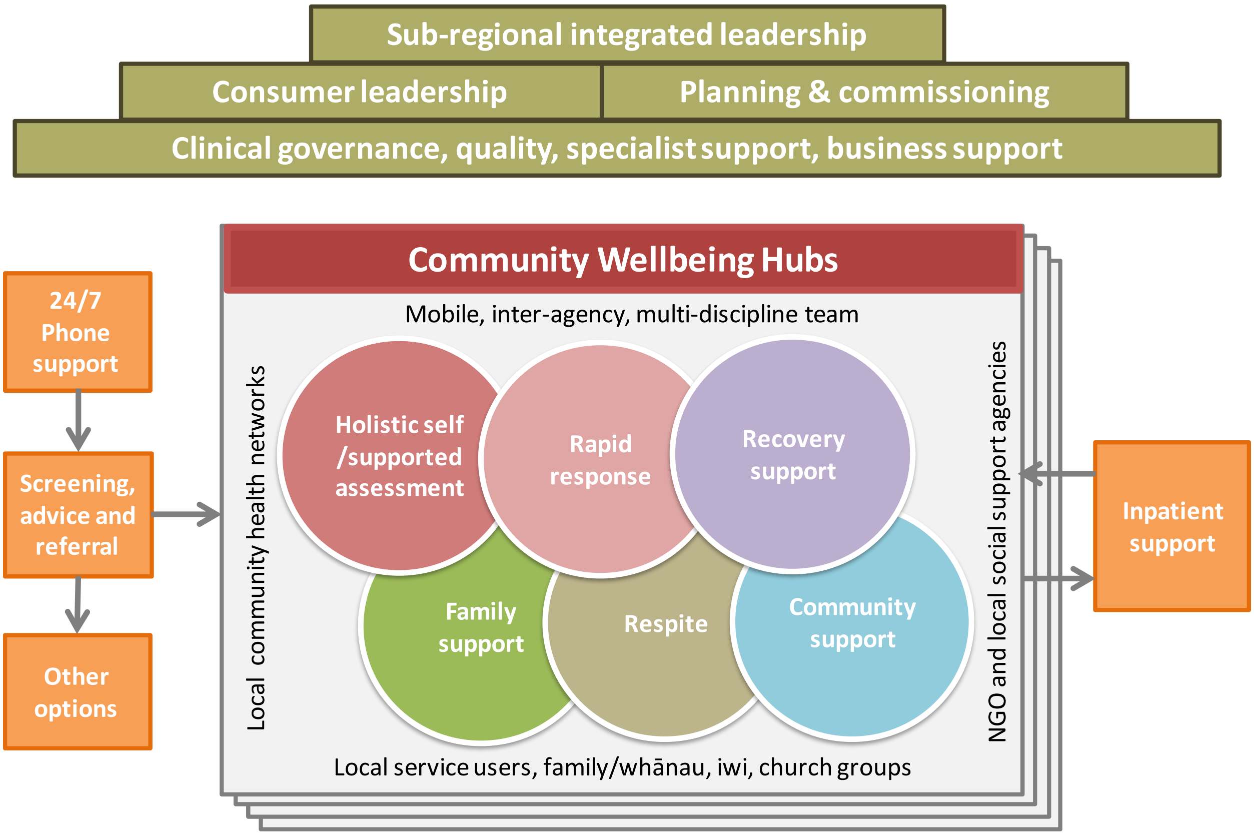
Blueprint II identifies eight priorities to achieve this vision.

1: Providing a good start: Respond earlier to MHA 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 MHA services.
3: Supporting people with episodic needs: Support return to health, functioning, and independence for people with episodic MHA issues.
4: Supporting people with severe needs: Support return to health, functioning, and independence for people most severely affected by MHA 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 31 shows an example of how a locality-based community wellbeing centre might operate.

Figure 31: 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 a mental illness such as depression or anxiety but also has 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 that attempts 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, and community- and home-based settings for people with mental health and/or co-existing MHA 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 MHA services.
Life course	All stages of life, from prenatal to old age.
MHA	Mental health and addiction.
MHA ringfence	Government mechanism to ensure that funding intended for specialist MHA services is used solely for those purposes.
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 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. Twelve 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 'MHA 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 whaiora'.
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 Nationwide Service Framework (see above) and funded through the MHA 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 enable 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 families and whānau from birth to five 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, and MHA services 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 MHA 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.