WAIRARAPA MENTAL HEALTH AND ADDICTION SERVICE REVIEW REPORT

Wairarapa District Health Board

Date	12 December 2018
Version	1.0
Status	Final Draft Report

Table of Contents

Acknowledgement

The Wairarapa District Health Board (**Wairarapa DHB**) wish to acknowledge all of those people and providers who gave their time and expertise to this review to examine the DHB's existing mental health and addiction services and programmes. There are many people who made themselves available, often at short notice, and whose genuine thoughtfulness and at times challenging feedback helped the review become a more robust process.

In keeping with the reassurances given to everyone who contributed to this review, individuals are not identified in this report.

Disclaimer

All care has been taken in collecting and reporting the information to date, however it is not possible to guarantee that the information is error free. If inaccuracies are reported these will be remedied in an updated version of the Final Draft Report.

***Contact for further information*:**

Nigel Broom, Executive Leader, Planning and Performance, Wairarapa DHB,

Email: Nigel.Broom@wairarapa.dhb.org.nz,

Cell Phone 027 507 2014.

1.0 Executive Summary

Context

The Wairarapa District Health Board (**Wairarapa DHB**) is budgeted to spend **$12.525** million in Mental Health and Addiction Services in 2018/2019 for the Wairarapa district with a population of **44,030** people (2017/2018 estimate)[1]. Despite the investment, access to the suite of services across the mental health and addiction continuum can be difficult; many areas of services operate in a fragmented manner; and primary care providers point to a significant shortfall in responses to high-prevalence mental health and addiction issues.

In February 2018, the Wairarapa DHB commissioned a review of Mental Health and Addiction (Alcohol and Other Drug (**AOD**)) services for their population[2] to develop a clear and considered view of the need for the people of Wairarapa who are experiencing harm related to mental health and addiction issues.

The review took place between the period March 2018 to May 2018 led by a Working Group comprising of representatives from personnel involved in delivering Wairarapa DHB secondary community mental health services (Adult and Child Adolescent) and Māori Health Unit, Service User, Wairarapa DHB senior manager involved in strategy and planning activities and an independent Review Manager who provided support of the review.

Method

The process for the review was led by the Planning and Performance Group of Wairarapa DHB. Key processes included a review of relevant national and local documents including DHB's Annual Plan, a stocktake of funded mental health and addiction treatment and support services for young people, adults and older people 65+, analysis of utilisation data (where available), and an extensive engagement with stakeholders who have an active interest in improved mental health and addiction services for individuals, family, whānau, hapū and iwi living in the Wairarapa district.

The five key strategic themes from the New Zealand Health Strategy 2016-2026 provided a frame of reference for consideration of the review findings.

The review terms of reference were broadly defined to include identifying opportunities for current resourcing 'specialist' mental health and addiction services and to the level of integration and collaboration between providers and other agencies. The terms of reference for the service review and Working Group are included in Appendix One and Appendix Two.

Understanding the needs of people experiencing mental health and addiction issues in the Wairarapa context is critical to determining how best to meet those needs. By way of a summary of findings and recommendations, the review found risk and alert factors, strengths, and areas needing development.

Service Investment

The review highlighted that the mental health and addiction (drugs and alcohol) programmes and services in the Wairarapa, like those around other parts of New Zealand, have evolved, focussed more often on adult mental health services and have incorporated many of the cultural responses into mainstream DHB specialist services and/or stand-alone NGO services. This has resulted in some services that may not be appropriate are not responding to specific population groups are often poorly integrated.

[1] HVDHB: *Copy of Pop Projections - Summary File (2017 Update)* (2 May 2018)

[2] The review focused on treatment services; health promotion and community services.

A snapshot of the Wairarapa DHB's commissioning (investment) in its Mental Health and Addiction Service available in Wairarapa is shown in Table One below. Detailed information on the type of service provided by provider in each service cluster is outlined in Appendix Three.

Table 1: Total Wairarapa DHB budgeted funding by Service Cluster by population age group 2018/2019

Service Cluster by Population Age	Youth 0-18 yrs	Adult 19-64 yrs	Older Person 65+	All Population	Total 2018/19 IDF Funding
Acute and Inpatient Services	181,972	1,520,065	630,304	-	**2,332,341**
Community-based clinical treatment and therapy services	1,699,741	2,341,366	-	-	**4,041,107**
Services to promote resilience, recovery and connectedness	36,200	2,542,292	-	-	**2,578,492**
Addiction	-	999,350	-	-	**999,350**
Family and Whānau	-	-	-	85,315	**85,315**
Kaupapa Māori	-	735,294	-	-	**735,294**
Pacific	-	-	-	-	**-**
Asian migrant and refugee services	-	-	-	-	**-**
Eating Disorder Service	17,303	27,611	-	-	**44,913**
Services providing Consumer Leadership	-	47,268	-	-	**47,268**
Mental Health of Older People	-	-	309	-	**309**
Perinatal Mental Health Services	-	-	-	73,329	**73,329**
Mental Health Other	9,288	71,300	-	21,816	**102,405**
Primary Mental Health	70,996	275,963	-	-	**346,959**
Forensic Youth	34,299	-	-	-	**34,299**
Forensic Adult	-	1,103,396	-	-	**1,103,396**
Total Funding	2,049,799	9,663,906	630,612	180,460	**12,524,776**
Funding % by Age	16.4%	77.2%	5.0%	1.4%	**100%**

Summary Findings

The review found that there is a much needed improved responsiveness of mental health and addiction services. Briefly, the review found:

- Overall, there was sizeable variability and gaps in the mental health and addiction services delivered to service users and their family/whānau.
- Wairarapa mental health and addiction services must provide for people across the age spectrum who are experiencing mental health or addiction-related issues, and their families/whānau, including children, adolescents and youth.
- National research indicates that Māori experience higher rates of substance use disorders than non-Māori. 17.2 percent of Wairarapa's population is Māori, with 43.10 percent of the Māori population < 18 years old and 49.50 percent are between 19-64 years.
- The overall population base is small and geographically spread. What is considered 'local' in Masterton is not local for those in South Wairarapa and in rural and coastal areas for whom the requirement to travel to Masterton for the majority of services can be a significant barrier to access.
- The majority of services are input based rather than outcome focused for measuring the impact they have on people's lives. Young people need responsive primary and secondary services, particularly youth aged between 15 to 24 years. In Wairarapa this age group makes up 25.5 percent (or one quarter) of the population.
- Current resources are weighted to mental health adult services rather than children, adolescents and youth, older people and addiction services.

- A tailored treatment pathway for service users is required. There was a lack of a clear referral pathway and directory of services, what they do, how to access them and when they should be accessed. Need to be clear on the purpose of "the system" (i.e. map the suite of services provided).
- A high number of people have unmet needs for housing/residential setting. These numbers vary over time as the needs of individual service users fluctuate as they progress their mental health and or addiction issue on a continuum between severe and recovery and wellness or stability.
- There is duplication and/or gaps in some service clusters creating barriers for equity of access.
- More strategic and efficient use of specialist mental health practitioners' time and skills to support a sustainable workforce across all levels of mental health and addiction support.
- A lack of an agreed Pathway of Care. This includes pathways to and from both mental health and addiction services.
- Identify and respond to a more flexible use of acute respite care - more frequent access to crisis respite in a community setting not on a hospital campus, longer periods of time, as a 'preventive' or maintenance option rather than only for those currently being supported by the Specialist Services, availability for people with co-existing problems.
- More employment and housing responses including short term and emergency accommodation is hard to find in Wairarapa due to the lack of social housing. A variety of accommodation options should be considered as an individualised package provided into wherever the service user was living.
- The addiction service interventions offered do not include step up -step down' accommodation options specifically for addiction service users.
- It's critical to further develop early intervention initiatives, in particular at a primary care level. The current mental health and addiction system is heavily weighted to treatment rather than early intervention and prevention.
- There is a need to better inform people in the community about the mental health and addition services available. Much more (and specific) mental health promotion and mental illness prevention activities required.
- Operational and clinical governance issues of clarity around the new MHAIDS[3] accountability pathway. There is uncertainty about how the mental health and addiction system now works between MHAIDS and Wairarapa DHB clinical teams. This is complicated by the ambiguity of accountability and operational management lines of MHAIDs and Wairarapa DHB services.

Each of these issues is considered in more detail outlined in Section 9.0.

Conclusion

It is crucial that mental health is given "parity of esteem" (Faculty of Public Health and Mental Health Foundation, 2016) with physical health. Not only because mental health and physical health are inextricably linked, but because of the impact that mental ill health causes. These impacts are significant and wide reaching; affecting individuals, whānau, communities and wider society through both social and economic costs. In the New Zealand context, the contribution of poor mental wellbeing to health, educational and social inequities is key.

The findings contained in this report are wide ranging and some aspects of service opportunities identified will be challenging to implement without the appropriate resources.

[3] Mental Health and Addiction Intellectual Disability Service (MHAIDS) 3 DHB (Wairarapa, Hutt Valley, Capital and Coast)

It is clear that there is further work to be done to enhance, develop and reshape Wairarapa's Mental Health and Addiction Service, but doing so will enable the service to proactively respond to national and local development and population need against a challenging financial background.

Certain populations were identified (and had been identified by stakeholders prior to the review commencing) as needing more or better service responses, including the older person, those who have high and complex needs related to their mental health and/or addiction issue, many of whom have not engaged well with secondary service responses to date.

Despite the challenges posed by the factors outlined in this report, the review found many strengths and creative and forward thinking initiatives in place in Wairarapa along with a relatively well resourced and well-functioning mental health and addiction sector.

There are passionate leaders in all parts of the 'service sector' including within the DHB and in the community, close relationships generally between the people involved in delivering services in the community; good comparative rates of access to specialist mental health and addiction services and a reasonably high level of involvement of Māori in the service delivery.

Both traditional Māori models and innovative approaches (for both Māori and non-Māori) mental health service provision are useful and that in general, mental health and addiction services are aligned to Government priorities. However, in some cases, it was not clear how effective the services are and whether they target those with the highest needs.

Improvement in services is reliant on substantial changes to improving access, but this must be balanced against the rising demand for both mental health and addiction services which is rising across the whole spectrum of care. Wairarapa will need to balance competing and conflicting priorities for service users and their family/whānau who desperately require mental health and addiction services.

There is a significant need for improved responsiveness of mental health and addiction services, driven by an overarching commitment of all parties to intervene early (early in terms of the age of those presenting with mental health related needs, early in the course of an evolving mental health and addiction issue, and early in the event of a relapse of an established condition); and to identify and respond flexibly to individual needs and provide services based on "what it takes to make a difference".

The review emphasises the need for further development of a continuum of interventions which ranges from broad population based and also targeted mental health (and alcohol and other drug related) promotion and prevention initiatives; early (and most often brief) interventions in a variety of community and primary care settings; well-structured service delivery for people with episodic but serious mental health problems; and well designed and comprehensive integrated arrangements for people who have enduring and serious mental health issues.

Although the DHB has yet to decide on what is the best level and configuration of Mental Health and Addiction services required, the review found services in place already have many of the elements needed to meet the needs of the population, albeit often isolated and not always properly coordinated, but this gives a sound basis upon which the mental health and addiction service can move towards delivering high quality interventions.

This draft report does not specify timelines for implanting change where opportunities exist, however, it should be recognised that a substantial period of time will be required to reshape the Wairarapa DHB Mental Health and Addiction Services. Other issues outside of the scope of this report are contractual obligations, union agreements and the wider context of the healthcare system.

The combination of the review findings contributes to opportunities regarding the potential future mental health and addictions service needs according to population projection and further contributing to discussions and development of: more effective and targeted population prevention; early intervention; and new models of care.

Any findings from the Government Inquiry report due at the end of October 2018 will be considered alongside the findings of the local Wairarapa DHB review. There is nothing being promoted in the review opportunities, which cannot be referenced in one or more of the key national strategic or policy documents and nothing being suggested that contradicts any of these key national directions.

1.1 Recommendations

On the basis of review findings, recommendations are set out below and cover two broad areas; operational and service recommendations. The recommendations are based on stakeholder inputs, literature, key stakeholder clinical knowledge and identifies where service opportunities can make the greatest impact on the greatest number of people, with an emphasis on up-skilling professionals and services that people interact with.

Recommendation: Increase access to community mental health and addiction treatment.

It is recommended that the Wairarapa DHB:

1. *Develop a Referral Pathway and access criteria for secondary mental health and addiction services which provides clear service and program pathways for increasing access and streamlining the treatment pathway. Services would be delivered around clinical care pathways with a focus on recovery and address unmet needs that are the single greatest contributor to poor health and social outcomes at an individual, family and population level.*
2. *Develop mental health funding model adapted to the needs of the older person with mental health/physical health issues.*
3. *Development of new assessment pathway that meets the particular needs of older people with mental health and addiction issues which is essential to help prevent admission and promote early discharge.*
4. *Continue to build on the trend towards family and whānau inclusive practice and ensure that there is clear provision for family/whānau to be offered treatment and support as people in their own right. This could include individual sessions, family education and support groups and multi-family treatment groups.*
5. *Proactively managing the impact of mental health services for the older person by increasing access to interventions that enable older people to retain or recover functioning, avoiding or delaying the need for more intensive and costly support.*
6. *Develop funding models which enable flexible application to fund brief intervention support for service user and family/whānau -focused and tailored service provision.*
7. *Establish acute crisis respite beds for specific populations, including the young, the older person and those with particularly complex conditions such as Coexisting Problems (CEP). Services to be provided in the community rather than on the hospital grounds.*
8. *Modify the provision of supported residential services to best fit demand including high and complex people under 65 years. This would mean increasing the number of housing and recovery beds.*
9. *Resource mental health and addiction community services to be mobile to ensure that services can reach those who need them. Ensure services are available and easily accessible to service users and their family and whānau within each local territories of Wairarapa with decreased waiting times in order to avert future adverse outcomes and improve outcomes.*

10. *Support access to services for those living on the rural and coastal areas, for example by ensuring flexi-funds are available to support people to get to Masterton-based services such as acute crisis respite and managed withdrawal.*

11. *Increase limited resources for drop-in services to reduce the risks of social isolation and relapse for service users and their family/whānau.*

Recommendation: Community services for young people and their families and whānau

It is recommended that the Wairarapa DHB:

12. *Review the purpose of Youth Alcohol and Other Drug (AOD) Multi Systemic Therapy Service. Consider level of resources required for young people who lack secondary and primary level support particularly under 12 year olds. Overall there is limited community services available to youth.*

13. *Develop meaningful day activity options for youth to improve their health and wellness, live a self-directed life and strive to reach their full potential.*

14. *Develop a range of brief intervention options (individual and group based) are available in settings where young people and their families and whānau live, learn and spend their free time. Ensure these options are culturally responsive to Māori.*

15. *Resource a rebalanced mix of rehabilitation options responses across a life course continuum. Ensure services are available and easily accessible to service users and their family and whānau with decreased waiting times in order to avert future adverse outcomes and improve outcomes.*

16. *Increase access to respite for youth and youth AOD Co-existing Problems (CEP).*

Recommendation: Address community services for Māori

It is recommended that the Wairarapa DHB:

17. *Establish a multicultural Mental Health and Addiction Service for Māori. Services that focus on the drivers of inequalities in mental health and addiction burden and outcomes that affect Māori in particular as well as other high needs populations. Consider a re-design of the mental health and addiction service delivery to address service gaps for Māori; this could include options such as re-locating the service into a marae community setting, developing programmes that are more explicitly holistic and reflective of Māori approaches, settings and governance.*

18. *Develop marae-based programmes to meet the needs of Māori based on best practice approaches. Consider whānau ora or healthy families' service continuum approach, which builds on the strengths of whānau and encourages whānau development. Engage Māori and families/whānau in any re-design and development. Health services are provided for the improvement of health outcomes and reduction of health inequalities for Māori who use services.*

Recommendation: Addiction service continuum:

It is recommended that the Wairarapa DHB:

19. *Develop a mixed DHB/NGO addiction service delivery model for the Wairarapa Population. Resource skilled staffing in the community and the Wairarapa DHB Provider Arm secondary service to include Community Based Alcohol and other Drug Treatment Services and clinical support to service users requiring Opioid Substitution Treatment (OST).*

20. *Resource addictions "step up and step down" respite care for addiction service users. Consider a sub-regional (Wairarapa, Hutt Valley and Capital and Coast DHB) service.*

21. *Establish a district-wide model of managed withdrawal which includes integrated community supported residential options and ensure equity of access across the district.*

22. *Establish a small multi-purpose residential service (hub) that provides a mix of options needed for addiction treatment and not currently provided locally in Wairarapa , including social residential managed withdrawal (social detox) care and supported accommodation available to support a period of stability for service users to cement gains post treatment.*

23. *Expand the scope/models used in community services to include outreach components i.e. Packages of Care (APOC) to provide capacity to those who need addiction treatment.*

24. *Develop a tailored treatment pathway for those who are dependent on methamphetamine and their families and whānau to ensure an effective treatment response is available, in the context of partnerships with other stakeholders and preferably as part of a community wide response to methamphetamine related problems. The pathway to be linked to national treatment provisions (available out of district and region) i.e., methamphetamine packages of care which includes residential treatment.*

25. *Partner with key agencies and providers across sectors to develop a comprehensive plan to support delivery of community addiction education (as related to other key issues such as family violence, vulnerable children, mental health, crime etc.) which identifies the objectives, mechanisms, responsibilities, evaluation methods and resources required for delivery.*

Recommendation: Workforce:

It is recommended that the Wairarapa DHB:

26. *Develop a sub-regional (Wairarapa, Hutt Valley and Capital and Coast) Workforce Development Plan that is designed to address the core component of future changes/service improvement initiatives*

27. *Develop mobile mental health and addiction specialist resources which are capable of operating across the entire Wairarapa district and which serve primarily to support the effective delivery of services through locality based teams.*

28. *Build the capacity and capability of all service providers to work in partnership with the service users through supporting and strengthening knowledge, experience and expertise of health workforce to mitigate the loss of experienced workforce.*

29. *Identify priority areas and develop strategies for increasing Māori workforce (including clinical and community based workers). In particular: examine options for career pathways and development; develop closer training links with other sectors to diversify the existing skill based of the Māori workforce; and evaluate recruitment and retention policies for Māori workforce.*

30. *Identify priority areas to grow the Community Support workforce. This includes development of peer support roles within the mental health and addiction teams as a further consideration.*

31. *Establish Advisor role/s (Adult Consumer Advisors, Youth Advisors, and/or Family Advisors) in the Wairarapa DHB Provider Arm.*

32. *Leadership and development of the workforce. Support a diverse workforce that is recovery focused, fosters independence and is well connected, to ensure we build trust, respect and confidence. This includes continued development of the community support workforce. A focused development of capacity and capability across the spectrum of support including enabling e-therapies, self-care/ whānau care and peer support.*

33. *Develop a sub-regional (Wairarapa, Hutt Valley and Capital and Coast DHB) workforce strategy for both mental health and addiction as a core component of future change/service improvement initiatives. This would include strategies to reduce recruitment and retention issues and the development of mental health and addiction career pathways both for those already working in health and social services and for new recruits.*

Recommendation: Integration and Collaboration

It is recommended that the Wairarapa DHB:

34. *Revise intake and assessment arrangements to remove the requirement for separate intake and assessment pathways for service users to address the inter-agency service coordination requirements of service users including young people and the homeless.*
35. *Develop new or revise current service programmes enabling integrated service modules for service users with Co-Existing Problems (CEP) with the aim of reducing siloed service provision between sectors for people with CEP.*
36. *Provide an environment that supports integration and collaborative practice across service delivery boundaries (including primary care) to ensure 'any door is the right door' and mental health and addiction sector builds the capacity and capability to respond to the needs of service user and their family/ whānau.*
37. *Take a whole of person approach by ensuring strong intra and intersectorial relationships to ensure people access the range of support available to achieve recovery and optimal outcomes.*
38. *Working partnership with Oranga Tamariki, Ministry of Social Development, Education and Justice organised through a lead entity for influencing the pathways through high risk mental health, care and protection, and justice services.*

Recommendation: Prevention and Early Intervention

It is recommended that the Wairarapa DHB:

39. *Consider the inter-generational perspective for improving mental health and addictions with the view to decreasing the incidence of health issues in future generations. This is thought to be due to the limited services funded for early intervention and strengthening primary-specialist-community (including social) integration.*
40. *Develop a continuum of early interventions which range from broad population based, targeted mental health and addiction related promotion, education and prevention initiatives; early (and most often brief) interventions in a variety of community and primary care settings including schools.*
41. *Undertake a multi-disciplinary approach to tackle mental health issues in schools, including coordination between: a social worker, adolescent psychologist, general practitioner, and drug and alcohol counselling available on-site at school.*
42. *Increased flexibility of counselling sessions. Information to be provided to the sector to explain the basis for the funding early intervention (mental health and addiction) counselling sessions.*
43. *Resource services and programmes that intervene earlier in the life course where there is strong evidence for effective interventions that reduce the burden and cost of mental health and addiction – with at risk families, children and adolescents.*
44. *Increase anti stigma and discrimination resource to enable service users to gain support, protection and redress if they are discriminated against.*
45. *Review suicide postvention governance and clearly delineate roles and accountabilities for the co-ordination and integration of suicide prevention activities and other suicide prevention programs across all levels of providers in the Wairarapa.*

Recommendation: Health Information and Education

It is recommended that the Wairarapa DHB:

46. *Develop a mental health and addiction service map aimed at informing people in the community of the range of services available.*

47. *Develop information and education programmes appropriate to the service user, their family/whānau and the community at large including on line (ie out of hours) –quality of information provided to families. Services to be designed to improve a person's health literacy, including improving knowledge, and developing life skills which are available and easily accessible to service users and their family and whānau.*

48. *Undertake a community sponsored marketing and information campaign promoting awareness of mental health and addiction services and how these are accessed.*

Recommendation: Quality, Process and Procedures

It is recommended that the Wairarapa DHB:

49. *Develop a clinical governance structure to support the work of all staff (clinicians and support staff) in the sub-regional mental health and addiction service This includes supporting and monitoring services to be integrated, flexible and responsive; a high performing network of people and agencies.*

50. *Develop guidelines to promote good practice in relation to the development of 'joined-up' mental health and addiction service planning for people with multiple service needs including homeless people*

51. *Plan effective triage systems for providing more group programmes, and ensuring robust systems are in place for prioritising need and monitoring demand and delivery.*

52. *Undertake the development or updating and maintenance of clinical guidelines and standards for improving high standards of care (clinical and non-clinical.*

53. *Develop transparent responsibility and accountability for those standards required for the delivery of care to the people who use the mental health and addiction services, their family/whānau.*

54. *Plan for the use of the Ministry of Health's Population-based Outcomes Framework for Mental Health and Addiction. The mental health and addiction service should be outcomes focussed (that is, have in place a routine outcome monitoring programme) and the outcomes should link to agreed clinical and service performance measures.*

55. *Undertake a review of prices being provided for one service category which is disproportionate to the price for other services. Develop equitable prices relative with the expected resources/costs of delivery.*

56. *Develop guidelines for engagement with family/whānau in the service user's recovery plan. This includes knowing who should be contacted, when a service users does not want family involved, and/or there is not the time or inclination to engage with family/whānau.*

57. *Establish systems for monitoring outcomes to ensure services are sufficiently resourced, developed or in place to report on service delivery expectations which should be clear and consistent as part of a Service Framework for each service cluster.*

58. *Ensure robust service user feedback complaint/feedback systems are in place.*

Recommendation: Collaborative leadership group:

It is recommended that the Wairarapa DHB:

59. *Review the Terms of Reference (TOR) for the collaborative mental health addiction leadership group to maximise positive outcomes for people experiencing mental health and addiction issues and their families and whānau. Consider resources to the group to enable them to implement key projects to meet identified priorities.*

2.0 Background

2.1 Review Setting

Epidemiological studies indicate that one in five New Zealanders at any one time experience a mental illness or addiction (Oakley Browne et al 2006)[4]. The New Zealand Health Strategy (2016)[5] aims to ensure that "All New Zealanders live well, stay well and get well" (p.13).

To achieve this aim, five strategic interconnected themes are articulated: People-powered; Closer to home; Value and high performance; One team and Smart systems.

Innovation will also mean purchasing outcomes rather than specific inputs and moving resources to the most effective services irrespective of whether they are provided by the Wairarapa DHB or Non Government Organisations (NGO) providers. The Strategy notes that systems need to find a balance between conflicting needs and priorities and make the best use of skills and resources to provide "a more integrated and cohesive system that works in the best interests of New Zealanders" (p.15).

The Wairarapa DHB funds a mix of mental health and addictions hospital in-patient services and community-based services for its vulnerable people (children, young people, adults and older people) from its Provider Arm and Non-Government Organisations and Primary Mental Health from its Primary Care provider. The services are provided within the broader context of health and other social service provision, all of which are underpinned by government priorities and local community imperatives.

Over recent years, the DHB has closely assessed its mental health and addition services. It recognises that DHB's investment in mental health and addiction service (as with many other DHB's) has not progressed sufficiently to respond to the changing environment, demographics, and community needs against the government and local priorities.

Until 2009, the DHB had been contracting with seven service providers, covering mental health, alcohol and drug addiction, mental health day programmes and community residential care services which had been in place for some years.

In 2008/2009 a review of the Mental Health & Addiction Services was undertaken and a new service model was developed as part of the mental health and addiction component of Tihei Wairarapa, a Wairarapa-wide initiative which explored how all services could integrate more closely to provide better and more holistic health care.

The Tihei Wairarapa set a five-year (2010 – 2015) direction for progressing the delivery mental health and addiction services in the Wairarapa, aligned to the Government's promise of "Better, Sooner, More Convenient" health care. Tihei Wairarapa aimed to address problems facing the district including:

- The ageing population and escalating incidence and impact of long term conditions;
- Poor health outcomes for Māori, Pacific, people living with high deprivation, and people living with long-term mental illness;
- Sector wide workforce constraints and restraints;
- Unnecessary levels of primary care services being provided in the secondary care setting
- Rigid primary care contracting models, acting as an impediment to the development of the Integrated Family Health Centre network;

[4] *https://nsfl.health.govt.nz/accountability/service-coverage-schedule/service-coverage-schedule-201718*
[5] Ministry of Health: *New Health Strategy 2016-2026 (2016)*

- Limited funding increases forecasted, with reductions of funding and efficiencies expected to be realised from the existing PHO infrastructure; and
- The need to improve the sustainability of Wairarapa DHB funding and service provision.

The review of Wairarapa DHB's Mental Health and Addiction Service was a matter of priority in response to several factors, including the DHB's increasing demands on its Mental Health and Addiction Services at a time when there are also significant fiscal pressures across the DHB. The review represents a significant and timely opportunity to improve wellbeing outcomes for the Wairarapa DHB population. Further, this approach is an important step towards addressing government and public expectations about how services respond to people with mental health and addictions issues.

Key factors considered for undertaking the review are outlined below.

Tihei Wairarapa

Tihei Wairarapa implemented in 2010, expired in June 2015. Services should be reviewed least every three years to update any traditional responses and/or practices. In accordance with the principle of continuous quality improvement, to achieve the expected outcomes, the Wairarapa Mental Health and Addiction Services are overdue for review, evaluation and adaption where necessary.

Mental Health Addiction and Intellectual Disability Services (MHAIDS)

In 2014 it was agreed that the Mental Health Addiction and Intellectual Disability Services of Capital and Coast, Hutt Valley and Wairarapa DHB's be integrated as a response to growing demand, and a mechanism to support the sustainability of specialist services across the Wellington sub region. The new MHAID Service 3DHB was launched in February 2015.

As a 3DHB service, MHAIDS spans three DHBs - Wairarapa, Hutt Valley and Capital and Coast DHB's -and includes local, regional, and national services. The local MHAID services are provided from multiple sites within the 3DHB sub-region across Wellington, Porirua, Kāpiti, the Hutt Valley and the Wairarapa. Te Korowai Whariki services include regional forensic and rehabilitation services covering the Central region while the intellectual disability services extend the length and breadth of the country from six bases located in Whangarei, Auckland, Cambridge, Wellington, Christchurch, and Dunedin.

Strengthening the locality perspective – Outcomes focused

Three key strategies that direct Wairarapa DHB's efforts in 2017/2018 and the coming years are set out in their Annual Plan 2017/18[6]. Improving equity of health outcomes; the 'triple aim' of balancing persons experience with quality and safety and wise use of resources; and taking an intersectorial approach to improving the health of the Wairarapa population.

Addressing local needs and providing services closer to home will be achieved by identifying where opportunities to free up resources for re-investment and/or identify where Wairarapa DHB needs to create longer term service sustainability to meet the needs of their population, will provide better directing of investment to address inequality and improve people's lives.

Cultural responsiveness

He Korowai Oranga, New Zealand's Māori Health Strategy sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. It was refreshed in 2014 so that it continues to be relevant and builds on the initial foundation of whānau ora (healthy families) to include mauri ora (healthy individuals) and wai ora (healthy environments.

[6] *Wairarapa DHB 2017/2018 Annual Plan*

An integrated care pathway is central to transforming to a more integrated service. Both within and across the Wairarapa DHB, the range of mental health and addiction services required do not always match a person's needs as they proceed through their various stages of recovery. There is still a lack of integration and poor co-ordination among service providers. There are some services for which there is a demand but do not exist, and other services cannot cope with the numbers seeking the service.

Alcohol and Other Drugs (AOD)

Prior to October 2016, Mental Health Solution Limited (delivered by Pathways Health Ltd) sub-contracted to Care NZ for the Alcohol and Other Drugs (AoD) Service components. Changes from October 2016, saw the AoD services being fully delivered by Pathways for the Wairarapa DHB population.

Government Rules of Sourcing

The third edition of the Government Rules of Sourcing[7] provide a framework that promotes responsible spending when purchasing goods, services and works, proactively managing procurement process and the delivery risks.

Government Rules of Sourcing Rule 7 applies when a) the procurement of goods or services or refurbishment works, or a combination of goods or services or refurbishment works, and b) when the maximum total estimated value (Rule 9) of the procurement meets or exceeds the value threshold of $100,000 (excluding GST). Even if the value of a procurement is less than the value threshold (set out in Rule 7), agencies are still expected to follow good procurement practice.

This final draft report sets out a summary of findings and provides recommendations aimed at setting out a realistic pathway to address identified gaps and improve integration of the current models of care that are operating within Wairarapa DHB Mental Health and Addiction Services.

2.2 Strategic Context

Nationally the health system is facing intense pressure for change stemming from rising costs, demographic shifts, growing consumer expectations and modern technologies. Demand for mental health services has also grown. More than half of New Zealanders are likely to experience a mental health disorder at least once in their lives. Each year approximately 20 percent of New Zealanders present to mental health services, and over 500 people die by suicide.

Responding to mental health and addiction needs in our population has been the focus of a number of government policies and programmes. Most recent strategies include the demand for future services to be "anytime, anywhere" requiring effective models that inform the delivery of services and responses. Strategic direction for mental health and addiction is guided by the New Zealand Health Strategy, mental health and addiction service delivery outlined in "*Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*[8], *BluePrint II: Improving mental health and wellbeing for all New Zealanders 2012*[9] and *Better Sooner More Convenient* Policy[10].

Key strategies currently in place are:

- *New Zealand Health Strategy*
- *Primary Health Care Strategy*
- *New Zealand Disability Strategy*

[7] Aproved by the Ministers of Finance and State Services and was endorsed by Cabinet on 30 March 2015. It applies from 1 July 2015

[8] Ministry of Health: *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 (the Plan),*

[9] Ministry of Health: *BluePrint II: Improving mental health and wellbeing for all New Zealanders (2012)*

[10] Ministry of Health: *Better Sooner More Convenient Care in the Community (2011).*

- *He Korowai Oranga: Māori Health Strategy.*

While there remains attention on improving mental health and addiction services, there is also understanding that there remains variability in service delivery around the country, and that important inequities exist – particularly for Māori. New Zealand's Māori Health Strategy, He Korowai Oranga[11] continues to set the framework that guides the health sector to achieve the best health outcomes for Māori. The strategy was updated in during 2013/14 to ensure its relevance for the future. The Strategy aims to achieve the vision of Pae Ora (Healthy Futures), building on the foundation of Whānau Ora (Healthy Families) to include Mauri Ora (Healthy Individuals) and Wai Ora (Healthy Environments).

In addition to the key national strategies, a variety of plans have been developed that guide DHBs at a national, regional and local level and which link into the DHB's Annual Plan. These include:

- Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017
- BluePrint II: Improving mental health and wellbeing for all New Zealanders 2012
- Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018[12]
- Central Region Regional Service Plan 2017-18
- Wairarapa DHB Māori Health Plan 2016-17
- Wairarapa (and Hutt Valley) Pacific Action Plan "Paolo mo tagala ole Moaana: Pacific Health Action Plan 2015-2018"

Attention to mental health need therefore also requires an understanding of broader Government priorities such as:

- The Prime Minister's Youth Mental Health Project.
- The Drivers of Crime work programme, with a focus on conduct disorders and alcohol and other drugs.
- Suicide Prevention Action Plan.
- Vulnerable Children and the work of Oranga Tamariki.
- Whānau Ora initiatives.
- Welfare Reforms.

Refer to Appendix Eight for further details of national strategies and policy documents. Appendix Eight is far from exhaustive (and their content only selectively highlighted), however, they outline key developments nationally and illustrate the alignment of the review findings at a broad level.

Government Inquiry on Mental Health

On 31 January 2018 the Government established an inquiry into mental health and addiction13 in response to widespread concern about mental health and addiction services in the mental health sector and the broader community. The ultimate goal of the Inquiry is to improve the mental health and addiction outcomes of New Zealanders.

The Inquiry is wide ranging and will look at how good mental health is promoted and supported in New Zealand and how the services currently respond to the needs of people experiencing mental health and addiction challenges, including people affected by suicide. Members of the public were invited to meet with the Government Inquiry panel in Wairarapa in May 2018.

[11] https://www.health.govt.nz/publication/he-korowai-oranga-Māori -health-strategy
[12] Ministry of Health: *Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018*
[13] *https://www.mentalhealth.inquiry.govt.nz/*

The Inquiry panel wanted to hear from the public about:

- What's working well?
- What's not working well?
- What could be done better?
- What sort of society would be best for the mental health of all of our people?
- Anything else you want to tell us?

The Government Inquiry into Mental Health and Addiction is chaired by former Health and Disability Commissioner, Professor Ron Paterson, and will report back to the Government by the end of October 2018.

Any findings from the government inquiry will be considered alongside Wairarapa DHB Mental Health and Addiction Service review findings.

Wairarapa DHB Priorities

Over the last few years, the Wairarapa DHB has faced the increasing demands on its mental health and addiction services at a time when there are also significant fiscal pressures across the DHB with many competing demands on their resources. This is placing a strain on ensuring appropriate levels of services are available for the suite of mental health and addiction services required by Wairarapa DHB.

The priorities for Wairarapa DHB are clearly outlined in a number of plans including *Wairarapa DHB Annual Plan 2017-18*[14]*.*

Wairarapa DHB's key responses linked to NZ Health Strategy to deliver improved performance focus include specifically identified actions aimed at improving equity of health outcomes. The two key priorities of the Wairarapa DHB are:

- Improve the quality of mental health services including reducing the rate of Māori under community treatment orders.
- Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.

[14] *http://www.wairarapa.dhb.org.nz/news-and-publications/reports-and-publications/annual-plan/wairarapa-dhb-annual-plan-2017-18.pdf*

3.0 Service Assessment

An assessment of current mental health and addiction service needs for the Wairarapa DHB population, including the needs of the person using the services and their family/whānau, was undertaken to identify challenges to current services, what's currently working and what's not working well.

The assessment process was complex due to the required analysis of a large amount of information, including interviews and a number of key Stakeholder Hui feedback.

3.1 The District

Wairarapa DHB services a population of 44,030 people (2017/2018 estimate)[15] and occupies the south-eastern corner of the North Island, east of Wellington and south-west of the Hawke's Bay region. It is lightly populated, having three district councils: Masterton, Carterton and South Wairarapa.

The South Wairarapa encompasses the towns of Greytown, Featherston and Martinborough. Carterton is one of the fastest growing area in New Zealand with Masterton district being the largest covering areas up to the Tararua District.

Characteristics relevant to consideration of mental health and addiction service delivery include:

- Wairarapa DHB has a slightly higher proportion of people living in high-deprivation areas than in low deprivation areas[16].
- The Wairarapa population is getting proportionately older: the 65-plus age group is projected to increase by more than 78 percent by 2026. Nearly a third of Masterton's population will be aged over 65 by 2031, according to census data projections. This showed roughly 30 per cent of people living in Masterton district, would be over 65.
- Wairarapa has a high percentage Māori population at 17.3 percent, slightly higher than the national average of 16 percent. Children and youth 0-18 years make up nearly half of the total Wairarapa Māori population at 41.1% (or 3,330 people) with the other half in the 19-64 years at 49.5% (or3,820 people).
- The Pacific population is 2.0 percent much lower than the national average at 6.5 percent.

Age, ethnicity and deprivation are all factors which are relevant considerations for Wairarapa DHB service planning, development and resourcing.

3.2 Service Provision in context

The specialist mental health and addiction services are funded for those people who are most severely affected by mental health and/or addiction issues. In addition to the access expectations set out in Rising to the Challenge, it is expected that DHBs will provide access to specialist services for a minimum of 3% of their population. A focus on early intervention strategies means specialist services are delivered to people who are at risk of developing more severe mental illness or addiction.

Te Rau Hinengaro The New Zealand Mental Health Survey Oakley- Browne, Wells and Scott (Eds) (2006)[17] provides guidance as to the mental health and addiction disorders by ethnic group and by severity and examines access to health services and socio-economic variables. The Service Coverage Schedule (SCS)[18] describes the expectations of all DHBs for funding of services.

[15] HVDHB Analyst_Population Projections - Summary File (2017 Update)_May 2018
[16] Ministry of Health My DHB available at: http://www.health.govt.nz/new-zealand-health-system/my-dhb; retrieved August 2018.
[17] Te Rau Hinengaro: The New Zealand Mental Health Survey
[18] Ministry of Health Service Coverage Schedule 2018/19

The DHB of Domicile (DoD) is the DHB responsible for funding services for its resident population. The 'resident population' of a DHB is defined in section 6 of the NZPHD Act as 'the eligible people residing in the geographical area of the DHB'. A DHB and its geographical area are defined by the territorial authority and ward boundaries outlined in Schedule 1 to the NZPHD Act.

The DHB of Service (DoS) is the DHB that provides the service. An Inter District Flow (IDF) outflow occurs when an eligible person receives treatment and the DHB of Service is not the District of Domicile for that person[19].

When assistance is required under the Mental Health (ACT) Act 1992, 90% of people presenting should be assessed within four hours. DHBs with isolated rural communities are to ensure that effective arrangements are in place. If a person is assessed as needing hospital care under the Mental Health (CAT) Act 1992, 90% should be admitted to a hospital within six hours of being assessed by a doctor or health professional.

Different levels of care are provided depending on the level of need of the service user and different population groups that have varying needs for the mental health and addiction services. Services are delivered across the continuum of care, regionally, sub-regionally and locally from a District Health Board and/or NGO (i.e. approximately 36.6 % of its mental health and addiction service spend includes NGO contracts for community residential facilities).

The services include a mix of mental health and addictions hospital in-patient services and community-based services for its vulnerable people (children, young people, adults and older people) from its Provider Arm and NGO's. The community-based addiction, residential, day care drop-in, recreational and vocational services are predominantly provided by NGO service providers utilising both registered clinicians and non-clinical workforce (FTE).

There are a number of community providers that do not receive mental health funding directly from Wairarapa DHB but receive health funding through sub-contracting arrangements with mental health providers. Such services include: talking therapies, counselling, advocacy and peer support, education and information, respite care, family and community support services to individuals, their families, friends and the community at large.

Other providers – excluding health community service groups – may access funding from: Ministry of Justice, Ministry of Social Development, Local Government, Department of Internal Affairs, Lotteries Grants Board, the Hillary Commission, Philanthropic Trusts or private sponsors/donations.

The treatment and care for mental health and addiction related issues are provided in a variety of settings. The environment, and level or type of care, depends on multiple factors: the nature and severity of the person's mental issue, their physical health, and the type of treatment indicated. While some service users are able to lead relatively healthy lives and manage their mental and/or addiction issue, others rely on full time care within specially designed residential programmes that provide 24 hour, seven days a week service both at a regional and local level.

Currently, the greatest service configuration gaps exist in mental health and addiction service provision for Māori, Pacific peoples, children and young people, and older people, particularly in gaining access to crisis and acute services.

3.2.1 Service Continuum

Access was the most commonly raised issue in the review feedback. Certain population groups were identified (and had been identified by Stakeholders prior to the review commencing) as needing more or

[19] CCDHB provides the majority of the regional 'specialty' services, including Forensic mental health services and inpatient services for rangatahi, adults and older people.

better service responses, including children and young people, older people 65+, and those who have serious high and complex needs related to their mental health and/or alcohol and other drug problems. Many of whom do not engage well with mental health and addiction service responses.

Although the number of Wairarapa mental health and addiction specialist services for children and young people has increased, gaps in access still remain, and lag well behind those of adult services.

Difficulties accessing mental health and addiction services for older people was an area of growing concern for service users and their family and whānau. Increasing access for 65+ needs to be consistent with trends reflecting population growth, growing social awareness, and increasingly open discussion of mental health issues for older people population of Wairarapa.

Both DHB specialist and NGO community services have an element of outreach and/or mobile component but these services are considered lacking across both adult and youth services. Services are not seen to be working in close partnership (i.e. having a shared pathway) with peer and community support service delivery.

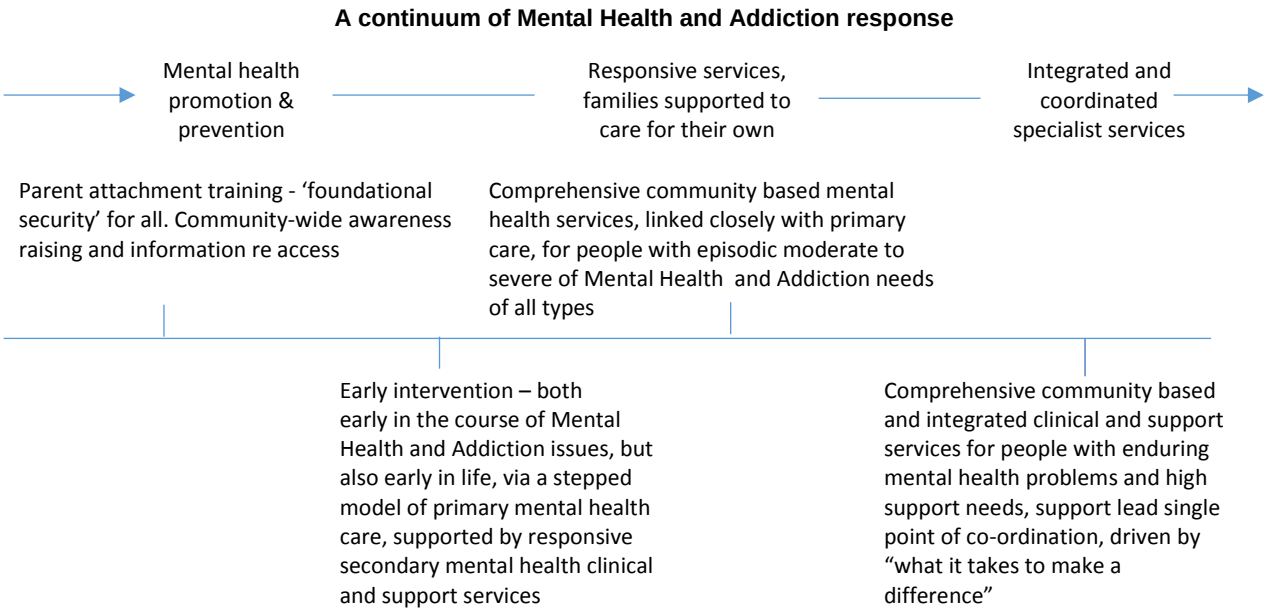
The review identified the need for further development of a continuum of early interventions which range from broad population based, targeted mental health and addiction related promotion and prevention initiatives; early (and most often brief) interventions in a variety of community and primary care settings including schools.

To achieve better mental health outcomes for individuals, families and communities, it is essential that the different parts of the Mental Health and Addiction System and other social services work well together, in order to provide continuity of care. This complete range of programs and services is referred to as a continuum of care.

The continuum of mental health and addiction service is complex and requires many levels of care to align with the needs of a service user. For the Wairarapa, there is not a consistent continuum of services i.e. crisis to housing and recovery to home for life within the person's community with limited access to supported accommodation in the community.

The continuum of responses is reflected in a basic form in the following diagram[20].

Figure 1: Continuum of Mental Health and Addiction Response.



[20] Tairawhiti DHB: *A Pathway to Better Mental Health* 2008

The current service structure does not consider the inter-generational perspective for improving mental health and addictions with the view to decreasing the incidence of health issues in future generations. This is thought to be due to the limited services funded for early intervention and strengthening primary-specialist-community (including social) integration.

An inter-generational perspective would provide for a continuum of effective responses where the health of current and future generations can be nurtured and protected, where those who develop mental health and addiction issues have ready access to needed help before their problems becomes too severe, and where there are excellent resources available for people who despite the best efforts of all develop enduring or serious illnesses.

The Wairarapa DHB funds a number of services (or programmes) on the response continuum so most mental health and addiction staff have experience or knowledge of a service continuum i.e. which services might be most appropriate given a person's needs, and what to expect for each service type. There are other staff don't work within the response continuum, which can result in people being readmitted to acute care i.e. an inpatient unit or community-based crisis respite.

The current Wairarapa services in place, as part of the continuum of care, are being limited by other factors not necessary related to staff resources. There are gaps in services for people with mild to moderate mental issues and people with multiple problems who may be passed between sectors. For example, in some cases, people (including youth) who are turned away from mental health services may later be picked up by the justice sector.

Recovery and resilience focused services form an essential part of the continuum of care in the mental health and addictions system and work in an integrated way with specialist services and other service providers. Although adequate staffing levels may be found in the recovery and resilience services, services are not reaching all the target population groups.

Planning to meet the age-based needs of specific populations was found to be lacking as a recent focus. With the population of people aged 65 years and older projected to increase significantly in Wairarapa by 2040, the Wairarapa mental health and addiction service responses for the elderly will need to take into account this growth, which although relatively slow for the immediate period, is growing.

Wairarapa receives acute inpatient services from Hutt Valley District Health Board at their Te Whare Ahura inpatient unit in Lower Hutt. Other inpatient services are provided from Capital and Coast District Health Board and its associated regional forensic services, rehabilitation and extended care, mental health for older person's psychogeriatric service and child, adolescent and youth rangatahi service based on Ratonga Rua campus in Porirua City.

Alongside the strengths, and as is likely to be found in any mental health and/or addiction service system, the review found there are opportunities for change both structurally and functionally across many parts of the service and continuum. For example, the review found there were gaps in the co-ordination and integration of suicide postvention activities and other suicide prevention programs across all levels of providers in the Wairarapa. There is a need for better governance and more clearly delineated roles and accountabilities for suicide prevention.

3.2.2 Community-based Clinical Treatment and Therapy

There are different service delivery models for the Wairarapa community –based clinical treatment and therapy services for children, adolescent and youth, adult and older people. The current types of treatment settings for receiving mental health and addiction care or services are hospital inpatient, community based acute crisis and community-based services which include mobile crisis teams, providing home-based acute treatment, and case-management services for ongoing treatment.

Their core business is specialist mental health assessment, treatment and follow-up. The key input for the services are the workforce.

The Wairarapa DHB Community Mental Health teams for adult (CMHT) and children, adolescent and youth (CAMHS) operate as individual teams, with sub-functions within the teams addressing various specialty and functional areas of service delivery e.g. crisis assessment, community mobile intensive treatment, maternal mental health etc.

Referrals to the Service may be made from any source, including self-referral. Some of the speciality services have specific requirements before accepting a referral. In these circumstances, the services have clear documented access criteria and protocols. These are communicated with family, whānau and others making contact with the Service.

There is a high level of responsiveness from the CMHT and CAMHS to primary care locally – GPs report that they can access telephone consults with a psychiatrist readily, and that clients they need assessed can in general be seen. There are regular primary/secondary service meetings between senior staff enabling good relationships and arrangements.

There are two types of compulsory treatment orders. One is for treatment in the community (a section 29 order) and the other is for treatment in an inpatient unit (a section 30 order). Most people subject to compulsory treatment access it in the community (approximately 88 percent in 2016)[21].

The national average number of people per 100,000 on a given day [22]subject to section 29 of the Mental Health Act, by DHB, 1 January to 31 December 2016 was 87 with Wairarapa DHB at 79, Hutt Valley DHB at 72 and Capital and Coast DHB at 113[23].

These statistics reinforce the need for the Wairarapa DHB to address the disparity of mental health outcomes for Māori. This is a specific action outlined in Rising to the Challenge (Ministry of Health 2012e) and Wairarapa DHB Annual Plan 2017/2018[24]. In addition, the number of Māori subject to section 29 of the Mental Health Act is now an indicator in the Māori Health Plans that the Ministry of Health requires every DHB to produce [25].

Gaps in clinical service provision currently exist for older people 65+ because different models have been created for different purposes (mental health treatment, primary care, or social support). These models have developed in response to different historical pressures rather than because someone overlooked elements while rationally laying out a service for older adults.

This has been further complicated because older adults experience coexisting physical health and/or social difficulties, making it easy for individual services to transfer responsibility to another “more appropriate” service i.e. Health of Older People Service.

Finally, cultural differences between physical and mental health and addiction providers were thought to hinder service user outcomes. “Physical” and “mental health or addiction” services, are often separated at clinical, organisational, policy and financial levels. Mental health and addiction care requires more of a team effort between psychiatrists, social workers, psychologists and case managers, with mental health visits typically longer, due to the nature of the issues.

[21] Office of the Director of Mental Health Annual Report 2016, page 20
[22] On a given day’ is the average of the last day of each month
[23] Source: PRIMHD data, extracted on 26 July 2017, except for data from Southern and Counties Manukau DHBs, which was supplied manually.
[24] Wairarapa DHB Annual Plan et al,: page 15
[25] This is a specific action outlined in Rising to the Challenge (Ministry of Health 2012e).

3.2.3 Services to promote resilience, recovery and connectedness

A clear sense of social connectedness and a sense of community has been developed in the Wairarapa to support community resilience. Many Stakeholders reported that their communities were very connected, however, there are challenges in the equity of access by different communities geographically within Wairarapa which have different needs and capacities for their service users and their families/ whānau.

Many service users and their families/whānau, particularly in South Wairarapa and rural areas do not have access to suitable expertise to give them the support they need. This can create disconnect between the services available and the service users need, often leading to an escalation of mental health and/or addiction issues and can create a vicious circle and a revolving door for service users and their family/ whānau. This issue is exacerbated for those who live outside of Masterton.

Stakeholders noted that in the socioeconomically disadvantaged communities, many people were already living in hardship. For example:

- Access to services can be difficult for people who have limited transport options. Some people have limited resources to get to appointments for example cars are in need of repair, some do not have money for petrol or for public transport.
- The level of resources required for different geographical locations does not meet the needs of the local population. While services are mobile to some extent, resources are limited in South Wairarapa and remote coastal locations.

3.2.4 Addiction Service

A broad range of services to meet the addiction needs of young people, adults, older adults, and those linked to the DHB via the criminal justice system are provided in the Wairarapa. These services range from brief early interventions to withdrawal services and longer treatment and support programmes, which address the physical and psychological needs of service users and their families, as well as wider social issues.

The majority of the Wairarapa addiction services are based locally, however there is a general agreement from Wairarapa stakeholders that these services are siloed with often limited interface with the Wairarapa DHB Provider Arm clinical teams. There are no DHB Provider Arm addiction services – the majority of addiction services (excluding intensive residential treatment service) are contracted to Pathways Health Limited, an NGO service, and Te Hauora Runanga O Wairarapa providing some community based addiction services through its Kaupapa Maori contract.

The clinical skill base of the NGO addiction service differs substantially from mental health NGO service with the level of competency for addiction service being registered practitioners e.g. registered nurses and addiction clinicians delivering the addiction services. The limited DHB Provider Arm addiction resource has been raised as a key issue by many stakeholders. The Wairarapa DHB's adult CMHT has three addiction clinicians and CAMHS has one addiction clinician. Stakeholders voiced a need for the resourcing senior medical officers and skilled clinicians in the Provider Arm secondary teams.

While the addiction intensive residential treatment based services make up only a small part of the overall addiction service profile, the youth and adult addiction treatment has historically used residential treatment as a major treatment intervention. Several of these services are based outside of the district, with beds being funded by the six Central Regions' DHBs.

The addiction treatment programmes provided locally are valued by the Wairarapa stakeholders, however, stakeholder feedback indicates there is insufficient management of access to all levels of addiction treatment both at a local and regional level to ensure service users get the right level of support when they need it.

This includes preparation for residential treatment and continuing support and care beyond the period of residential treatment and lack of local supported accommodation available to support a period of stability for service users to cement gains post treatment.

Underlying all of the above is the need for ongoing leadership and development of the workforce. Feedback suggests there is a lack of understanding about the overall addiction treatment continuum and gaps in understanding the differences between residential and other treatment options to meet the diverse range of addiction treatment needs. This has resulted in variability in the delivery of effective addiction services and interventions for service users both locally and across the sub-regional addiction services for the Wairarapa, Hutt Valley and Capital and Coast DHB populations.

This means the current addiction service configuration across the sub-region is sub-optimal and it is not always possible for staff to deliver care in line with an evidence based five tiered approach developed by the Central Region in 2014[26].

A standardised service model was developed by the Central Region addiction working group early 2014, was agreed through a wide socialisation process across the six (6) DHB's in Central Region. This model has not been fully implemented in the Central region. The new model for people who enter into and from residential addiction services requires:

- A greater focus on respite care (step up step down)
- Capacity to treat co-existing mental disorders
- Development of addiction peer support services
- Capacity to manage the provisions of the new SACAT Act.

Innovation and flexibility is required to meet the constant changes in the wider addiction environment. Feedback strongly supports the need for development of shared criteria and clear pathways to support an integrated journey for service users and their family and whānau.

3.2.5 Cultural

Reducing inequalities between Māori and non-Māori can be achieved by empowering whānau to achieve their own health and development goals. The current service configuration lacks a broad range of quality and choice mental health and addiction services for Māori.

The DHB's cultural assessment and service delivery function is integrated within both community mental health teams (CMHT/CAMHS). Where possible, both a cultural and clinical team member will undertake all new assessments of Māori jointly. The proportion of Māori clinicians, taken as a proportion of the Māori population in Wairarapa, is not equivalent to the level required to reduce inequality.

Although there are Kaupapa-based cultural teams situated in the NGO community working together to provide cultural responses, there is limited, if any, evidence of continuity of care for Māori between mainstream and Kaupapa Māori services, between mental health and addiction services, between mental health and addiction and other health services, and between health and wider government social services.

This is creating barriers for enabling Māori to present earlier to mental health and addiction services and for promoting choice in Kaupapa Māori models of practice. More work needs to be done to ensure services are responsive to Māori and when models of practice incorporate a better understanding of the importance of whānau, Māori approaches to health, and the interface between culture and clinical practice Māori participation in the planning and delivery of mental health and addiction services for Māori.

[26] *Central Region AOD Service Model 2014*

3.2.6 Workforce

There are many creative and forward thinking people working in the Wairarapa mental health and addiction services and there is a reasonably resourced sector in place for the Wairarapa population. There are passionate leaders in all parts of the 'service sector' including within the DHB and NGOs; close relationships generally between the people involved in delivering services in the communities; good comparative rates of access to some specialist mental health services; and examples of providers working well beyond their minimum contractual requirements, with passion and flair.

Wairarapa services often 'unseen' work of the unpaid workforce – those family members and friends who provide essential ongoing care for those with serious and enduring mental health and/or addiction illnesses.

In the main, the Wairarapa DHB specialised teams appeared to have good morale and team cohesion. While staff in all service teams (DHB and NGO) spoke about demand pressures and the challenges of service changes, all agreed these issues were relevant to both the adult and CAMHS services. Staff involved in the acute end of community services (crisis and community teams) appeared to be particularly under pressure with their dual role of supporting community mental health and crisis respite services.

Issues relating to a sustainable workforce was a key concern for stakeholders, suggesting a shift in the practice of specialist clinicians could be based on more complementary service provision. This would require relationships of trust and a high degree of collaboration between the NGO support workforce, primary care and secondary mental health and addiction clinicians.

Key to this issues could be removing the weight of care coordination from clinicians and freeing up the time pressure on clinicians who generally have the greatest extent of technical and professional training. This has the possibility of freeing up clinicians time to advance practice in new or underdeveloped areas such as primary mental health; training (including NGOs); further development of more specialisation in areas such as addiction and maternal mental health etc. It has been suggested that a support worker in an NGO could perform the care coordination role using this model.

Whilst Wairarapa DHB has a number of innovative initiatives and/or workforce development, there is limited development in a sub-regional and/or district-wide integrated mental health and addiction workforce approach with a high level of leadership, innovation and collaboration.

Māori Workforce

The development of the Māori health workforce is a strategic priority for improving local responsiveness to Māori consumers and Māori service performance in Wairarapa District.

The review found there is an inadequate number of qualified Māori mental health and addiction professionals across all disciplines who can draw on their culture and professional skills to provide services to Māori people. Developing the ongoing capacity, capability and competence of the Māori health workforce would contribute to the establishment of incentives to recruit and retain the health workforce.

The mental health and addiction workforce needs to include well supported qualified Māori mental health professionals to develop and provide culturally competent services in which whānau are recognised as being central to providing support to the service user in understanding their situation and working towards recovery. In whatever role, Māori mental health and addiction professionals should be given adequate culturally appropriate support and mentorship.

In relation to Māori youth and their whānau, research has identified the need to improve the delivery of child and adolescent mental health services through respectful partnerships, cultural support, and Māori workforce development[27].

Community Support Workforce

The results of the adult mental health and addiction workforce: 2014 survey of Vote Health Funded services[28] identified that the community support workforce, including peer support, was the largest part (31%) of the adult mental health and addiction workforce. Twenty one per cent of community support workers were employed by DHB services, 72% were employed by adult NGO mental health services and a further 7% were employed by adult NGO addiction services. Because community support is the largest workforce, it has a significant role to play in implementing opportunities identified as a result of the review.

Support workers comprise 31 per cent of the adult mental health and addiction workforce (2,988 FTE positions). Whilst 21 per cent of community support workers worked within DHB MH&A services, 72 percent (2,142) are employed by adult mental health NGO services and 7 per cent (209) are employed by adult addiction NGO services. The difference between mental health and addiction services can be explained by the number of staff working in addiction services who are now classified as Dapaanz addiction practitioners[29].

In 2014, community support workers comprised 8 per cent of the total child and adolescent mental health/addiction (CAMHS/AOD) workforce. Of this total (141.7 actual FTEs), NGO CAMHS/AOD services employed 81 per cent of this particular occupational group (115.1 actual FTEs).

Some of the key issues for the development of the community support workforce include:

- The breadth and diversity of community support roles (including peer support roles)
- Retention and recruitment challenges for DHB's and NGO's.
- The need for an education and career pathway for community support workers.
- The possibility of creating a distinct professional identity.

Stakeholders identified a greater investment in workforce development was required so that staff are better equipped to respond to the needs of service users from a person-centric, non-service defined perspective. Wairarapa, Hutt Valley and Capital and Coast , as a sub-region, lacks a whole-of-system approach to workforce development for staff recruitment and retention, leadership development at all levels, and developing and supporting NGO and Primary Care organisations to deliver better services more efficiently.

3.2.7 Operational and Clinical Governance

Stakeholder's highlighted that effective clinical governance was a priority for clinical care delivery and for ensuring that regulatory and statutory policy, processes and procedures are in place. The clinical governance structure would need to support people to receive appropriate, timely, quality and safe care across a wide range of providers at a regional, sub regional and local level.

[27] McClintock, K, Tauroa, R, and Mellsop, G, "An examination of child and adolescent mental health services for Māori rangatahi [youth]". *Int J Adolesc Youth* 2016; McClintock, K, Moeke-Maxwell, T, and Mellsop, G, "Appropriate child and adolescent mental health service (CAMHS).

[28] *Adult mental health and addiction workforce: 2014 survey of Vote Health Funded services* Te Pou, 2015

[29] *Fast Track: Discussion paper. Challenges & opportunities for the mental health & addiction community support workforce (2017)*

As part of changes to the wider Mental Health and Addiction structure in 2015 for Wairarapa, Hutt Valley and Capital and Coast DHB's, the new MHAIDS was implemented to improve integration as a response to growing demand, and provide a mechanism to support the sustainability of specialist services across the Wellington sub region.

A professional reporting line now exists from the General Manager of MHAIDS clinical services to the Wairarapa DHB Clinical services. The establishment of MHIADs Service 3DHB saw realignment of the roles of the CCDHB operations managers: i.e. CCDHB extended the role of the mental health and addiction operations managers across the 3DHB space.

Stakeholders highlighted issues of clarity around the new MHAIDS accountability pathway. There is uncertainty about how the mental health and addiction system now works between MHAIDS and Wairarapa DHB clinical teams. This is complicated by the ambiguity of accountability and operational management lines of MHAIDs and Wairarapa DHB services. For example, people are not sure who deals with complaints – MHAIDS or Wairarapa DHB? The Stakeholders saw an accountability pathway as enabling a focus on managing across the boundaries to ensure good integration of care for the Wairarapa population.

3.2.8 Consumer and whānau leadership and engagement

Stakeholders raised the issue where a lack of funded or low-cost treatment options was resulting in an over-reliance by GPs on medication. Mental health prescriptions have increased by 50% over the last five years, with the number of antidepressant prescriptions rising from 1.1 million in 2001 to 1.7 million in 2016, and the number of antipsychotics rising from 392,000 in 2006 to 551,000 in 2016.[30] Similarly, people who have improved in mental health and addiction services but need support to maintain their wellness and/or recovery are reporting that they are unable to get that support.

These views were reinforced by feedback from service providers suggesting the current contracting environment tends to focus on intensive interventions when people are most unwell, and overlook the support people need — on the pathway in and the pathway back out into their life in the community.

Wairarapa has a Mental Health and Addiction Leadership Group (MHALG) in place as part of the Tihei Wairarapa model of care. The MHALG leads the integration of mental health and addiction service with Primary Care using a 'Stepped Care Service Model'.

Issues for the MHALG have been cited as priorities shifting, capacity to take a lead or participate in planned change initiatives; perceived power imbalance amongst DHB funded and non DHB funded members. Improving wider community connectors and forums would require reviewing the existing groups Terms of Reference (TOR) and membership for the right focus. This would mean developing MHALG into something more meaningful for the community.

3.3 Client Access

During 2016/2017, approximately 2,138 people with a Wairarapa domicile code were seen in in either Mental Health and/or Addiction services (or 4.8% of the population). This includes any service activity provided by the 6 central region DHBs. The data was grouped as follows:

1. According to whether the activity was recorded by a locally funded Wairarapa provider (local) or whether the provider was funded under another DHB (IDF).
2. Grouped on service categories i.e. Community Support or Child Adolescent Mental Health Service; and

[30] *https://www.pharmac.govt.nz/about/2016/mental-health/.* Note that some prescriptions will be off-label, that is, prescribed for a reason other than mental health.

3. Where the category is "Unknown", it refers to a provider outside the 3DHB sub-region.

The percentage of people using mental health and addiction services who live in Wairarapa DHB district and the proportion of services provided by the DHB's and NGO's, do not match the individual DHB population split. The key groups of people who experience health disparities are recognised as Māori, Pacific, Refugees, and people with disabilities and long term physical health conditions (including older people).

Using the Ministry of Health 2017/2018 Population Access data[31], this translates to 2,085 unique client [32](or 4.67 % population) in the Wairarapa district accessing services in a one year period. Refer to Table One.

Table 1: Total Unique Client Access (Mental Health and Addiction) Apr 2017_Mar 2018

DHB of Domicile	Ethnic Group	Clients seen Age 0-19	Age 0-19 Pop	Age 0-19 %	Clients seen Age 20-64	Age 20-64 Pop	Age 20-64 %	Clients seen Age over 65	Age Over 65 Pop	Age Over 65 %	Unique Total Clients Seen	Total Pop	Unique Total % Clients seen
Wairarapa District Health Board	Maori	172	3330	5.17	449	3820	11.75	25	570	4.39	646	7720	8.37
Wairarapa District Health Board	Other	325	7910	4.11	1011	20125	5.02	103	8875	1.16	1439	36910	3.9
Wairarapa District Health Board	**Total**	**497**	**11240**	**4.42**	**1460**	**23945**	**6.1**	**128**	**9445**	**1.36**	**2085**	**44630**	**4.67**

Of the 2,085 total unique clients accessing the Wairarapa Mental Health and Addiction Service in 2017/2018, a total of 792 unique clients or 38.0 percent total client access, accessed addiction service only:

- 111 adolescents and youth were between the ages of 0-19.
- 668 adults were between 20-64 years
- 13 people were over the age of 65+.

Table 2: Total Unique Client Addiction Access Apr 2017_Mar 2018

DHB of Domicile: ADDICTION	Ethnic Group	Clients seen Age 0-19	Age 0-19 Pop	Age 0-19 %	Clients seen Age 20-64	Age 20-64 Pop	Age 20-64 %	Clients seen Age over 65	Age Over 65 Pop	Age Over 65 %	Unique Total Clients Seen	Total Pop	Unique Total % Clients seen
Wairarapa District Health Board	Maori	63	3330	1.89	246	3820	6.44		570		309	7720	4
Wairarapa District Health Board	Other	48	7910	0.61	422	20125	2.1	13	8875	0.15	483	36910	1.31
Wairarapa District Health Board	Total	111	11240	0.99	668	23945	2.79	13	9445	0.14	792	44630	1.77

The total 2,085 unique clients accessing the service is further broken down as:

- 39.5 percent of these clients were seen by DHB's only.
- 46.1 percent seen by NGO's only.
- 14.3 percent seen by both a DHB and an NGO.

Table 3: Total Unique Client Access by DHB/NGO or both Apr 2017_Mar 2018

DHB of Domicile	Ethnic Group	Clients Seen by DHB Only	% Clients Seen by DHB Only	Clients Seen by NGO Only	% Clients Seen by NGO Only	Clients Seen by Both DHB and NGO	% Clients Seen by Both DHB and NGO	Unique Total Clients Seen
Wairarapa District Health Board	Maori	190	29.4%	351	54.3%	105	16.3%	**646**
Wairarapa District Health Board	Other	634	44.1%	611	42.5%	194	13.5%	**1439**
Wairarapa District Health Board	Total	824	39.5%	962	46.1%	299	14.3%	**2085**

[31] Ministry of Health Priority Policy PP6 Improving the health status of people with severe mental illness through improved access_*PP6_mhp1621_Apr 17_Mar 18.*

[32] A unique client is based on the individual NHI but who may access mental health and addiction service once or multiple times during the time period of the reporting.

4.0 Stocktake Profile

A stocktake and profiling of all current Mental Health and Addiction services available to people domiciled in the Wairarapa DHB district was undertaken as part of the review.

4.1 Operating Environment

Achieving wellness or whānau ora is everyone's responsibility: Mental Health and Addiction Service, service users, families/whānau and the wider community. The operating environment the Wairarapa DHB Mental Health and Addiction Service recognises this and puts the service user at the centre of care, surrounded by the family, friends and the partners who are most likely to provide support to the individual.

The spectrum of Mental Health and Addiction services provided by the Wairarapa DHB, include Primary mental Health, Secondary, Hospital (Acute Inpatient, Rehabilitation and Extended Care, Managed Withdrawal, Psychogeriatric), community residential treatment and support services. The services are delivered by the Wairarapa DHB Provider Arm and Non Government Organisations (NGO) and from out of district DHB's and other NGOs via Inter District Flow (IDF) across the continuum of care, both regionally sub-regionally and locally.

The wider Wairarapa community provides different types of treatment programs and services for people with mental health and/or addiction issues. The complete range of programs and services is referred to as a continuum of care or system of care. Not every community in the Wairarapa has every type of service or program on the continuum. Providing an integrated and coordinated system of care across the health and other sectors, includes general practice and primary care providers.

No single provider delivers the full range of mental health and/or addiction services, therefore all services in the mental health and addiction sector must work collaboratively and co-operatively to provide a well-integrated and seamless continuum of care. The majority of these providers have been providing mental health and addiction services for over ten years, with several for over twenty years plus. Two providers are national organisations and the others are either local Wairarapa services or sub regional service.

A key step in achieving Rising to the Challenge goals is developing a culture of responsiveness where service users, families, whānau and significant others are actively supported and involved in treatment and recovery. This includes social and economic inequalities associated with poor health outcomes.

Effective, robust planning and partnerships within and across health service providers, other government-funded services and private sector service providers are critical in enabling better recovery outcomes for service users, their family, whānau and communities.

There are a range of specialist services available for the Wairarapa population. The national expectations and requirements for secondary mental health and addiction services are the high-level, non-negotiable conditions that set the services available.

In the operating environment of mental health and addiction, relationships with primary care services are essential and are complementary with secondary level mental health and addiction services e.g. acute inpatient services and consultation-liaison services to other medical departments.

Services for Young People

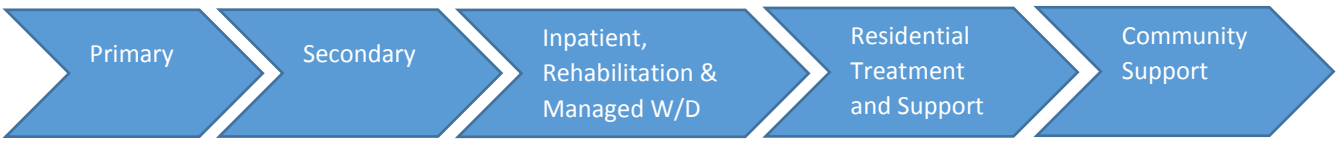
The contracted range of services for young people < 18 years is provided in Figure 2.

Figure 2: Mental Health and Addiction services for children, adolescents and youth.

Services for Adults

A snapshot of contracted mental health and addiction services for adults 20-64 years and older people 65+is provided in Figure 3.

Figure 3: Overview of contracted Mental Health and Addiction services for Adult and Older People.



A mental health or addiction service is funded using a nationally consistent purchase unit classification system to measure, quantify and value a service. The purchase unit definition describes the nature of the service, where it is delivered (setting), who delivers the service e.g. Secondary or Primary Care and who the service caters for (adults, children, youth, adolescents, older people, Māori) etc.

The purchase units have been grouped by service cluster (or area) to identify sets of services e.g. community support services, acute inpatient and/or cultural services. These major service clusters were developed to match the Ministry of Health cost pools relevant to the National Cost Collection and Pricing Programme. People's needs change over time, and over the course of their treatment. The service clustering allows for a degree of variation in the combination of services provided to meet the service user need within the cluster.

The nationally consistent Service Clusters are summarised in Table Four below:

Table 4: MHA Service Cluster 2018/2019

Service Cluster	Description
Acute and Inpatient Services	Acute services provide assessment and treatment for people with severe mental illness either in a hospital or through intensive home treatment.
Community-based clinical treatment and therapy services	An integrated model of treatment in the community. It includes services from detoxification through to aftercare and also involves the coordination of any number of non-specialist services that are needed to meet client's need.
Services to promote resilience, recovery and connectedness	Communities working together to increase our communities' mental resilience and reduce their risks of mental illness.
Addiction	Continuum of Addiction services will offer a range of high quality treatment options of varying intensity and delivered in various settings
Family and Whānau	Mental health and addiction service responses to families and whānau encourage and support families/whānau to participate in the recovery of service users and ensures that families/whānau, including the children of service users, have access to information, education and support.
Kaupapa Māori Mental Health and Addiction Services	Kaupapa Māori specialist mental health and addiction services that have been specifically developed and are delivered by providers who identify as Māori.

Service Cluster	Description
Pacific Mental Health and Addiction Services	Services that provide a holistic approach to mental health and addiction issues, from initial engagement, assessment, and treatment through to discharge; that recognise Pacific frameworks as necessary to increase the service access rates of Pacific people and engage them within a service for the duration of treatment
Asian migrant and refugee services	Refugee Services a holistic approach to mental health and addiction issues, from initial engagement, assessment, and treatment through to discharge. It recognises cultural frameworks as necessary to improve the access to services for Asian, Migrant and Refugee people and to support them within a service for the duration of treatment and facilitate the recovery process
Eating Disorder Service	Eating disorders' encompassing a range of conditions that have overlapping psychiatric and medical symptoms. These conditions are considered to have multi-factorial aetiology with strong genetic as well as environmental factors
Services providing Consumer Leadership	Services specifically refer to mental health and addiction services provided by people who identify as current or former mental health and/or addiction service users.
Mental Health of Older People	Service is a multi-disciplinary Specialist service for older people
Perinatal Mental Health Services	Service covers pregnancy and the first postnatal year. This focus allows for greater recognition of the profound effects that parental mental illness can have on the foetus, infant and toddler
Primary Mental Health	Primary care service offerings through ongoing interventions
Mental Health Other	Nonspecific mental health and addiction services. These purchase codes do not have specific nationwide mental health and addiction service specifications, but may be included under a Tier One national service specification.
Youth Forensic Specialist Community Service	Youth forensic services are specialist mental health and addiction services that exist to respond to the needs of young people who are or may be severely affected by mental health and or alcohol and other drug (AOD) problems and have seriously offended, or are alleged to have seriously offended.
Adult Forensic Mental Health Community Service	Service is facility centred with a range of outreach services delivered in prisons, courts, community based and home-based settings, delivering safe, recovery focused, culturally responsive specialist forensic mental health care including effective assessment, treatment and rehabilitation. For people with mental health and or co-existing (mental health and addiction) needs who are currently in the justice system and or who are: special patients declared to be restricted patients under section 55 of the MH (CAT) Act; remandees per SS 38/44 CPMIP Act 2003, Section 25s (CCPMIP 2003) or Hybrids i.e., SS 34 i (b) 1 CPMIP 2003 and clients of General Mental Health Adult Services (GMHAS) that have behaviours that present a high level of risk to others.

4.2 Service Type

The range of mental health and addiction services currently available to Wairarapa population in the service clusters are summarised in Table Five below. Further details on the description of mental health and addiction services can be found in Appendix Six.

Table 5: Wairarapa DHB Mental Health and Addiction Services Provided 2018/2019

Service Cluster	Service type
Acute and Inpatient Services	• Acute inpatient: an inpatient unit at Hutt Valley DHB hospital (inclusive intensive care beds). • Psycho-geriatric inpatient service (Ratonga Rua Porirua). • Rehabilitation Sub-Acute/Extended Care Inpatient Beds. An inpatient recovery-oriented for people who are assessed as requiring care in a more structured environment (Ratonga Rua Porirua). • Managed Withdrawal- Inpatient Services. Hospital or community-based medically managed withdrawal. • Child, Adolescent and Youth Inpatient Beds for people under the age of 19 with acute mental health disorders, and cannot be treated safely in an outpatient setting (Ratonga Rua Porirua). • General Hospital Liaison Service (Auckland Starship) • Infant, Child, Adolescent and Youth Crisis Intervention Service (Auckland Starship) • Acute Crisis Respite Service: Respite care: predominantly designed for Adult although there is a bed for Child and Youth crisis respite. • Hospital Liaison: provides psychiatric assessments to Hospital inpatients. • Clinical Rehabilitation / Sub-Acute / Extended Care Inpatient Beds.
Community-based clinical treatment and therapy services	• Adult Community Mental Health (CMHT): community based assessment and treatment services to people through community follow-up and outpatient clinics. • Intensive Residential AOD service. Treatment services for people who have particular requirements. • Consultation, liaison, advice, information and education service provided for older people with dementia. • Mental Health Older People Dementia Behavioural Support • Consultative service within a specialist eating disorder service in an outpatient or community setting. The service is integrated with an inpatient or residential eating disorder service. • Clinical Paediatric Outpatient Services for Eating Disorders. • Community Mental Health Service – Early Intervention for people with first time psychosis. • Child and Youth Mental Health (CAMHS): a community based assessment and treatment service for children and youth up to eighteen years • Infant, child, adolescent, and youth package of care. Dual Disability (Mental Health with Intellectual Disability) • Infant, Child, Adolescent and Youth Community Clinical Services • Child, adolescent and youth intensive clinical support Mobile service to provide intensive clinical assessment. • Child, adolescent and youth alcohol and drug Community with accommodation • Maternal Mental health - regional clinician and local psychiatrist • Primary Care and Hospital consult Liaison
Services to promote resilience, recovery and connectedness	• Enhanced community support service (ECS) and community mobile support service • Mental Health housing and recovery residential service • Infant, Child, Adolescent and Youth Package of Care (Wrap Around) • Activity based service. A recovery-oriented service to assist people with mental illness to develop their life and living skills and enjoy their relationships with others.

Service Cluster	Service type
Addiction	• Managed Withdrawal- Inpatient and community based services • Intensive Residential AOD treatment services. Community assessment and treatment intensive addiction service with accommodation. • Clinical treatment/ counselling 1-1 • Social Detox residential service • Opioid substitute therapies (OST) – Methadone Programme • Child, Adolescent and Youth community alcohol and other drugs (AOD) service. • Kaupapa Maori clinical addiction service. • Single Point of Entry Community based offenders alcohol and other drug specialist services • Community based service to provide an intensive outreach alcohol and other drug day treatment programme. • Co-existing Disorders – For those people who may have co-existing mental health and addiction issues
Family and Whānau	• Family/whānau support Community Support Worker
Kaupapa Māori	• Kaupapa Māori community based clinical and support services. Oriented community based assessment, treatment and therapy service targeted for Māori. Kaupapa Māori services are based within a Kaupapa Māori framework and responsive to the needs of tāngata whaiora and their whānau.
Perinatal Mental Health	• Specialist Community Team – Perinatal Mental Health. Service to provide direct specialist perinatal mental health care to meet the needs of the mother and her infant. • Perinatal Mental Health Respite Service
Services providing Consumer Leadership	• Consumer Advocacy. An advocacy service provided by current or former mental health and/or addiction peer support service users
Eating disorder service	• Specialist Eating Disorders Service with Accommodation. • Clinical Outpatient Services for Eating Disorders • Consultative Service within a Specialist Eating Disorder Service
Mental Health Other	• Mental Health – workforce • Mental Health – flexifund Youth MST • Mental Health – flexifund – Addiction Adult
Mental Health of Older People	• Mental Health of Older People: Dementia Behavioural Support Advisory Service
Primary Mental Health	• Primary Mental Health Child, Adolescent and Youth Co-existing Disorders, Mental Health & Alcohol & Other Drugs. • Primary Mental Health Adult. Strengthening primary care service offerings through ongoing interventions such as talking therapies. • Services providing suicide prevention and postvention support, including those under the current Suicide Prevention Action Plan
Forensic and Rehabilitation	• Youth forensic services are specialist mental health and addiction services • Forensic Mental Health Medium Secure Service • Forensic Mental Health Prison Mental Health Service • Forensic Mental Health Court Liaison Service • Forensic Mental Health Community Based Forensic Intensive Service for Recovery • Forensic Mental Health Services - Community Based Intensive Service for Recovery Stepdown House

4.3 Primary Mental Health

Primary mental health (PMH) care is an integral part of services delivered by primary care. It encompasses health promotion, prevention, early intervention, and treatment for mental health and/or addiction issues[33].

PMH care is aimed at those with mild to moderate mental health and/or addiction issues (estimated at 17 percent of the population). Primary care also supports people with low prevalence mental health and/or addiction issues, in conjunction with specialist mental health and addiction services.

As part of the Primary Healthcare Strategy[34,] DHBs provide a general primary care response to the needs of people of any age with mild to moderate mental illness. In addition to this, access to primary mental health interventions are funded for the following specific population groups:

- The enrolled population focused on Māori, Pacific and/or low income. The expected outcome is increased access to psychological and psychosocial interventions for these at-risk groups.
- Youth primary mental health services, available to all youth in the 12 to 19 year age group (regardless of PHO enrolment) who require such a service. The expected outcomes are to enable early identification of developing mental health and/or addiction issues and better access to timely and appropriate treatment and follow up.

The aim of PMH services is to increase access to talking therapies and other psychosocial interventions and the specifically funded components include

- Extended general practitioner or practice nurse consultations.
- Brief interventions (for both mental health and addiction)
- Individually tailored packages of care (which cover a variety of services such as cognitive behavioural therapy, medication reviews, counselling and other psychosocial interventions) group therapy.

PMH services are being delivered across all 20 DHBs (mostly through contracts with PHOs but some with NGOs and one DHB delivering directly). The population groups noted above have free access. PMH services are based on a stepped care model. Stepped care is a model of matching interventions to need so that the most effective, yet least resource intensive, is delivered first.

In additional to these services, many Primary Mental Health coordinator roles have been established. These roles provide consult liaison and clinical assessment and support the delivery of primary mental health services across New Zealand.

[33] *https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/primary-mental-health*
[34] *https://www.health.govt.nz/publication/primary-health-care-strategy*

5.0 Service Commissioning

A "ring fence" is in place to protect spending on mental health and addiction services within each DHB's budget. According to the Ministry of Health's Operational Policy Framework[35], DHBs cannot reduce their annual spending on mental health and addiction services unless they can show that a change in service delivery would reduce costs while keeping or improving service levels.

Nationally, in 2015/16, community mental health services and community support[36] together received 35% of DHB mental health and addiction funding, followed by adult inpatient services (17%), child and youth mental health services (11%), alcohol and other drug services (10%, including opioid substitution therapy), and forensic services (9%). Primary mental health and mental health of older people received 2% and 4% of DHB funding respectively[37].

Health Workforce New Zealand (HWNZ) estimates that, by 2020, the demand for health services, including mental health and addiction services will have doubled while funding will increase by only 30.0 to 40.0 percent. In addition, the government has clear expectations that service quality will be maintained while access to mental health and addiction services significantly increases.

The mental health and addiction services Wairarapa DHB funds are provided by either a DHB service or an NGO provider (including community organisations, Māori providers, and primary health organisations). DHBs provide a greater share of services overall, including all inpatient services.

In the Wairarapa, all of alcohol and other drug services are provided by an NGO. The Ministry of Health funds and coordinates problem gambling services, and these services are delivered wholly by NGOs.

The review team was asked to include an analysis of the relative investments between adult (CMHT) and children, adolescent and youth mental health services (CAMHS).

Although definitions of commissioning differ, the literature agrees that it is more than traditional planning and funding and more than procurement processes[38]. Commissioning encompasses all three of the goals of the NZ Triple Aim model:

- Improved quality, safety and experience of care
- Improved health and equity for all populations
- Best value for public health system resources (see Figure 4).

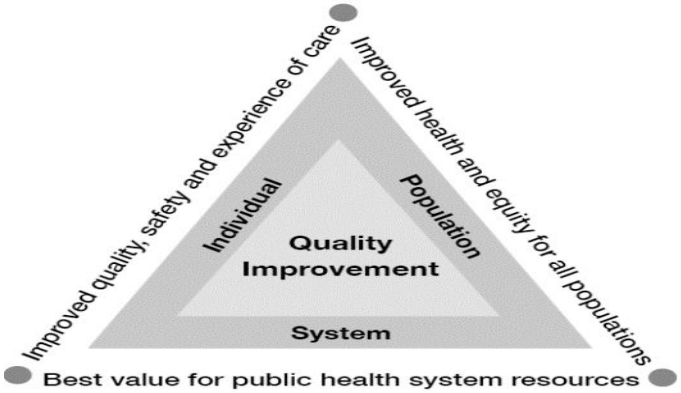
[35] *https://nsfl.health.govt.nz/accountability/operational-policy-framework-0/operational-policy-framework-201819*

[36] Community support services help people to engage with their community, including accessing and maintaining accommodation, employment, and social activity.

[37] *www.hdc.org.nz/media/4688/mental-health-commissioners-monitoring-and-advocacy-report-2018.*

[38] Ministry of Health *Commissioning Framework for Mental Health and Addiction - A New Zealand guide*, 2016

Figure 4: The New Zealand Triple Aim for quality improvement



Source: Health Quality and Safety Commission

5.1 Population Group

The review was asked to provide a comparison of funded mental health and addiction services against the age range of the population i.e. <18 years, 19-65 years and 65+ years to determine whether the services are sustainable within the current health sector environment .

In 2018/2019 the Wairarapa DHB is budgeted to fund **$12,525** million specialist mental health and addiction services for those people who are most severely affected by mental illness or addictions. Despite the investment, access to the suite of services across the mental health and addiction continuum can be difficult; many areas of services operate in a fragmented manner; and primary care providers point to a significant shortfall in responses to high-prevalence mental health and addiction issues.

Total funding is budgeted to be contracted as follows:

- Wairarapa DHB Provider Arm $4,522,419
- Wairarapa NGO's $3,991,026
- IDF District Health Boards $2,310,524 (exclusive Top slice Forensic)
- IDF NGO's $ 593,380
- Top sliced Forensic and Rehabilitation $1,107,428

For national consistency, the range of services are clustered using provider reporting to PRIMHD and the use of appropriate mental health and addiction purchase unit codes.

The current budgeted funding for Wairarapa DHB mental health and addiction services across specific service clusters is set out in Table Six.

Table 6: Total Wairarapa DHB budgeted funding by Service Cluster 2018/2019

Service Cluster	Total Funded 2018/2019
Acute and Inpatient Services	2,332,341
Addiction	999,350
Asian migrant and refugee services	-
Community-based clinical treatment and therapy services	4,041,107
Eating Disorder Service	44,913
Family and Whānau	85,315
Forensic Mental Health Services	1,103,396
Kaupapa Māori Mental Health and Addiction Services	735,294
Mental Health and Addiction Other	102,405
Pacific Mental Health and Addiction Services	-
Perinatal Mental Health Services	73,329
Primary Mental Health	346,959
Services providing Consumer Leadership	47,268
Services to promote resilience, recovery and connectedness	2,578,492
Youth Forensic Mental Health Service	34,299
Grand Total	**$12,524,776**

Largely, Wairarapa's 44,030 population consists of 25.48 percent of the population being < 18 years old, 52.4 percent are between 19-64 years and 21.12 percent are 65+ years. There is an inequity of funding between CAMHS, adult and older people's mental health and addiction services.

The prevalence of serious mental health and/or addiction problems for the group aged 65+ years is 1.1% who met criteria for serious disorder[39]. Children, youth and older people's mental health and addiction service needs further investment and areas of adult mental health would benefit from reprioritisation of resources in some community services.

Table 7: Total Wairarapa Population by Age Group

Population	Youth 0-18 yrs	Adult 19-64 yrs	Older Person	Total Population 2018/2019
Population #	11,200.00	23,715.00	9,115.00	**44,030.00**
Population %	25.44%	53.86%	20.70%	**100.00%**

Total budgeted funding 2018/2019 for mental health and addiction treatment and therapy by Service Cluster by population group is outlined in Table Eight.

[39] Te Rau Hinengaro, Ministry of Health, 2006, p.31.

Table 8: Total Wairarapa DHB funding for Population Group by Service Cluster 2018/2019

Service Cluster by Population Age	Youth 0-18 yrs	Adult 19-64 yrs	Older Person 65+	All Population	Total 2018/19 IDF Funding
Acute and Inpatient Services	181,972	1,520,065	630,304	-	**2,332,341**
Community-based clinical treatment and therapy services	1,699,741	2,341,366	-	-	**4,041,107**
Services to promote resilience, recovery and connectedness	36,200	2,542,292	-	-	**2,578,492**
Addiction	-	999,350	-	-	**999,350**
Family and Whānau	-	-	-	85,315	**85,315**
Kaupapa Māori	-	735,294	-	-	**735,294**
Pacific	-	-	-	-	**-**
Asian migrant and refugee services	-	-	-	-	**-**
Eating Disorder Service	17,303	27,611	-	-	**44,913**
Services providing Consumer Leadership	-	47,268	-	-	**47,268**
Mental Health of Older People	-	-	309	-	**309**
Perinatal Mental Health Services	-	-	-	73,329	**73,329**
Mental Health Other	9,288	71,300	-	21,816	**102,405**
Primary Mental Health	70,996	275,963	-	-	**346,959**
Forensic Youth	34,299	-	-	-	**34,299**
Forensic Adult	-	1,103,396	-	-	**1,103,396**
Total Funding	2,049,799	9,663,906	630,612	180,460	**12,524,776**
Funding % by Age	16.4%	77.2%	5.0%	1.4%	**100%**

The population by age shows:

- Although a quarter of the population are < 18 years, funding for this age group is approximately 16.4 percent of the total funding.
- There is a disproportionate distribution of funding for adult community support to the population group 19-64 years at 77.2 percent of the funding.
- Wairarapa DHB has a higher than national average of older people at 20.7 percent with limited resourcing at only 5.0 percent.
- Children, youth and older people's mental health and addiction services require appropriate level of funding with areas of adult mental health benefiting from reprioritisation of resources in some community services.

The population by Ethnicity shows:

- Māori population in the Wairarapa is 17.2 percent. 43.10 percent of the Māori population are < 18 years old, 49.50 percent are between 19-64 years and 7.40 percent are 65+ years.
- The Pacific population is 2.0 percent of the total population. Within the 2 percent, 43.60 percent are less than 18 years old.
- Asian population numbers are similar to Pacific population at 2.70 percent with the largest number at 63.4 percent between 19-64 years.
- All "Other" population has 20.9 percent < 18 years old, 54.60 percent are between 19-64 years and 24.50 percent are 65+ years.

Table 9: Total Population by Age and Ethnicity

Ethnicity	Youth 0-18 yrs	Adult 19-64 yrs	Older Person	Total Population 2018/2019
Māori	3,310	3,730	540	**7,580**
Māori Population %	43.7%	49.2%	7.1%	**17.22%**
Pacific	395	450	45	**890**
Pacific Population %	44.4%	50.6%	5.1%	**2.02%**
Asian	315	755	120	**1,190**
Asian Population %	26.5%	63.4%	10.1%	**2.70%**
Other	7,180	18,780	8,410	**34,370**
Other Population %	20.9%	54.6%	24.5%	**78.06%**
Total Population Group	**11,200**	**23,715**	**9,115**	**44,030**
Total Ppopulation %	**25.44%**	**53.86%**	**20.70%**	**100.00%**

5.2 Service Investment

The types of mental health and addiction services Wairarapa delivers (or funds other providers to deliver) are summarised in this section. Some specialist and high cost services are provided by other District Health Boards as these are not clinically or financially feasible to provide at a local location – forensic and residential rehabilitation and extended care, however, these services are available to the district-wide population.

The array of Wairarapa community mental health and addiction services vary depending on which service is provided. It refers to a system of care in which the service user community, not a specific facility such as an acute inpatient unit, is the primary provider of care for people with a mental and/or addiction issues. The mental health and addiction services currently available to Wairarapa population by service cluster are outlined below.

Acute and Inpatient Response

Acute inpatient and acute crisis respite alternative care is provided for people in the acute stage of mental illness, who are in need of a period of close observation and/or intensive investigation, support and / or intervention, where this is unable to be safely provided within a community setting.

The Wairarapa DHB Community Mental Health Team (CMHT) act as the point of entry for all individuals being referred into adult and child/youth mental health services.

Wairarapa services for acute inpatient response are include two (2) beds (or 730 bed nights) provided to Wairarapa DHB Population by Hutt Valley DHB's Te Whare Ahuru (TWA) funded via a fee for service arrangement. Other urgent acute inpatient response services are provided by five (5) District Health Boards: Auckland, Capital and Coast, Hutt Valley, MidCentral DHB and Whanganui DHB plus one (1) NGO: Bizcom via IDF arrangement.

The acute inpatient services are complemented by Community Mental Health Teams, Community Alcohol and Drug Services, Infant, Child, Adolescent and Youth Community Services, Kaupapa Māori Mental Health Services, Maternal Mental Health, Forensic Liaison and Prison Services, Specialist Eating Disorders Services, and Methadone Treatment.

Acute Alternative Respite Service

Acute crisis respite is an option for people who would otherwise require admission to acute inpatient mental health services or who need a period of support to maintain or prevent deterioration of their mental health status. Overall, acute crisis respite services are expected to reduce the number of emergency department presentations and/or acute hospital admissions.

Acute crisis alternatives to inpatient care are available to Wairarapa population for people who are in crisis. Currently the mental health crisis respite service is delivered in a dedicated six (6) bed service in Wairarapa hospital-based ward. It is operated 24 hours/7 days per week and includes five (5) beds for adult CMHT and one (1) crisis respite beds for children, adolescent and youth delivered by CAMHS .

Note: The Wairarapa acute crisis respite service (adult and youth) is funded by clinical FTE and is not included in the total for the Acute and Inpatient Service Cluster, rather, is included in the Community-based Clinical Treatment and Therapy Service Cluster.

Community-based Clinical Treatment and Therapy Service

Community-based Clinical Treatment and Therapy Services provide clinical speciality or longer-term treatment services. The bulk of clinically relevant services for child and youth and adults are predominantly mental health nurses, psychiatrists, clinical psychologists and other skilled workforce.

Service need and access for adults over 65 years is relatively complicated by a range of co-occurring physical and cognitive conditions. The evidence for beneficial impact interventions such as talking therapies for the elderly is strong. Dementia is predicted to become the largest single resource use area in the health sector. Evidence also indicates that approximately 40% of elderly acute medical bed usage relates to depression forming the largest single driver of total usage[40].

Services are provided by two (2) District Health Boards: Capital and Coast and Wairarapa DHB plus three (3) NGO's Central Health, Emerge Aotearoa and Mental Health Solutions Limited (Pathways Health Limited).

Services to Promote Resilience, Recovery and Connectedness

The provision of services to promote resilience, recovery and connectedness. The goal of these services is to keep people healthy and out of hospital and improve mental health outcomes. At the service level, these services build community resilience and wellbeing as part of a whole of life-course approach[41], whole of government and whole of community approach to mental health, and importantly also to wellbeing**.** The workforce are predominantly non-clinical mental health community Support workers.

These services are provided by Wairarapa and Hutt Valley DHB's and two (2) NGO's: King Street Artworks and Mental Health Solutions Limited (Pathways Health Limited. Specific services in this cluster include:

- Community mobile support service – services are delivered Monday to Friday 8:30am top 4:30pm.
- Enhanced community support service – delivered 7 days a week from 7am to 10pm. This service is more intensive support focused on living independently in the community and included medication management/supervision.
- Mental Health residential services – Residential services are provided 7 days a week
- Day Activity and Living Skills Service (Adult and Youth)
- Infant, Child, Adolescent and Youth Package of Care (Wrap Around).

Community Support Service

Community Support is a key service is supporting people with mental illness to live well in the community. The services are provided predominantly by non-clinical workers that do a range of support work such as assistance with household activities.

[40] Anderson, David et al. 2009. "The need to tackle age discrimination in mental health A compendium of evidence"
[41] Blueprint II Improving mental health and wellbeing for all New Zealanders (page 16)

These activities include cooking and cleaning; supporting access to community day activities and events; and accompanying consumers to appointments e.g. with Work & Income or health services. Home-based support service coordination and residential coordination services are also incorporated into the Community support services.

Housing and Recovery Service

The housing and recovery support services are for people who experience mental health disorders, and who would respond positively to a housing and recovery environment and actively agree to access this type of service. Staff sleep overnight on the premises but are available to respond if required. For people who experience mental health disorders with higher levels of acuity with 24-hour support, are provided by appropriately trained and qualified support workers and access to clinical staff are required to meet individual needs.

Wairarapa has eight (8) housing and recovery residential beds (or 2,920 beddays) both awake staff and responsive staff, supporting its population or 1:5,003. It is important to note that the services is funded on a non-clinical FTE basis not on an occupied bed day rate. Wairarapa has a considerably lower number of residential beds per head of population in relation to Capital and Coast DHB (**CCDHB**). The optimal level of housing and recovery beds for CCDHB (excluding long term deinstitutionalised clients) has been suggested at 110 or 1:2,891 people. This suggests an optimal level of residential beds for Wairarapa population should be 15.5 beds or 5,657.5 bed days.

Addiction Service

The Alcohol and Other Drug (AOD) continuum of care includes treatment and support options of varying intensity provided in various settings and utilising a range of treatment and support modalities and includes a continuum of care which operates as an integrated whole with linkages to other services or agencies.

Service users move between community and residential settings, with all services providing support that is mutually-strengthening to the person's recovery process. People experiencing more severe issues generally require a more intensive response.

The importance of partnership between service user and treatment provider is underscored. The best outcomes are achieved when treatment options are available, service users are well informed about options and their goals and choices are respected. Strong family and whānau connections are predictors of recovery, therefore family and whānau involvement is critical in making services effective.

Addiction Supported Accommodation Service

Wairarapa has four (4) addiction supported residential beds (or 1,825 beddays) available for its population. Set up for addiction support, this service includes social detox residential service and planned respite including enhanced community support service users from time to time.

While service users are supported by staff and can attend other outside programmes, they are independent in the majority of their daily activities. The duration of stay depends varies depending on their need.

Community addiction service for adults and youth

These services are delivered by 6 FTE (two 0.50 FTE for youth and four for adult) and a team leader for both population groups. There is one registered withdraw management clinical FTE who works within a tight scope related to detox cases. The services are delivered Monday to Friday 8:30am to 5.00pm. Service users can be seen outside of these hours in exceptional cases. Day programmes are also provided.

Referrals are via self-referral, families, GP's schools, employees and other health and local agencies.

Opioid Substitution Treatment Service (OST) – Methadone programme

This service is delivered by three (3) clinical FTE, a Team Leader and 0.4 FTE Senior Medical Officer (GP). It is felt that additional medical and clinical presence on site within the Wairarapa DHB Provider Arm would increase the provision of treatment for OST service users and other drug related issues.

Other national changes to consider when developing Wairarapa DHB addiction services are:

Substance Addiction Compulsory Assessment and Treatment (SACAT) Act (2017)

The Substance Addiction Compulsory Assessment and Treatment Act (2017) states that compulsory status will generally be for a maximum of eight weeks but may be extended for a further eight weeks for people with suspected brain injury. The Act requires the development of flexible treatment options, including provision for managed withdrawal treatment as close as practicable to the person's community. This includes provisions for new roles and systems that to be developed or formally assigned within the sector.

An implication for Wairarapa DHB is consideration of the infrastructure and workable pathways which have been developed for this client group. This will require appropriate treatment settings being available to stabilise and treat those who are subject to the Act, such as an inpatient or residential managed withdrawal facility and appropriate residential treatment options.

Proposed devolution of methamphetamine withdrawal management funding

The Ministry of Health has indicated that for residential methamphetamine withdrawal management will be devolved to DHBs (currently managed nationally). This funding will be applied to support all adults requiring withdrawal management (rather than being limited to those with methamphetamine related issues) in one or more of the following ways:

- To support existing social managed withdrawal service provision and/or pathways
- As part of any re-modelling of withdrawal management care Review of Addiction and Other Drug (AOD) Services November 2016.
- To assist DHBs to respond to updated compulsory addiction assessment and treatment legislation anticipated to be introduced in the near future.

Devolved funds are likely to be re-allocated on the basis of identified need rather than necessarily at the current level of funding to the region or population share. There may be opportunity for the Wairarapa DHB to access some of this resource.

Services are provided by three (3) DHB's: Capital and Coast and Hawkes Bay DHB and five (5) NGO's: Care NZ, Mental Health Solutions (Pathways Health Ltd), Nova Trust Board, Odyssey House Trust and The Salvation Army New Zealand.

Kaupapa Māori Mental Health and Addiction Services

The Kaupapa Māori Mental Health and Addiction Services are those Kaupapa Māori specialist mental health and addiction services that have been specifically developed and are delivered by providers who identify as Māori.

Providers of these services may be within a District Health Board (DHB) Provider Arm, a community or iwi organisation, and maybe be accountable to local, whānau, hapū, iwi, Māori communities and the DHB. In the main, the CMHT and CAMHS services target Māori but are not provided as such.

Wairarapa funds one (1) NGO: Te Haoura Runanga O Wairarapa to provide a Kaupapa Māori service incorporating Māori beliefs and understandings. The services are delivered as a programme of services "by Māori, for Māori" meaning services specifically targeted to Māori and are delivered by Māori.

Pacific Mental Health and Addiction

The findings from *Te Rau Hinengaro* also show that Pacific peoples carry a higher burden of mental illness than the general population. The profile in relation to Pacific peoples' mental health and addiction is complex, with compounding risk and protective factors that are different from other ethnic groups. Access rates to services are low compared to need, particularly for Pacific children and adolescents.

When Pacific peoples do access services, evidence shows it tends to be a later presentation, at the more severe end of the continuum[42]. Status and setting are important to help address engagement issues. Service approaches such as home visits, face to face, and the identification of the key person in the family, who is recognised as the decision maker are critical.

Wairarapa DHB currently does not specifically fund the provision of Pacific Mental Health and Addiction Services for population although Wairarapa Pacific population makes up 2 percent of its population. In the main, the CMHT and CAMHS services target Pacific but are not provided as such.

Family and Whānau

The Wairarapa DHB funds limited resources for the provision of Family and Whānau Services. This creates barriers for family and whānau who wish to be involved in assisting the recovery of their family member and are often the foundation for the enhancement of the person's inner strengths, support, security, and identity.

The family/ whānau service provides both accessible information and responsive services to enable family and whānau to access the help they need to support their family member's recovery. Although the service funding is limited, the service includes; information, education, advocacy, training and support. The service for family and whānau recognise and build on the capacity of the family and whānau, understand and affirm their experience of supporting someone with a mental illness or addiction.

Supporting Families Wairarapa Family and Whānau Services.

Asian migrant and refugee services

The service provides a holistic approach to mental health and addiction issues, from initial engagement, assessment, and treatment through to discharge. Asian, Migrant and Refugee people are defined as:

- **Asian**: People originating in the Asian continent, east of and including Afghanistan and south of and including China based on Statistics NZ Asian ethnicity categories.
- **Migrant**: Migrants or 'immigrants' are people that were born overseas who come to settle in New Zealand.
- **Refugee**: People from a refugee background arrive in NZ under one of three categories. (Each year around 750 people enter NZ under the UNHCR quota system, 300 enter with family reunification migration status and a further group of varying size enter as asylum seekers.)

Wairarapa DHB currently does not specifically fund the provision of Asian migrant and refugee services.

[42] BluePrint II et.al.; page 17

Eating Disorder Service

Wairarapa DHB funds the provision for Eating Disorder Service. This service is provided by HVDHB Provider Arm as a Central Region Service.

As outlined in *Future Directions for Eating Disorders Services in New Zealand*[43], the eating disorders service provides:

- Seamless service delivery across primary, secondary and tertiary settings, straight-forward transitions between services, continuity of care and appropriate discharge planning.
- Effective early identification and treatment.
- A range of services and a multi-disciplinary approach to care.
- Enable service users to actively participate in the planning of their own recovery.
- Support service users as close to their home as possible.

Services providing Consumer Leadership

Service Users are the past, the present and the future of Wairarapa DHB Mental Health and Addiction services. To ensure service user and family/whānau participation in the development and quality improvement of service delivery, many DHB's have Adult Consumer Advisors, Youth Advisors, and Family Advisors based in their Provider Arm secondary services.

The Advisor roles are part of service leadership advising management and do not provide individual advocacy or support. Wairarapa DHB does not fund Advisor roles in its Provider Arm.

Wairarapa DHB's funds services providing Consumer Leadership. The service place emphasis on the value of the lived experience and expertise of people with experience of mental illness or addiction and provide Advocacy based on the concepts of mutual support and the importance of shared experience.

The service is provided by Oasis Network Inc.

Mental Health of Older People

The mental health of older person service is a multi-disciplinary Specialist service for older people and excluding psychogeriatric, Wairarapa DHB, as with other DHB's, funds are limited in the Mental Health for Older People service cluster. This service cluster includes services that provide a holistic approach to meeting the complex health and social mental health and addiction needs of older people, from initial engagement, assessment, and treatment through to transition and discharge.

Older People pathway of care

It has become evident that in order to meet the demands of the demographic rise Wairarapa's older people with complex physical and mental health issue, there is a need to change the way in which mental health and addiction services are delivered. Developing an older person's pathway of care that provides an alternative to hospital admission and which supports an early intervention approach is crucial to stemming the flow of admissions to hospital. This would include the development of new assessment pathway that meets the particular needs of older people with mental health and addiction issues which is essential to help prevent admission and promote early discharge.

Funding includes Alzheimer's Society Regional Dementia BP funding used for hosting a DBAS Web directory and Northern Regional Alliance's Central Regional Dementia training hub.

[43] Ministry of Health: *Future Directions for Eating Disorders Services in New Zealand (2008)*

Perinatal Mental Health Services

The Perinatal Mental Health Services is provided to Wairarapa DHB by Capital and Coast DHB as part of a Central Region Service. The Service covers pregnancy and the first postnatal year. This focus allows for greater recognition of the profound effects that parental mental illness can have on the foetus, infant and toddler.

Primary Care Mental Health Services

Primary care is a critical component of health systems and population mental health improvement, with social goals as much as clinical service goals. In recent years, the role of primary care in mental health care has been enhanced by the provision of dedicated funding including Primary Mental Health (PMH).

In 2003, the Ministry of Health obtained funding for specific provision for primary mental health care. Prior to this funding for mental health and illness had been directed at those with severe and enduring illnesses, nominally 3% of the population. The target population for the new PMH initiatives was those with 'mild/moderate' mental disorders, a nominal 17% of the population at any time.

Wairarapa's primary mental health care is an integral part of services delivered by primary care teams. Services encompasses health promotion, prevention, early intervention, and treatment for mental health and/or addiction issues. Access to primary mental health interventions are funded for specific population groups i.e. the enrolled population focusing on Māori, Pacific and/or low income. As part of the Tihei Wairarapa model, two Primary Care Mental health clinician roles were set up (1.0 FTE funded by Compass Health and 1.0 FTE established in Wairarapa DHB Adult CMHT)

The expected outcome is increased access to psychological and psychosocial interventions for these at-risk groups. Youth primary mental health services is available to all youth in the 12 to 19-year age group (regardless of PHO enrolment) who require such a service. The expected outcomes are to enable early identification of developing mental health and/or addiction issues and better access to timely and appropriate treatment and follow up.

Mental Health Other

The "Other Mental Health Services" are often linked to other service delivery models to cover the costs for flexible funding for mental health services in addition to specific services with a unit of measure client, available bed day, occupied bed day or FTE and/or cover service development projects.

Funding includes mental health suicide prevention. Wairarapa DHB Provider Arm and four (4) NGO's: Emerge Aotearoa, Oasis Network Inc., Presbyterian Support Northern and The Salvation Army New Zealand deliver these services.

Adult and Youth Forensic Mental Health Community Service

The Forensic Services are managed nationally as a top sliced funding pool. In previous years only, Inpatient Forensic services were top sliced. From 2013/14 the Forensic top slice has included funding for inpatient, outpatient and community Forensic services. This covers services provided by DHB Provider Arm's and NGOs. There are no Inter District Flows for Forensic services for:

- Youth forensic services are specialist mental health and addiction services.
- Adult Service is facility centred with a range of outreach services delivered in prisons, courts, community based and home-based settings, delivering safe, recovery focused, culturally responsive specialist forensic mental health care

Other Community Services

There are a number of community providers that do not receive mental health funding directly from Wairarapa DHB but receive health funding through sub-contracting arrangements with mental health providers. Such services include: talking therapies, counselling, advocacy and peer support, education and information, respite care, family and community support services to individuals, their families, friends and the community at large.

Other providers – excluding health community service groups – may access funding from: Ministry of Justice, Ministry of Social Development, Local Government, and Department of Internal Affairs, Lotteries Grants Board, the Hillary Commission, Philanthropic Trusts or private sponsors/donations.

Refer to Appendix Three for details of Providers service by Service Cluster.

5.3 Inter District Flow - Outflow

Inter District Flow (IDF) arrangement i.e. services delivered by either an out of district DHB or NGO and on behalf of Wairarapa population, are based on contract information, local knowledge, PRIMD data or data held in hospital patient management systems. There is no agreed methodology for the splits. Each DHB group makes their own decisions on how best to split these contracts.

Wairarapa DHB's IDFs (Inter-district flows) and associated funding arrangements ensure the DHB manages inflows and outflows as effectively as possible given their populations needs.

The review of Wairarapa DHB funding did not include its IDF INFLOW funding.

Non- IDF services are delivered at a local level by Wairarapa DHB Provider Arm or local NGO's.

IDF - DHBs Provider Arm

Mental health and addiction services are provided by six (6) out of district DHBs Provider Arm: Auckland District Health Board, Capital & Coast DHB, Hutt Valley District Health Board, MidCentral District Health Board, Northern Regional Alliance and Whanganui District Health Board.

IDF - Non Government Organisation (NGO)

Mental health and addiction services are provided by a number of other out of district NGO's.

6.0 Service Opportunities

This section outlines those service opportunities relating primarily to service gaps and/or improving models of care. It is understood that it will take significant time and dedicated resources to implement the opportunities identified by this review.

6.1 Service Change

Many areas of the Wairarapa mental health and addiction services benefit from the positive collaboration and working relationships that exist between the Wairarapa DHB and its providers – these areas tend to enable a positive environment in which discussions about services can be supported. However, there are still too many areas where services are not resourced to improve services for the service user and their family/whānau.

It is difficult to quantify the levels of unmet need for the Wairarapa population as there is only limited data available. Nevertheless, the review has found that the system can't, as it is now, prevent the numbers of people who need the services from increasing. New thinking and new organisation around mental health and addiction service delivery is required.

Central to the way mental health and addiction services deliver care in the future is a reorganisation of support services to the people using the service so that the way in which interactions occur are focussed on the individual in need, not on the priorities of the service deliverer[44].

The review reveals the current service configuration as sub-optimal, meaning that it is not always possible for Wairarapa DHB and its providers to deliver care in line with an evidence based approach. The services currently consists of a number of professional/ staff groups, some of whom appear to have limited formal interaction with one another. A number of ad-hoc arrangements are in place with staff and providers providing good services but these are often not properly integrated within the wider continuum of care.

The Life Course of Illness Model[45,] derived from the Blueprint II and Rising to the Challenge provides guidance on how the DHB might meet the future needs of its population based on a steady move away from institutionalisation and in recent years focusing on:

- Care that is close to home and family/whānau, and keeping the person connected to their communities
- Focusing on a recovery philosophy where the person is able to build resilience
- The person and family/whānau involvement in treatment planning and decisions
- Recovery environments that is comfortable, therapeutic and safe for the person using the service.

A key objective for all DHB's is system integration. As stated in the DHB's Annual Plans, health systems that are well integrated provide a sustainable system where people receive services from the right person, at the right time and in the right place.

To improve mental health and addition outcomes for service users and their family/whānau, Wairarapa DHB will need to be more innovative in the range of interventions it offers. Improvement in addiction services is reliant on substantial changes to improving access, however, this must be balanced against the rising demand for mental health services which is also rising across the whole spectrum of care. The Wairarapa DHB will need to balance competing and conflicting priorities for investment for people who desperately require both service types.

44 *https://www.platform.org.nz/uploads/files/on-track-knowing-where-we-are-going(1).pdf* (p 9)
45 Ministry of Health: *Blueprint II: Improving mental health and wellbeing for all New Zealanders – How things need to be*, (p 14)

Opportunities exist for funding to be prioritised and made available to help local areas develop new approaches to the delivery of mental health and addiction, ensuring that services are better connected with physical health care and other health services.

Workforce shortages in some mental health and addiction professions need to be addressed. There is also a need to investment in training and education aimed at giving GPs, nurses and other staff in all parts of the continuum of care, the skills to help people with mental health and addiction issues enjoy the same care and outcomes as anyone else.

For each of the ten key Themes, Stakeholders at the Closing of the Loop Hui (29 March 2018) were asked to prioritise opportunities for service change as part of this review. The priority service opportunities are an essential starting point (but not limited to):

- Develop a Referral Pathway and access criteria for secondary mental health and addiction services.
- Establish crisis respite beds for specific populations, including the young, the older person and those with particularly complex conditions such as Coexisting Problems. Services to be provided in the community rather than on the hospital grounds.
- Acute Packages of Care (APOC) available for a person which is delivered in their own home rather than going into crisis respite facility.
- Providing additional resourcing and enhancing access to peer support in all service areas including crisis respite services.
- Enhance the response for people over 65 years with mental health issues. Opportunities to fund a service with support workers who have a special interest in working with over 65 population including day programmes.
- Modify the provision of supported residential services to best fit demand including high and complex people under 65 years. This would mean increasing the number of housing and recovery beds.
- Establish a multicultural Mental Health and Addiction Service (Māori).
- Enhance response for Addiction services. This includes:
    - Respite (Step up and step down) Residential
    - Establish Provider Arm clinical support to service users for Opioid Substitution Treatment (OST) and addiction treatment services.
    - Establish additional Addiction Supported Accommodation.
    - Addiction Packages of Care (APOC)
    - Addiction Peers Support Service
    - Youth AOD COEXISTING Problems (CEP)
    - Youth AOD Multi Systemic Therapy Service
    - Local options for youth intensive addiction treatment and follow up.
    - Develop a cross-sector approach or community-wide strategy for Methamphetamine use.
- NASC. Mental Health and Addiction NASC coordination of services impacts on housing and other social issues related to a person's mental health and addiction issue.
- Outreach models to support and address long term mental health and addiction issues, homelessness etc.
- Youth: There is a section of lost youth; cohort of vulnerable youth. These young people lack NGO's and primary level support particularly under 12 year olds. Overall there is limited community services available to youth.

- Day activity: Create more safe places for socialising and activity based structure across the geographical spread of Wairarapa particularly in South Wairarapa.
- Employment Support (Individual Placement and Support) Supported employment etc. diversity of services and options.
- Greater availability of marae-based programmes to meet the needs of Māori.
- Development of a sub-regional Work Force Development Plan (including addressing the lack of qualified Māori mental health professionals).
- A multi-disciplinary approach to tackle mental health and addiction issues in schools.
- Increased prevention and early intervention services for children, youth and their families/whānau, particularly intergenerational issues such as addiction or family violence.
- Address discrimination and to enable service users to gain support, protection and redress if they are discriminated against.
- Develop information and education services appropriate to the service user, their family/whānau and the community at large is a priority including out of hours –quality of information provided to families.
- Improve clinical governance protocols and standardised processes.

6.1.1 Service Schedule

The review found several opportunities for change. These include gaps in the range of services for priority population groups: youth and older people who are severely affected by mental illness and or addiction issues; improving overall understanding of Māori models of mental health and wellbeing; and ensuring primary health care is skilled in recognising early signs of mental illness and addiction issues.

Feedback identified the lack of standardised models of care across the sector continuum in place to deliver Value for Money (VfM) in practice (interpreted as improved quality and performance of mental health and addiction service). The service schedule appraises the issues identified by the review and identifies opportunities that are potentially feasible for resolution/mitigation for closing service gaps and improving models of care relating specifically to development and implementation of more operational elements.

These are those projects that can be undertaken to improve models of care across a continuum of care i.e. many operational opportunities are system-wide across both the MHAID 3DHB sub-regional space and/or at a local level for all population groups. Closing Service Gaps are scheduled over a two year period and Improving Models of Care taking longer, over three year period. The Service Schedule outlines opportunities in the following service clusters:

- Increase access to community mental health and addiction treatment.
- Community services for young people and their families and whānau.
- Address community services for Māori.
- Addiction service continuum.
- Workforce.
- Integration and Collaboration.
- Prevention and Early Intervention.
- Health Information and Education.
- Quality, Process and Procedures.
- Collaborative Leadership Group.

Refer to Appendix Four: Service Schedule on details of service gaps and improving models of care opportunities.

7.0 Methodology and Scope

7.1 Methodology

The review Working Group membership comprised of:

- Nigel Broom – Executive Leader, Planning and Performance (Chair). Planning and Performance leads the delivery of Wairarapa DHB's annual planning and budgeting including forecasts and reviews, ongoing performance monitoring, reporting, analysis and financial modelling of emerging business opportunities.
- Dr Nicholas Pascoe - Psychiatrist with Wairarapa DHB specialist mental health service.
- Waka Saba - Manager for the MHAIDS Operations Centre (Te Haika) & Kaihautu (Advisor for Māori). Waka is member of the MHAIDS 3DHB; Leadership Board, Clinical Governance Group, Quality, Patient Safety Group and the Kaumatua Kaunihera.
- Clarissa Broderick - Team Leader of the Addiction Service for the last 13 years and is currently seconded to the role of Associate Operations Manager for the Adult Community Mental Health and Addictions, MHAIDS 3DHB.
- Jayne Coombes - Operations Manager for Adult Community Mental Health and Addictions Teams (CMHT). Manager for a team of different health professionals and support workers which provides assessment, treatment and support for people with mental illness, MHAIDS 3DHB.
- Helen Mitchell-Shand – Quality assurance and improvement (QA/I) systems and Project Coordinator for Mental Health and Addiction, MHAIDS 3DHB.
- Jason Kerehi - Executive Lead Māori Health - Wairarapa DHB from 2015 after six years as CEO of Rangitāne o Wairarapa. Māori Health Directorate leads the Wairarapa DHB initiatives to improve Māori Health gain across Primary and Secondary services.
- Holly Coombes – Clinical Psychologist, Wairarapa Child Adolescent Mental Health Service (CAMHS).
- Pete Critchley - Member Wairarapa Mental Health and Addiction Consumer Network and Leadership Group.

The review has been undertaken through a mix of methods including a desktop review of literature, data collection and considerable stakeholder engagement. In the undertaking, the review considered the following:

- Assessment of current Mental Health and Addiction Service needs of the Wairarapa population including the needs of the person using the services and their family and whānau. This included identifying challenges to current services, what was currently working well and what was not working well.
- Service stocktake and profiling to establish an accurate view of all current Mental Health and Addiction Services available to people domiciled in Wairarapa DHB district.
- Review of current Mental Health and Addiction services available and the extent to which they provide value for money, their alignment with health priorities and how the services could be improved. Identify opportunities to improve value for money.
- Identify opportunities for proposed changes to future mental health & addiction services to be provided to the Wairarapa population.

Literature and document resources

This draft report drew on a number of sources of information, the majority of which emerged from the engagement process. Other Information was gathered from a range of written resources. The review included a desk-top analysis that comprised:

- Scanning relevant strategy, policy and planning documents identified by Wairarapa DHB for the purposes of the review.
- Providers' current Mental Health and Addiction contracts (or specifications) for services and all related Inter District Flow Services46
- Service utilisation data for the period 1 July 2016 – 30 June 2017 for all Wairarapa DHB publically funded Mental Health and Addiction services (inclusive of IDF services) was collated and analysed.

7.2 Scope

In Scope

For the purposes of the review, Wairarapa DHB included all Wairarapa based Mental Health and Addiction services and programmes delivered by the DHB Provider Arm, Non-government Organisations (NGO), Primary Mental Health and any services provided by other DHBs. Specifically, the review included:

- Provider Arm Services (Child, Adolescent Mental Health Service (CAMHS) Adult Community Mental Health) and Crisis Respite Service.
- Wairarapa DHB funded Non-Government Organisation (NGO) Services.
- All services provided to Wairarapa DHB domiciled population via Inter District Flows (IDF).
- Primary Mental Health (General Practice).
- Any other Ministry of Health funded Mental Health & Addiction Services i.e. Single Point of Entry for Community Based Offenders.

Out of scope

This review focuses solely on Wairarapa DHB Mental Health and Addiction Services. It does not cover any other Wairarapa DHB health services.

7.3 Stakeholder Engagement

The Stakeholder engagement process used by Wairarapa DHB for the review focused on undertaking a number of stakeholder Hui and individual interviews to assist the DHB to finalise recommended opportunities for future service delivery, scheduled for submission to the Board.

The review engaged with the following categories of stakeholders:

- NGO Providers' key personnel delivering and/or managing Mental Health and/or Addiction Services.
- Wairarapa DHB personnel involved in delivering secondary and community mental health services (Adult and Child and Youth).
- Wairarapa DHB senior personnel involved in strategy and planning activities.
- Māori.
- Consumer: 20 Service users in attendance.
- Family: Family members in attendance.

[46] Inter District Flow *2018_19 IDF Forecast - Mental Health All Regions MERGED V2.1_September 2017*

- Primary and Secondary schools.
- Primary Care (General Practice).
- Suicide Postvention Group.
- Emergency Department (ED).
- 31 Individual interviews.

The Wairarapa DHB identified and arranged Hui and individual interviews with stakeholders for the review. The first round of Hui and interviews were undertaken during March 2018 – May 2018 with over 135 people involved in the engagement process.

Engagement with stakeholders was principally via face to face meetings. A set of (7) questions were asked to all:

1. What is working well?
2. What is not working well?
3. What are the gaps?
4. How well are the needs of tangata whaiora met?
5. How well are family/ whānau included/supported?
6. What are the opportunities
7. Anything else?

A small number of people who were unable to attend either a Hui or an individual interview also provided feedback via email and in written submissions.

A written summary of the feedback/views was recorded with over more than 1,700 individual responses recorded. The Stakeholder responses were collated and analysed to provide a more detailed picture of current service provision. This information contributed to developing a set of reoccurring Themes. The review team is aware that, although this process has been reasonably comprehensive, it is not a perfect process. Undoubtedly there are views, which have not been heard that should have been.

A "Closing the Loop" Hui was held at the Copthorne Solway Park on Tuesday 29 May 2018, attended by approximately 95 attendees. The ten reoccurring themes identified through the stakeholder engagement process were fed back to the stakeholders with an opportunity to provide additional feedback and to ensure feedback had been captured correctly. Participants also workshopped their top three opportunities for the future.

A list of stakeholders engaged with as part of the review is set out in Appendix Five.

8.0 Wairarapa Population

8.1 Population Profile

Every year thousands of New Zealanders use mental health and addiction clinical secondary services. They come from all communities, age groups and ethnic groups. An increasing proportion of these people are less than 20 years old. Māori are over-represented in acute services and a growing number have drug-related/ mental illnesses.

In reviewing the mental health and addiction services in Wairarapa, it was important to consider the nature of the area and its people. The Wairarapa DHB serves a population of 44,630 people (2017/2018 estimate) who call the Wairarapa home and incorporates Masterton, Carterton, and South Wairarapa (Featherston, Greytown and Martinborough).

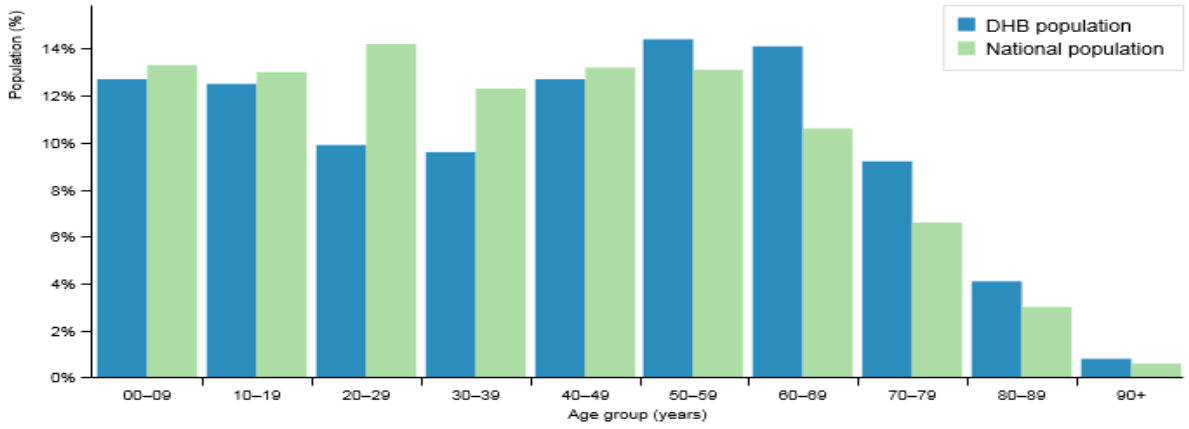
Population by Age

Wairarapa's population tends to be significantly older than the national average and as such require additional funding for the older and more expensive element of their population compared to the average[47].

Table 10: number and percentage of Wairarapa population in age grouping

Age	Maori	Maori	Pacific	Pacific	Other	Other	Total Population	% Pop
0-18	3,330	29.7%	395	3.5%	7,475	66.7%	**11,200**	25.4%
19.64	3,820	16.1%	455	1.9%	19,440	82.0%	**23,715**	53.9%
65+	570	6.3%	55	0.6%	8,490	93.1%	**9,115**	20.7%
Total	**7,720**	**17.5%**	**905**	**2.1%**	**35,405**	**80.4%**	**44,030**	**100.0%**

Graph 1: percentage of population in each age bracket, within the DHB and nationally



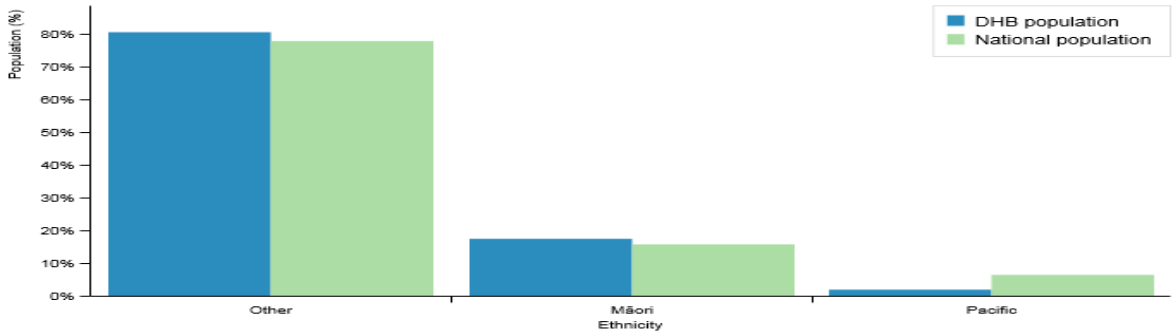
[47] *https://www.health.govt.nz/new-zealand-health-system/my-dhb/wairarapa-dhb/population-wairarapa-dhb*

Population by Ethnicity

In 2017/2018, Wairarapa's proportion of Māori population at 17.5 percent, slightly higher than the national average of 16 percent.

Only 2 percent of the Wairarapa population identifies as Pacific, much lower than the national average at 6.5 percent. 80.4 percent of Wairarapa population identify as "Other" which is higher than the national average of 77.7 percent.

Graph 2: percentage of population in different ethnic groups, within the DHB and nationally.

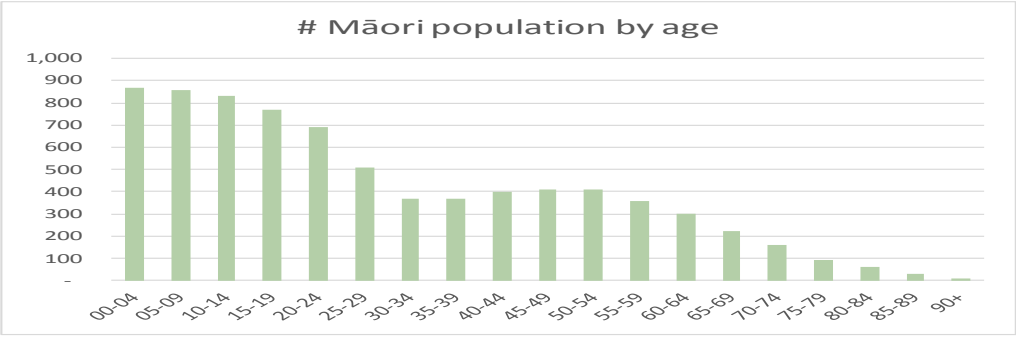


Māori population

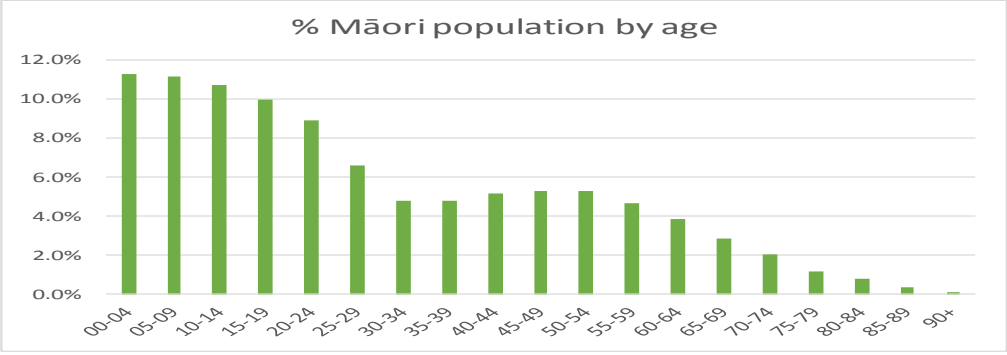
Wairarapa has a Māori population of 7,720 people (or 17.5% population) with both a high children & youth population and adult population between 19 and 64 years:

- 0-18 years = 3,330 (or 41.1% total Māori population)
- 19-64 years 3,820 (or 49.5% total Māori population)
- 65+ years = 570 (or 7.4% total Māori population)

Graph 3 Number of Māori population in different age groups



Graph 4 percentage of Māori population in different age groups

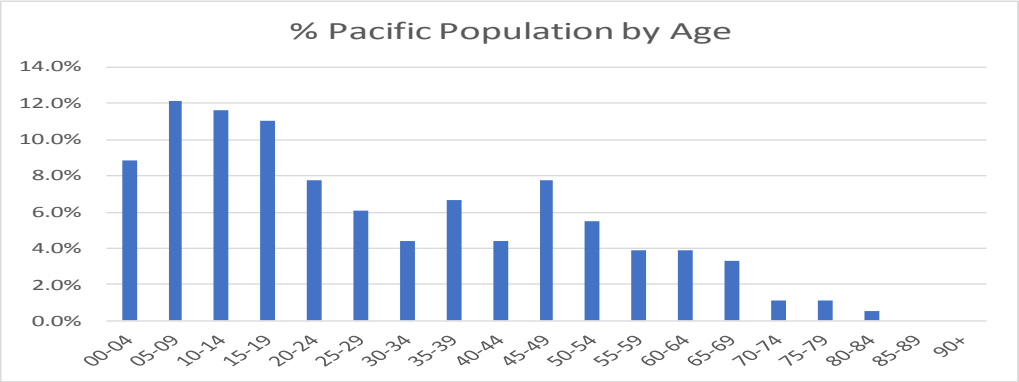


Pacific population

Wairarapa's Pacific population of 905 people (or 2.1%) have similar numbers for children and youth population and the adult population between 19 and 64 years:

- 0-18 years = 395 (or 43.6% total Pacific population)
- 19-64 years 455 (or 50.3% total Pacific population)
- 65+ years = 55 (or 6.1% total Pacific population)

Graph 5 percentage of Pacific population in different age groups

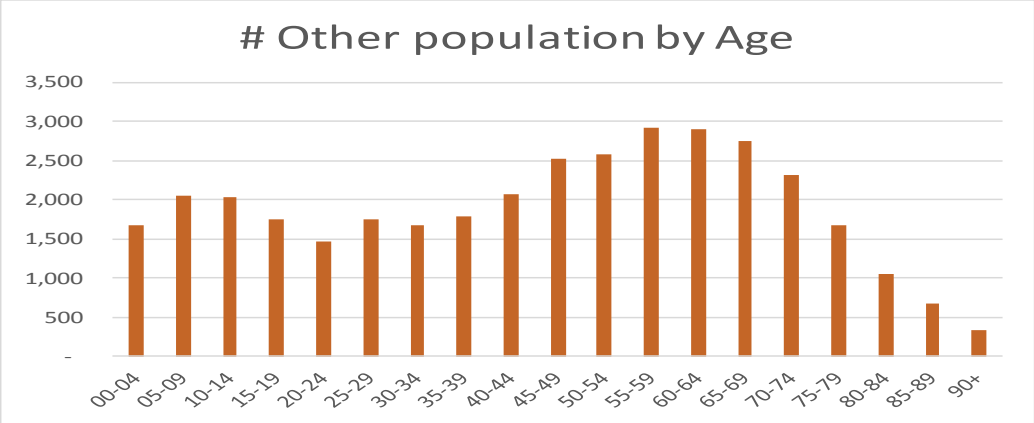


"Other" population

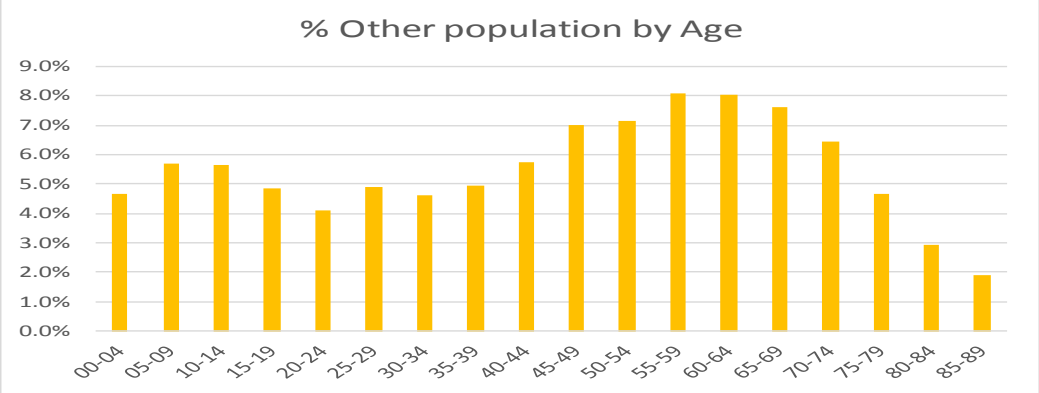
Wairarapa has a total "Other" population of 35,405 people (or 80.4%). The adult population aged between 19 and 64 years represents over 50% of the total "Other" with a large number of aging people 65 years and over:

- 0-18 years = 7,475 (or 20.9% total Other population)
- 19-64 years 19,440 (or 54.6% total Other population)
- 65+ years = 8,490 (or 24.5% total Other population)

Graph 6 Number of Other population in different age groups



Graph 7 percentage of Other population in different age groups

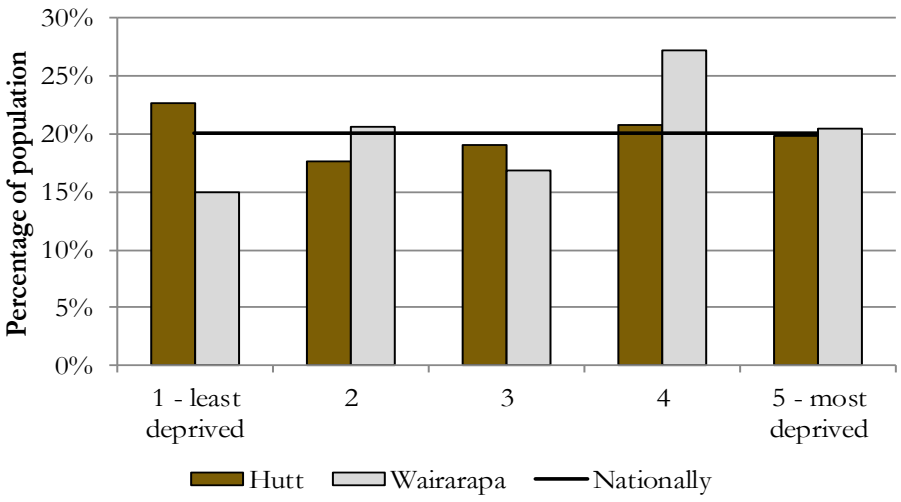


Deprivation

Wairarapa has a slightly higher proportion of people in the more deprived section of the population when compared to the national average with a higher proportion of the population in quintile 4 and a lower proportion of the population in quintile 1.

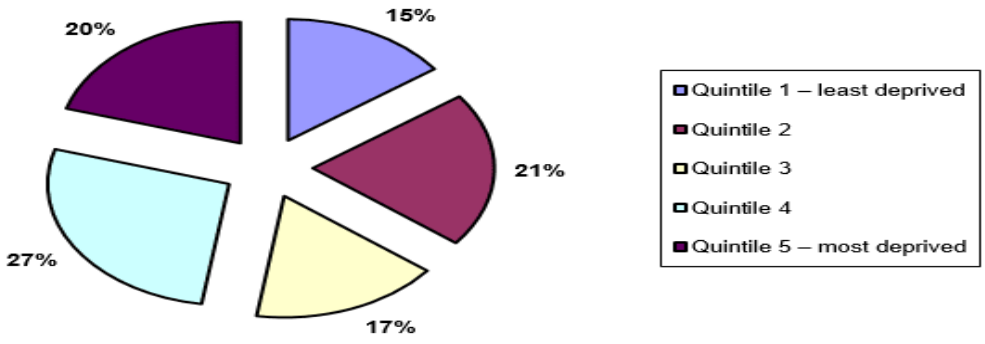
Te Rau Hinengaro established that for the most highly deprived population (those in deciles NZDep 9 and 10) there is a higher prevalence of serious mental disorder at 6.9% of the population meeting criteria over the past 12 month period, as opposed to 4.7% of the total population of New Zealand.

Figure 5 - Deprivation by quintile, 2016/17



Source: Data provided by Ministry of Health; Sapere analysis

Graph 8: Deprivation 2016/17.

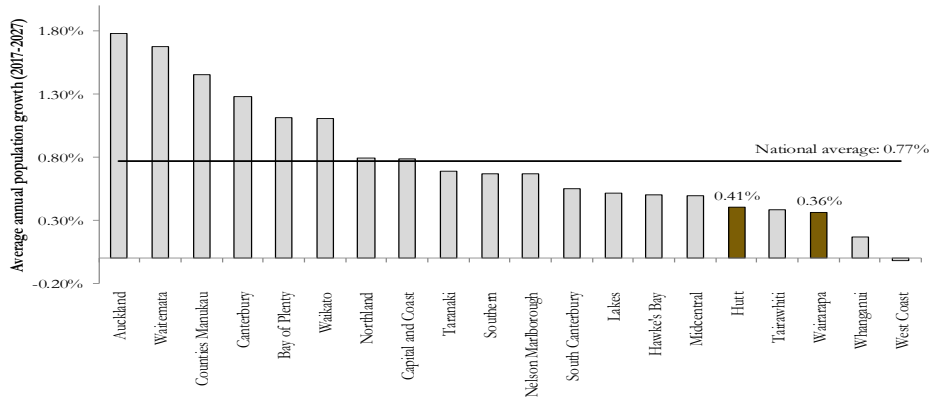


Projected Population Growth

Over the next 10 years, the Wairarapa population is expected to grow slowly with an expected growth average of 0.36 percent each year. This growth rate is below the national annual average which is 0.77 percent increase.

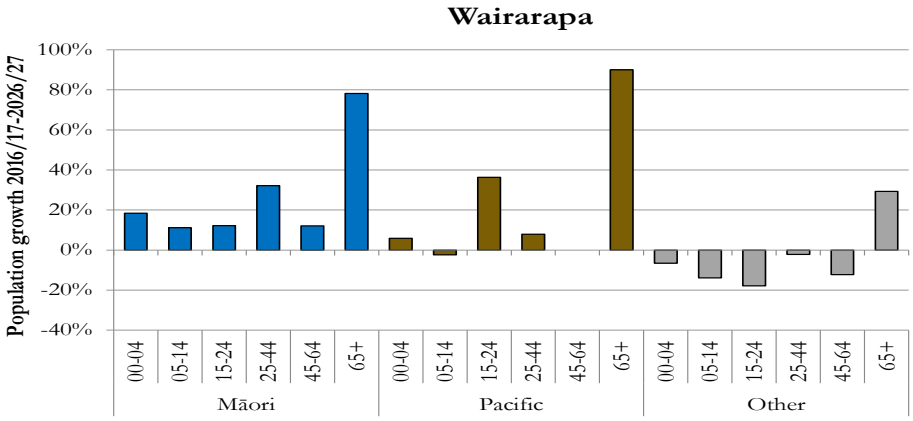
In the Wairarapa between 2013 and 2028, the number of persons aged under 17 is forecast to increase by 211 (2.1%), and will comprise 21.4% of the total population. The number of persons aged over 60 is expected to increase by 4,320 (39.1%) and comprise 31.4% of the total population.

Figure 6 - Average annual population growth 2016/17-2026/27



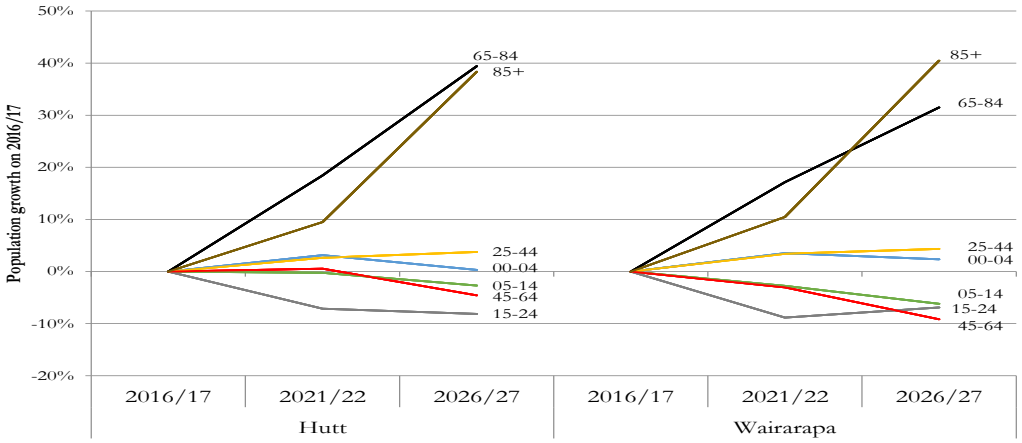
Source: Data provided by Ministry of Health; Sapere analysis

Figure7 - Growth 2016/17-2026/27, by ethnicity & age



Source: Data provided by Ministry of Health; Sapere analysis

Figure 8 - Population growth on 2016/17 by age group, Hutt and Wairarapa DHB



Source: Data provided by Ministry of Health; Sapere analysis

Population summary for Wairarapa Local Territories:[48]

- Masterton district is projected to increase by 2.6% by 2027, which represents 650 more residents.
- Carterton district is projected to increase by 6.8% or about 600 residents.
- South Wairarapa district is projected to increase by 3.7%, which represents an increase of 375 residents.

Table 11: Wairarapa Forecast Change between 2013 and 2038

Area	2013	2018	2023	2028	2033	2038	Total change	Avg. annual % change
Wairarapa Total	42,390	45,062	47,048	48,931	50,718	52,775	+12,615	+0.87
Carterton District Council	8,490	9,214	9,721	10,147	10,473	10,914	+2,945	+1.00
Masterton District Council	24,100	25,441	26,428	27,364	28,425	29,571	+6,738	+0.82
South Wairarapa District	9,800	10,406	10,899	11,421	11,820	12,290	+2,933	+0.88

Demand

It is expected that the number of people accessing a reconfigured integrated mental health and addiction service within the Wairarapa would increase. However, current data at this time does not provide sufficient granulation to determine which local territory within the Wairarapa DHB district will be impacted accurately predicting the numbers by age and ethnicity.

[48] *Population and household forecasts, 2013 to 2043, prepared by .id, the population experts, March 2018.*

9.0 Review Discussion and Findings

9.1 Key Themes

From the stakeholder feedback and discussion, the review found ten themes emerged as key directions for the future. Additional details/definition can be found in Appendix Seven.

Table 12: Key Review Themes

Theme: *Kaupapa*	**Definition: *Whakamaramatanga***
Access: *Tuwheratanga*	Services is available and easily accessible to service users and their family and whānau with decreased waiting times in order to avert future adverse outcomes and improve outcomes
Recovery and resilience: *Te Ta Ora me Te Tu Kaha*	People improve their health and wellness, live a self-directed life and strive to reach their full potential.
Reducing disparities for Māori: Te whakaore I ngā mate e panei Ki a Ngai Māori	*Health services are provided for the improvement of health outcomes and reduction of health inequalities for Māori who use services.*
Workforce: *Kaimahi*	Building the capacity and capability of the Service providers to work in partnership with the service users through supporting and strengthening knowledge, experience and expertise of health workforce.
Communication and relationship: *Te hononga Korero me te Whakawhānaungatanga*	Collaborative communication which supports and strengthens positive relationships
Integration and collaboration: *Te Mahi ngātahi*	Providing an environment that supports integration and collaborative practice across service delivery boundaries to ensure 'any door is the right door' and mental health and addiction sector builds the capacity and capability to respond to co-existing disorders.
Physical health and wellbeing: *Te Ora a-Tinana a-wairua a-hinengaro*	Improving service user access services required for improving physical health needs for overall physical, mental, and social wellbeing.
Prevention and Early Intervention: *Hei Rongoa*	Preventing illness and promoting health to reduce the need for secondary or tertiary health care
Health information and education: *Matauranga Hauora*	Providing health information and education designed to improve a person's health literacy, including improving knowledge, and developing life skills which are available and easily accessible to service users and their family and whānau.
Quality, process and procedures: *Tikanga*	Accepted clinical guidelines and standards are maintained for improving high standards of care (clinical and non-clinical), transparent responsibility and accountability for those standards for the delivery of care to the people who use the mental health and addiction services, their family/whānau.

The discussion and findings reflect the review team's access to multiple sources of information; literature, engagement and those who provided written feedback. The review team is of the opinion that the common themes derived from stakeholders and source information supports the validity of the findings.

Key theme feedback is discussed below on how well the needs of the Wairarapa population is being met in these areas.

9.1.1 Access: *Tuwheratanga*

Access to Services

Access to Wairarapa DHB mental health and addiction services needs attention. Access to treatment is seen as siloed with a greater coordination and integration required through a shared system response. This would involve primary and secondary specialist services collectively agreeing on how they will work together and support one another to provide seamless, effective services for people experiencing mental and addiction issues.

Access issues identified by the review found many young people, especially those without psychosis, had difficulty accessing secondary mental health services if the child or youth didn't meet the criteria for access as they weren't considered to have serious issues or they had multiple moderate issues (such as mental illness and intellectual disability).

Youth often had a period of decline when they sought help from people such as doctors and school guidance counsellors. Most were unable to access secondary services until a crisis occurred. Suicide attempts and serious self-harm were common at this point. Young people who received treatment through the Emergency Department didn't always receive follow-up care or a referral to secondary services.

Some Stakeholders commented that the demand for addiction services in the Wairarapa was growing and that alcohol and other drug issues for youth were occurring at an earlier age. There was a need for better access to addiction services for people in the Wairarapa. The review also found that addiction service is generally under resourced. This situation is not consistent with what is known about the potential need for youth services.

Feedback suggests it is timely to consider the *Youth AOD Model of Care and Service Development Plan*[49] developed as a sub-regional plan for Capital and Coast, Hutt Valley and Wairarapa DHB's and, in particular, to consider developing Kaupapa Māori addiction programmes based in a community settings such as marae.

Referral Pathway

A well-functioning mental health and addiction system should be able to deliver across a continuum of care. Stakeholders raised concerns that pathways in and out of the services are not always understood and a referral Pathway should be mapped. The criteria and pathway to counselling in primary car is not clear exasperated by inadequate referral management processes.

Stakeholders raised concerns around difficulties transitioning youth to adult services due to the lack of pathway clarification. Transition to adult service for a youth is highly problematic as the entry criteria is interpreted in different ways depending on the provider. There is a lack of opportunity to maintain up to date knowledge of "who is doing what" and how linkages are enabled and or strengthened.

[49] CCDHB, HVDHB, Wairarapa DHB: *Youth AOD Model of Care and Service Development Plan, (2015)*

Acute Response

Many stakeholders interviewed in the course of this review saw the absence of safe secure facility in the Wairarapa for people in crisis as an issue in that New Zealand Police become the transport services for acute services. The "high and complex" people needing admission to an acute inpatient unit must travel to Hutt Valley or Capital and Coast inpatient units. This results in a disconnection from family.

Service users have to travel to other DHBs inpatient units which was not always seen as appropriate. In particular, young people who used adult inpatient units generally found them traumatic, especially if they were subject to compulsion and seclusion. Females reported feeling unsafe in the inpatient units.

Areas highlighted were around the following services:

- Need to revisit dedicated on-call team.
- Consideration of a specific triage/crisis position at CAMHs available during public holidays.
- Opportunity to review after hour's service.
- Private and safe area and at Emergency Department for any in mental distress
- Secure unit with appropriate support in place in Wairarapa Hospital.

Community-based Acute Support

Key issues arose around the lack of clarity on what crises respite is. Often people think they are in hospital while in crisis respite and expect inpatient unit level of care. Stakeholder feedback suggests that the current configuration is not the ideal arrangement and crisis respite would be better placed in a home like environment in a community setting. The review found there are not enough crisis respite beds for specific populations, including the young, the older person and those with particularly complex conditions such as Coexisting Problems.

The review found the arrangement for crisis respite mental health care for the older person is problematic as it can be difficult to provide a safe and protected environment for older people in the crisis respite facilities. Community-based crisis respite options should provide more effective alternatives for this population group.

Feedback suggests crisis respite should include step-up and step-down care as an alternative to inpatient admission or to provide support after an acute episode of illness. There are exciting community-based initiatives that can be modelled from, such as Counties Manukau funded Tupu Ake in Papatoetoe. It is a peer-led acute service for people struggling with mental illness in the community and provides a real alternative to hospital admission.

There are few options for a person requiring crisis respite care other than to a bed due to the limited Acute Packages of Care (APOC) available for a person which is delivered in their own home rather than going into crisis respite facility.

Feedback found a lack of clinical leadership and accountability in parallel with overall management responsibility and accountability - both of which are identified as issues throughout many levels of the service at both a local and Mental Health Addiction Intellectual Disability (MHAIDS 3DHB) level.

The lack of integrated clinical governance and leadership is felt to be impacting on delivering an effective and integrated continuum of service responses including policy for Wairarapa DHB population and individual needs.

There is a need to strengthen clinical governance processes between Wairarapa DHB, MHAIDS 3DHB and Community Providers. Developing a collaborative leadership which support closer working relationships in and between services across the whole district was identified as a priority and would include greater partnership, leadership and participation of service users and their family/whānau in system-wide decision-making processes.

In addition, the lack of clarity of funding sources, mechanisms and processes for service provision is making it difficult to specify the nature of the service that should be provided to monitor performance and to redesign the services effectively.

9.1.2 Recovery and Resilience: *Te Ta Ora me Te Tu Kaha*

Mental health and wellbeing are fundamental to a strong, functional and resilient society. Promoting wellbeing for everyone means targeting those health and social factors that foster good mental health and the development of resilience, including access to housing, education, employment or other meaningful activity when employment is not available.

Services to address the full spectrum of need for mental health and addictions support in the community, includes services for those people who present with a dual diagnosis, challenging behaviours and fluctuating support requirements. Services for people would flex appropriately to meet the different stage of a person's recovery journey, their age and include natural supports.

Key gaps in recovery and resilience mental health services identified were:

- Designated Māori mental health professional positions sit with Māori Health Directorate and then go out to work in respective Specialist clinical teams.
- NASC. No Mental Health and Addiction NASC coordination of services impacts on housing and other social issues related to a person's mental health and addiction issue.
- Outreach models are needed to support and address long term mental health and addiction issues, homelessness etc.
- Youth: There is a section of lost youth; cohort of vulnerable youth. These young people lack NGO's and primary level support particularly under 12 year olds. Overall there is limited community services available to youth.
- Day activity: Create more safe places for socialising and activity based structure. Support recovery from mental illness and addiction is vital, however, there are very few group based programmes. There are minimal service available older people. King Street is good but not so good for those without disability. Provide drop in centre/day activity for young people.
- Housing. The review team found that Iwi services often work with people with difficult social circumstances when it would be highly desirable to access a range of housing options aligned to the housing strategies of Housing New Zealand.
- Employment. Employment Support (Individual Placement and Support) Supported employment etc. diversity of services and options
- Supported Accommodation. Ideally for those with housing needs and enduring mental health issues, there would be an increase in supported accommodation responses available. This would include a flexible pool of community support or peer worker staffing as required. Currently there are time delays in accessing such accommodation solutions (including suitable housing availability and a period of time needed to determine the preferences and needs of service user) due to the limited service in place. This would include supported accommodation for addiction.

- Peer Support. A potential gap is peer support delivered services. Establishing a peer service for mental health and addiction community and crisis respite services, has the potential to change culture and improve service delivery.
- Access to services for older people also remains well below expectations. An ageing population means that addressing the mental health needs of this group will be increasingly important in the years to come.
- Mental illness in older people is often complicated by conditions more commonly associated with ageing, in particular physical and cognitive conditions. Where such complications occur, specialist expertise is required.
- Quality services will recognise and respond to these multiple and complex needs through effective multidisciplinary co-operation.
- The primary health care sector is often the first point of contact when people experience a mental illness. The capacity of providers to recognise and determine people's needs is important in ensuring people gain access to appropriate services

The requirement for a cross-sector approach or community-wide strategy was seen by Stakeholders as important as was developing a better more integrated treatment pathway tailored to those who have addition issues. The need for some or a large improvement in co-existing problems capability through a mixed addiction service delivery model.

For example a key issue for Stakeholders was the continuity with specialist care. There's a gap in Provider Arm clinical support to service users for Opioid Substitution Treatment (OST) and addiction community treatment service. Whilst the current NGO addiction provider is required to align (link) with secondary services as reflected in contracts and service specifications, the eligibility criteria and structure that supports the Wairarapa funded addiction service is siloed.

A mixed addiction delivery model would include both the Provider Arm and NGO in the addiction service delivery.

Key gaps in the addiction service continuum were identified as:

- Existing community support services tend to focus on mental health and not addiction issues. It was noted that packages of care are available but limited as they are often difficult to access/implement. Social work service is available but seen as a very limited resource for addiction services and are mainly for mental health service users rather than addiction service users.
- Methamphetamine use. Anecdotally methamphetamine use is a concern in Wairarapa. Stakeholder feedback reinforced this view with a number of Stakeholders raising methamphetamine use as a significant issue in Wairarapa district.
- Social Detox. Peoples substance abuse have changed dramatically over the last decade, with the primary substance of abuse more recently shifting from alcohol to an increase in other opioids The limited number of social detox beds available to Wairarapa, identifies a serious need for an increase in community-based social detox services which may include beds and addition packages of care (APCO).
- Young Māori males (aged 15 to 24 years) are a group with high needs and service planning should ensure that effective responses are targeted at this group.
- Addiction service continuity is required for people from referral to treatment and aftercare post discharge, and including community level support throughout.
- Managed withdrawal services. Access to managed withdrawal services across the continuum is patchy. While there is a planned inpatient medically managed withdrawal option available through IDF's (CCDHB as Provider) this appears to be seldom accessed and feedback indicates that the process to access this service is not necessarily understood by all of those involved in referring to it.

- There are very limited local options for addiction supported accommodation.
- There is no Step up - Step down service in the Wairarapa (and across the sub-region) for those who require before and/or after intensive residential addiction treatment. This represents a lack of opportunity to prepare service users for intensive residential treatment, or integration back into the community.
- There are limited intensive day programmes in the Wairarapa for addition service users to access. Stakeholders noted that the option of holistic programmes, providing integrated cultural and clinical approaches would be helpful.
- People with Co-Existing Problems (CEP) particularly those who are under the Mental Health Act have very limited access to intensive residential addiction treatment facilities.
- Local options for youth intensive addiction treatment and follow up. There are no local options for youth addiction supported accommodation. Youth addiction residential treatment is currently available, but the service is delivered out of district in the Hawkes Bay and not well utilised. Factors cited include the high cost, distance from whānau, the need for the young person to be motivated and to maintain motivation.

9.1.3 Reducing Disparities for Māori: *Te Whakaore I ngā mate e panei Ki a Ngai Māori*

An overarching aim of the health and disability sector is the improvement of health outcomes and reduction of health inequalities for Māori. Service providers are expected to provide health services that will contribute to realising this aim. For Māori, secure cultural identity is dependent on not only being able to identify as Māori but also having effective access to participation in society, e.g. taking part in activities with whānau and on the marae and contact with other Māori.

The Stakeholders noted that the current issues in Māori mental health and/or addiction services are well documented. The most common 12-month disorders among Māori were anxiety disorders (19.4%), mood disorders (11.4%) and substance use disorders (8.6%). The most common lifetime disorders among Māori were anxiety disorders (31.3%), substance use disorders (26.5%), mood disorders (24.3%) and eating disorders (3.1%)[50].

Lifetime suicidal ideation was reported by 22.5% of Māori, with 8.5% making suicidal plans and 8.3% making suicide attempts. Māori females reported higher rates of suicidal ideation, suicide plans and suicide attempts compared with Māori males across lifetime and 12-month periods..

Responsiveness to Māori is also built on the recognition of whānau ora, or healthy families, which builds on the strengths of whānau and encourages whānau development. Despite service improvements, Māori still tend to access mental health services at a later stage of illness and with more severe symptoms. There is a strong link between health and culture, and the wellness of tangata whaiora (people seeking wellness) both depends on and is affected by the wellness of family/whānau.

Services improve when Māori take an active role in planning and delivering services, and when models of practice incorporate a better understanding of the importance of family/whānau, and the interface between culture and clinical practices.

The review found overall services were lacking in mechanisms that facilitate Māori access to services and the provision of appropriate pathway of care which include but not exclusive to: referrals and discharge planning; ensuring services are culturally competent and that tangata whenua are actively involved in planning for mental health and addiction services and service provision provided that meet the health needs of Māori.

[50] Te Rau Hinengaro: The New Zealand Mental Health Survey, p 139

Specific Stakeholder feedback recognised services for young people needs to be kaupapa Māori and that services need to be clearly designed towards meeting the needs of young Māori males.

The review identified a relatively high level of involvement of Māori in the Wairarapa mental health and addition services, however, the Māori rates of acute hospital admissions continue to exceed non-Māori and these are similarly matched by concerns over service utilisation, how they are accessed and the patterns of Māori admissions. For many Māori, initial contact with a mental health service is via the police or welfare services, and under compulsion.

Whānau Ora Service Continuum

Stakeholders strongly agree that services in the Wairarapa district must be designed to meet the needs of Māori. Greater availability of marae-based programmes was suggested by many.

Sustained, ongoing efforts are required to develop pathways of care, environments and a workforce that are more effective for Māori mental health and/or addiction service users and their family/ whānau.

Whānau Ora brings together Māori aspirations around mental health and provides an approach which builds whānau capability and provides support for Māori families to achieve their maximum health and wellbeing[51].

The review highlighted the importance of supporting effective partnerships with Māori and whānau for addressing a 'high tolerance' for mental health issues in Māori communities. This would include Iwi aspirations to provide care for their own and to create local initiatives that are seen to influence change. Stakeholders also said it was important that all services were safely provided, risks were minimised and that clinical care would be maintained and not compromised.

This means for services to be effective for Māori they need to:

- Be culturally appropriate.
- Address the barriers to Māori accessing mental health and addiction services.
- Increase access for Māori to appropriate mental health and addiction services.
- Meet the broader health and mental health needs of the service user in the context of their whānau.
- Understand the circumstances of the service user's life and goals.
- Recognise a Māori world view in service delivery.

9.1.4 Workforce: *Kaimahi*

The future, emerging workforce will need to ensure that it can deliver the right 'mix' of services for people with perhaps the most significant factor shaping the need for new skills and areas of specialised knowledge being the change in the make-up of demographics, with an increase in the number of youth and older people making up the population.

The findings from the review found that role clarity was one of the most important features for the workforce to operate at top-of scope. There were mixed findings in relation to workforce capacity for child, adolescent and youth, adult and Older People, i.e. some stakeholders feeding back that services are under capacity and some with an inability to meet demand, which can be reflected in long waiting times.

All agreed that an integrated mental health and addiction services workforce across all levels of need provided by a workforce that has competency and skills to deliver services that match the persons need was a priority for Wairarapa DHB.

[51] Mauriora Ki Te Ao – Living Universe Limited. 2010. *Whānau Ora Integrated Services Delivery.* Wellington: Ministry of Health.

The Ministry of Health's *Lets Get Real* [52] describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services in New Zealand. It does not replace any of the existing professional competency frameworks, and has been designed to complement them.

Stakeholders commented on the workforce issues nationally (and locally) and acknowledged there is not a large enough workforce to deal with the current mental health and addiction need which will impact on the service quality. Difficulty around recruitment and retention of mental health staff was a common theme. Extensive training and retraining are essential to bring the workforce up to the relevant level of skill in the relevant numbers.

Treatment and support could be provided by a broader range of professionals than is the case now. Workforce capabilities and strategies are needed for the development of a range of professional roles, including clinical ones either within community-managed organisations or as part of a collaborative team with other services, while also blending social support and peer worker roles into the community-managed workforce.

It was also suggested that that consideration needs to be given to workforce planning given that the workforce is ageing.

Māori Workforce

There is a need to focus on Māori resilience and a special opportunity to learn and use insights from mātauranga Māori more widely. Māori are under-represented in the health and disability workforce in almost every area, holding back both Māori provider development and improvements in mainstream delivery to Māori. Extending workforce development initiatives, such as targeted training programmes and scholarships, is therefore vital.

It has been argued, that for Māori, unless cultural factors are formally considered during assessment and diagnosis, the gap between the mental health status for Māori and other consumers will never reduce[53.] This was regarded as a key issue by both Māori and mainstream health providers of the primary and secondary care sectors. Māori workforce development needs acceleration and greater co-ordination.

Wairarapa is fortunate to consist of strong marae based iwi, who's social, economic and political structures are operating and led by excellent Māori health leadership. Stakeholders recognised the mutual benefits in a cross sectoral approach to Māori health workforce development, highlighting the need for a culturally competent mainstream mental health and addiction workforce to respond to the needs of Māori people and deliver informed support. Professional education, training and development for all health and mental health and addiction workers should strongly emphasise Māori perspectives on health and wellbeing.

Peer Workforce

Having support from people with lived experience of mental illness and/or addiction and recovery (such as a peer support worker, or family/whānau) was raised by many. Peer workers, have been employed by the mental health sector for years but they do not always encounter positive acceptance. Stigma and discrimination, sometimes subtle and sometimes obvious, can cause a divide between the peer workforce and other staff. Formal structures, policies and procedures that support the peer workforce and provide a development pathway have been identified as a key priority.

[52] Ministry of Health: *Let's get real: Real Skills for people working in mental health and addiction (2008)*

[53] Elder, H and Tapsell, R, "Māori and the Mental Health Act". In Dawson, J and Gledhill, K, *New Zealand's Mental Health Act in Practice*. Wellington:VUW Press; 2013: Chapter 14.

Addiction Workforce

Changes to the current thinking about alcohol and other drug use was identified because excessive and inappropriate use are both symptoms of and causes of mental health issues. The addiction workforce needs to foster a person-centered approach with a focus on self-management, complementing clinical treatment and the recovery journey.

It is acknowledged that the co-existing mental health and addiction problems (CEP) result in worse outcomes for people. It is expected that providers would utilise the tools and resources that have been developed by Te Pou and Matua Rāki to assist staff to work with people with co-existing mental health and addiction issues[54].

Managed withdrawal services are limited and almost invisible in Wairarapa. In an addiction continuum of service, managed withdrawal treatment is often a starting point in supporting a person to stabilise and regain some capacity to engage in further treatment. There is a priority to engage key stakeholders (including peer and community support workers) in defining a district-wide managed withdrawal model, to strengthen the inpatient medical service and to consider funding to fill the gap in the locally provided social residential managed withdrawal service.

Methamphetamine use has been noted as a key concern for many stakeholders in the community. A skilled workforce providing outreach services applies not only to those who use methamphetamine but needs to be considered across both adult and youth addiction services. Working in close partnership (i.e. having a shared pathway) with peer and community support services should also be considered.

Synthetic cannabis. New Zealand is being overwhelmed by synthetic cannabis. Harder than methamphetamine, synthetic cannabis, better known as the "zombie drug", is being churned out in underground labs and is up to 70 times more potent than naturally-grown cannabis. This substance is usually a dried herb or plant material that is sprayed with a synthetic cannabinoid. It can also come as a liquid, which can be used in a vaporiser.

There are hundreds of synthetic cannabinoids, which were all invented in the past 20 years. The chemicals aim to imitate the effects of THC, the ingredient in cannabis which makes you high. However they are significantly more toxic, dangerous and react in unpredictable ways to cannabis. All synthetic cannabinoids are illegal to purchase and use, there are no longer any approved products.

Wairarapa DHB (as with other authorities) are struggling to cope with the damage the controversial drug is inflicting on communities One of the difficulties of addressing the use of synthetic cannabis is that there doesn't appear to be a clear profile of a user. Hospital emergency rooms are coping with the physical side-effects that synthetic cannabis cause in some people, including paranoia, panic attacks, headaches and prolonged vomiting, and, in extreme cases, psychosis, kidney failure and heart conditions.

Different age groups are using the drug, although New Zealand Police have found it is popular among the homeless and members of vulnerable populations.

Leadership

The review found the mental health and addiction workforce required effective leadership with a commitment to improving health and wellbeing of people using the services, their family and whānau. Leadership would need to include and the active engagement of the health, justice and social sectors to support recovery.

[54] *https://www.matuaraki.org.nz/initiatives/co-existing-problems/141*

The review highlighted the opportunity to provide a mechanism for collaborative leadership across the Wairarapa mental health and addiction services to support closer working relationships between services and across the whole district.

9.1.5 Communication and Relationship: *Te Hononga Korero me te Whakawhānaungatanga*

Positive relationships between mental health and addiction services was a common theme in feedback. Many stakeholders noted that relationships are good and people work well together. This was expressed from a range of perspectives including mental health and addiction staff, community service managers, family/whānau and out of district providers.

Although close relationships generally existed between the people involved in delivering services in these communities, Stakeholders acknowledge the challenge of improving access for service users and their family/whānau and the opportunities to make improvements. Comments indicate that maintaining effective relationships was seen as key to good access and reinforces that distance is a barrier.

Many services in the community are ideally placed to identify people showing early signs of mental health issues. The review found, better relationships must be developed between primary health care, housing, employment, education and welfare services. Strong partnerships and networks will give more co-ordinated support to people affected by mental illness or addiction.

9.1.6 Integrated and Collaborative Services: *Te Mahi ngātahi*

The review found a high level of responsiveness to primary care locally. GPs report that they can access telephone consults with a psychiatrist readily, and that patients they need assessed can in general be seen. There are regular primary/secondary service meetings between senior staff enabling good relationships and arrangements to be made at that level.

The cultural assessment and service delivery function is integrated within the adult and youth community mental health teams, such that all sections of the community service work together and provide cross-cover.

The community mental health inpatient service provided by the Hutt Valley DHB inpatient Unit Te Whare Ahuru, operates well from the perspective of clinical staff, however, the afterhours Crisis Respite Service (CRS) is not as responsive as needed and is thought to be spread too thin.

Stakeholders commented that for the benefit of service users and their family/whānau, there should be more co-working between services and in some cases between the different disciplines working within services. Continuity of care and follow-up services was required, for example when a young person is discharged from hospital following a self-harm event.

The following comment illustrates this theme overall:

> *"There is a sense that people are working in silos across sectors and community groups. It needs leadership to pull it together".*

Recognising the growing importance and complexity of community-based care, Stakeholders acknowledged the need for better integration of health care with other government agencies and community-managed providers that serve the public need.

Multiple stakeholders identified the community hub model which would see services located under one roof. This would enable health, justice and social services to work as an integrated care team and will help avoid duplication of effort for the service user and their family/ whānau.

An integrated care team would see General Practitioners (GPs) and community mental health and addiction and other health professionals together in multidisciplinary teams, including pharmacists, public dental services and private allied health professionals.

There are also major social influences on health and wellbeing, such as education, unemployment, housing and discrimination. A range of sectors beyond 'health' is seen as central to the success of integrated and collaborative service delivery, including income support services, education, employment and housing supports provided by other government agencies and community-managed organisations.

Overall, the review found while the Wairarapa had good links with other organisations, there was a general need for greater collaboration between services such as between primary and secondary mental health and addiction services and between sectors such as health, education and justice.

9.1.7 Physical Health and Wellbeing: Te Ora a-Tinana a-wairua a-hinengaro

Wairarapa has the country's highest suicide rate per capita. One in four secondary students report poor emotional well-being, and 16% of female students and 9% of male students have clinically significant depressive symptoms. New Zealand's youth suicide rates are amongst the worst in the OECD[55].

The suicide rate for 15–19-year-olds in 2013 was 18 per 100,000, accounting for 35% of all deaths in this age group. We need to intervene earlier. Young people should be a priority, as it is an opportunity to intervene early, before mental health and/or substance disorders are fully established. This can improve long-term health and social outcomes such as remaining engaged in education[56].

Stakeholders voiced a need for better governance and more clearly delineated roles and accountabilities for suicide prevention. At present, there are gaps in the co-ordination and integration of suicide prevention activities and other suicide prevention programs across all levels of providers in the Wairarapa.

Youth in Schools

Schools are critical for the health and wellbeing of young people. Effective learning environments, adults having high expectations of students, adults providing appropriate caring relationships for students, safe school environments and opportunities for meaningful participation in school life are all important predictors of good outcomes for teenagers.

The need to build primary mental health services and collaboration across primary and secondary care has been identified. The primary care services such as GPs are a key point of contact for accessing secondary mental health services, however, young people, in particular young males, are less likely to access primary health.

A multi-disciplinary approach to tackle mental health issues in schools, including coordination between: a social worker, adolescent psychologist, general practitioner, and drug and alcohol counselling available on-site at school. A South Wairarapa GP highlighted challenges in managing patients with mental health and addition issues that are unique to their district[57]. These included:

- Access to diagnosis and treatment particularly with some specialty services either not on-site or only available during office hours.
- Maintaining related or relevant skills due to infrequency of exposure
- Suboptimal governance structure across the Wairarapa

[55] New Zealand's mental health and addiction services: *The monitoring and advocacy report of the Mental Health Commissioner* (February 2018)
[56] Available at: *http://www.pmcsa.org.nz/wp-content/uploads/17-07-26-Youth-suicide-in-New-Zealand-a-Discussion-Paper.pdf*
[57] Wairarapa Times Age, Wairarapa by Cal Roberts, 30 Apr 2018

- Workforce constraints.

Compared to the general population, people with severe mental illnesses are less likely to have their physical health needs identified or to receive appropriate treatment for these. Part of the problem is seen as a lack of clarity over whether responsibility for providing primary health care to this group of people lies principally with GPs, mental health teams, or both.

Stakeholders proposed integrating physical and mental health care which would involve full participation of both professional teams. Efforts to develop an integrated care must focus on the integration of physical and mental health, addressing in particular challenges well known for this population group for example:

- High rates of mental health conditions among people with long-term physical health problems.
- Reduced life expectancy among people with severe mental illness, largely attributable to poor physical health.
- Limited support for the wider psychological aspects of physical health and illness.

9.1.8 Prevention and Early Intervention: *Hei Rongoa*

The review identified early intervention as crucial. Around 4% of children aged 2–14 years have already been diagnosed with emotional and/ or behavioural problems at some time in their life[58]. The review found more is needed to effectively intervene early when people are unwell and to help them maintain their wellbeing. By intervening early this would support people towards a quicker recovery.

The Ministry of Health strategic and policy documents such as the New Zealand Health Strategy 2016 and Rising to the challenge indicate this early intervention work is judged a high priority. This suggests a shift of focus, from crisis-driven responses towards prevention and early intervention. The costs for not intervening early to issues as they emerge for the person, community and government are well documented.

A large number of the Stakeholders commented that early intervention is essential and something that can be readily influenced by the development and orientation of services and must be a priority for the Wairarapa DHB.

'Early intervention' meant different things in different context. For some Stakeholders it meant encouraging earlier access to help for people with less serious problems. For others it meant responding at the first opportunity to signs or symptoms of relapse with people who have long-term mental health or addiction, with a view to averting full-blown issues.

Māori youth experience high rates of self-harm, suicide, addiction, and mental health issues. This has implications for a greater rate of adverse mental health and psychosocial outcomes that carry on into adulthood[59] if early intervention, prevention, and treatment are ineffective. Effective intervention and support are imperative, including a focus on cultural identity and holistic well-being.

[58] New Zealand's mental health and addiction services – The monitoring and advocacy report of the Mental Health Commissioner, 2018

[59] Gibson, K, Abraham, Q, Asher, I, *et al*., *Child poverty and mental health: A literature review*. Auckland: New Zealand Psychological Society and Child Poverty Action Group; 2017: https://researchcommons.waikato.ac.nz/handle/10289/11484.

Primary Care in Mental Health and Addiction Care

The common mental disorders such as anxiety and depression that are most often seen in primary care contribute a greater proportion of the population burden of illness than the kinds of disorders more often seen in secondary care, simply because of their high prevalence[60].

The aims of the Primary Mental Health initiatives are to: develop prevention, early intervention and treatment activities that would reduce the prevalence of common mental health illness; develop PMH workforce capacity and capability; and build effective links with other mental health care providers, especially but not solely secondary care, so that primary care is an effective coordinator of care for people with enduring illness.

The review found currently the Wairarapa DHB community mental health and addiction services offer a variety of forms of liaison and collaboration with primary care, for the care of both people with severe and enduring mental health and addiction issues and those people with mild to moderate mental health and addiction issues.

Although there is an increasing degree of collaboration, i.e. psychiatrists clinics in GP practices, the mental health and addiction care is still most often provided by a 'specialist'and GP practices are used to handling the service user themselves and don't have a lot to do with secondary services.

Feedback from primary care providers suggest that systemic issues still exist such as the difficulty in accessing specialist services in a timely way, poor or no communication back to the GP i.e. letters/intake assessments not shared (Emergency Department, Mental Health Services, Pathways Health Limited–Addiction), the tendency of secondary services to accumulate clients and hold them in the service for long periods contributed to primary/secondary service integration issues.

Particular issues raised relevant to the role of primary care in mental health and addiction includes:

- Multiplicity of funders make it difficult for referrals
- MDT coordination of service provision for service users
- CAMHS service very limited difficult to engage i.e. more youth specific psychologist's time.
- Culturally appropriate services need to be whānau based including a focus on youth.
- Lack of a single point of entry for referral to social services.
- Siloed mental health and addiction services – not integrated in Wairarapa.
- After hours addiction service.
- Counselling services especially younger people
- Mental health and addiction training for engaging long term condition (LTC) service users with primary care.
- Capacity in primary care.
- GP prescribing for Opioid Substitution Treatment (OST).

Inter-generational

For the nurturing of children's mental health, there is a need to focus particularly on parenting skills, prevention of family violence, encouraging opportunities for play, exercise, and learning self-control skills, fostering healthy human interactions, behaviours, and skills in the cyber world, as well as underlying drivers of stress, particularly poverty and housing problems.

[60] *Toolkit for Primary Mental Health Care Development: Report 2010*

For everyone, mental-health services need to be part of the social infrastructure that is in the business of fostering health as well as short-circuiting the descent into despair for individuals, family, whānau, and community[61]. Many people mentioned the need for prevention and early intervention for children, youth and their families/whānau, particularly when there were intergenerational issues such as addiction or family violence.

In addition, some Stakeholders believed more support was required to meet the needs of children whose parents had mental disorder. Reaching families early, even as early as pregnancy, was seen as important for supporting parent-child attachment and the social-emotional development of infants and young children.

Early intervention in Schools

Schools were seen as playing an important role as they were often the first point of contact for children with mental illness. Children and youth do not necessarily visit their GP and may not present with mental health issues. Early intervention in schools has the potential to reduce adult crime activity and associated poor outcomes for those children by 50–70%.

Co-ordination and co-operation across services that contribute to the mental health and wellbeing of children and young people and their families i.e. education, social relationships and communities was seen by the review as a priority. This includes social workers support in schools and in primary care.

Stigma and Discrimination

Stigma and discrimination can be both a consequence and a cause of social exclusion, and a major barrier to successful participation in society for excluded groups and individuals. Stigma creates a barrier for accessing mental health and addiction services i.e. prevents early access to services. Although one in five New Zealanders experience a mental illness or addiction, many people with mental illness and addiction are marginalised and stigmatised as a result. Misunderstanding about mental illness and addiction in the general community remains.

A priority for Stakeholders was the normalisation for seeking mental health and addiction services to address discrimination and to enable service users to gain support, protection and redress if they are discriminated against.

9.1.9 Health Information and Education: *Matauranga Hauora*

Review participants commented that service users with mental health issues are increasingly becoming more active participants in their treatment and recovery. However, at times, their participation may be limited by incomplete, unclear, or insufficient information. Primary Care (GP's) were also not familiar with the suite of community based mental health and addiction services.

People who need the services need to know how to access these Knowledge of what's available and what other community services are provided is lacking. The review found there was a general lack of information/visibility on what services are available to the Wairarapa population.

Better information and education appropriate to the service user, their family/whānau and the community at large is a priority. This would be centred on a level of understanding, assistance with interpreting and comprehending information when necessary, and information on the treatment.

[61] Sir Peter Gluckman: *Toward a Whole of Government/Whole of Nation Approach to Mental Health, May 2017*

Other health information and education issues identified were:

- Health literacy – needs more public awareness for mental health and addiction including schools.
- Information on mental health and addiction services. Make it transparent.
- Communication to parents where to go for support and understand why/where/how to help.
- Out of hours –quality of information provided to families.

9.1.10 Quality, Process and Procedures: *Tikanga*

Quality issues was highlighted by the review as one of the most pressing issues in mental health and addiction services and the implementation of quality assurance and improvement systems as one of the most promising means to improved care. Improving the System was seen as a priority for improving the quality of mental health and addiction care, complementing the clinical treatment.

Clinical Governance

The clinical governance arrangement would see an alignment of policy and legislation with the attainment of good quality mental health and addiction outcomes. Improvements would include coordination across different providers, involvement of consumer advocates, and leveraging of resources and incentives from across the health care system. Key partners would be brought into the quality improvement process, correctly aligned to meet policy objectives and to promote evidence-based mental health and addiction interventions.

Other clinical governance issues were:

- The upskilling of treatment protocols and staff at Wairarapa DHB for treating people with mental health issues presenting to ED– especially psychiatrists and support staff in crisis respite.
- Agreed protocols and standardised agreed processes.
- Schools/providers need clear expectations of what each other provide. This could be achieved via agreed protocols.
- Clear service descriptions, role clarity and regularly monitoring service delivery.
- Better performance management.

Quality Policy and Procedures

The review highlighted number of quality issues including procedures for managing risk, incident reporting and for identifying and addressing poor performance standards. Stakeholders noted quality improvement should be brought into routine service management and delivery with accreditation procedures and that quality standards need to be better developed and resources allocated for their implementation. These would be embedded for a whole system approach.

The establishment of lines of responsibility and accountability, programme of quality improvement, including clinical audit was also seen as a key issue. Lack of standardised information technology-based data sources, limited evidence for mental health quality measures, lack of provider training and support, and cultural barriers to integrating mental health care within general health environments were also identified as key issues.

In addition, the review found the mental health and addiction lacked consistent outcome measures and tools embedded in current information systems and other changing technologies. Outcomes would need to be assessed more routinely, and measurement-based care should become part of the overall culture of the mental health and addiction care system.

The lack of ability for system-wide routine data collection within existing electronic health care systems is seen as impeding continuous quality improvement for service users and their family/ whānau. Moreover, many of the challenges that providers address with their service users and family/ whānau include service needs beyond health care (employment, housing, education, criminal justice and welfare). The quality of this care is not always measured to ensure improved mental health outcomes and recovery.

Feedback suggests these services must be coordinated across different providers, settings, agencies and even sectors, to improve quality where there are no measures to assess accountability for these services. To mitigate this challenge, embracing the use of the Ministry of Health's Population Outcome Framework is suggested.

There are no measurements for working with whānau to get best and equitable outcome for them. Much depends on the individual worker and how they work as opposed to service commitment. A well-integrated locality-based cross agency service delivery system based on good working partnerships amongst the Mental Health and Addiction Service, the Wairarapa DHB, primary care and a number of other key stakeholders is key.

Appendix One: Review Terms of Reference

Review MHAS Wairarapa Terms of

Appendix Two: Review Working Group Terms of Reference

2. Wairarapa DHB MHA Service Review

Appendix Three: Service Provision by Provider

Wairarapa DHB services provided by the Wairarapa DHB Provider Arm, Non-Government Organisations (NGO) and from out of district DHB's and NGOs via Inter District Flow (IDF) arrangements.

Local Wairarapa delivered mental health and addiction services

Provider Group	Provider	Organisation	Service Description
Wairarapa DHB Locally funded NGO's	Mental Health Solution (sub contracted to Pathways Health Limited)	Pathways Health Limited has provided mental health services in the Wairarapa since 2011/12. From 1 November 2016, they are also contracted to provide addiction services (previously subcontracted to Care NZ until 30 October 2016). Services are provided by clinical and non clinical FTE.	***Mental Health*** Pathways deliver community and residential mental health services which include the following: • Community mobile support service • Enhanced community support service (ECS) • Mental Health residential service ***Addictions*** Pathways deliver community based alcohol and other services including AOD addition counseling to adults and youth. They deliver opioid substitute therapies (OST) clinics subcontracted with a local general practitioner. Addition services include: • Social Detox residential service • Community alcohol and other drugs (AOD) service – Adult • Community alcohol and other drugs (AOD) service – Child, Adolescent and Youth • Opioid substitute therapies (OST) – Methadone Programme.

Provider Group	Provider	Organisation	Service Description
	Te Hauora Runanga o Wairarapa	Te Hauora Runanga o Wairarapa (THROW) is a local Kaupapa Māori mental health and addiction provider that has been operating in Wairarapa for over twenty years. Integrating Māori tikanga / beliefs and kaupapa / practice with western psychiatry and facilitating links for Māori whaiora / consumer with other services such as whaiora has produced positive outcomes for the whaiora and their whānau	Alcohol and other drug (AOD) service. Oriented community based assessment, treatment and therapy service for mental health and addiction issues that is accessible, coordinated and effectively targeted for Māori. The service will be based within a Kaupapa Māori framework and responsive to the needs of tāngata whaiora and their whānau.
	King Street Artworks	King Street Artworks is a local mental health provider whose main purpose is to provide a safe and inclusive community in which individuals can maintain or regain their mental wellness through creative expression. King Street Artworks' open door policy is essential as it recognizes that early intervention and self-directed care which uses creative art as the modality and environment to promote individual service users recovery journey. They have been successful in maintaining service user's recovery or initiate any addition support or care through a well-established network of health and social services.	A recovery-oriented mental health activity based service to assist people with mental illness to develop their life and living skills and enjoy their relationships with others.
	Supporting Families Wairarapa	Supporting Families Wairarapa have been delivering family / whānau service for Wairarapa population for several decades. This service includes local family / whānau support, information and advocacy service.	Supporting Families Wairarapa is funded by the Wairarapa DHB for one Community Support Worker and was the first non-government organisation (NGO) in the Wairarapa to employ a Consumer Advisor.
	Oasis Network	Oasis Network has been delivering Peer / Consumer service in the Hutt Valley since 2006. Services commenced in Wairarapa in 2016 to provide Peer support and advocacy across Wairarapa five days a week.	An advocacy service provided by current or former mental health and/or addiction peer support service users and service to cover the costs for mental health workforce development.

Provider Group	Provider	Organisation	Service Description
	Compass Health Wairarapa	Primary health care management throughout the Wellington, Kapiti & Wairarapa regions since 1995.	• Primary Mental Health – Youth - Child, Adolescent and Youth Co-existing Disorders, Mental Health & Alcohol & Other Drugs • Primary Mental Health Strengthening primary care service offerings through ongoing interventions such as talking therapies
Wairarapa DHB Provider Arm	The Wairarapa Community Mental Health Service comprise of services for adult and children and adolescents. Their core business is specialist mental health assessment, treatment and follow-up. They have a local crisis respite and crisis assessment, treatment team. These services work closely with the NGO services and primary care services. Acute inpatient services are delivered from Hutt Valley DHB.		• Acute Crisis Respite Service • Adult Community Clinical Mental Health Service (inclusive of Psychotherapy and Primary Care Liaison) • Infant, child, adolescent & youth community mental health services • Kaupapa Māori Community Based Clinical and Support Service • Mental Health - workforce

Inter District Flow delivered mental health and addiction services: Other DHB

Provider Group	Provider	Organisation	Service Description
Inter District Flow (IDF) **District Health Boards - Other**	Auckland DHB Provider Arm	Auckland Hospital	Rapid assessment and intervention service for infants, children, adolescents and youth experiencing a mental health crisis. The services are highly mobile and are available in the setting and at the time when the crisis is occurring.
	Capital & Coast DHB Provider Arm	Community Mental Health Service comprise of services for adult and children and adolescents. Their core business is specialist mental health assessment, treatment and follow-up.	• Adult Acute Inpatient • Rehabilitation Sub-Acute/Extended Care In -patient Beds • Child, Adolescent and Youth Inpatient Beds • Co-existing Disorders – Mental Health Addictions • Community Clinical Mental Health Service (inclusive of Psychotherapy and Primary Care Liaison) • Dual Disability (Mental Health with Intellectual Disability) • Community Mental Health Service – Early Intervention for people with first time psychosis • Infant, Child, Adolescent and Youth Community Clinical Services • Managed Withdrawal- Inpatient Services • Perinatal Mental Health Specialist Community Service • Psychogeriatric
	Hawkes Bay DHB Provider Arm	Community Mental Health Service comprise of services for adult and children and adolescents. Their core business is specialist mental health assessment, treatment and follow-up.	Intensive Residential AOD service. Treatment services for people who have particular requirements that are unable to be met in less structured or supported settings.
	Hutt Valley DHB Provider Arm	Community Mental Health Service comprise of services for adult and children and adolescents. Their core business is specialist mental health assessment, treatment and follow-up.	• Adult Acute Inpatient • Child, adolescent and youth intensive clinical support Mobile service to provide intensive clinical assessment • Clinical Pediatric Outpatient Services for Eating Disorders • Consultative service within a specialist eating disorder service • Consultative service within Specialist Pediatric Eating Disorder Service

Provider Group	Provider	Organisation	Service Description
	MidCentral DHB Provider Arm	Community Mental Health Service comprise of services for adult and children and adolescents. Their core business is specialist mental health assessment, treatment and follow-up.	• Adult Acute inpatient
	Whanganui DHB Provider Arm	Community Mental Health Service comprise of services for adult and children and adolescents. Their core business is specialist mental health assessment, treatment and follow-up.	• Adult Acute Inpatient • Consultation, liaison, advice, information and education service provided to the community including service users, carers, and other service providers to older people with dementia, and thus enable a greater community awareness of dementia
	Northern Regional Alliance	The Northern Regional Alliance (NRA) was formally established in 2013 by the Northern Region District Health Boards. The Alliance is an amalgamation of two former companies, the Northern DHB Support Agency Limited (NDSA) and the Northern Regional Training Hub (NoRTH).	• Mental Health Older People Dementia Behavioral Support • Supports the DHBs where there is benefit from working regionally to meet: Minister's objectives and Goals that the DHBs have committed to in the Northern Region Health Plan and in their individual DHB Annual Plans.
Total Other District Health Board IDF			

Inter District Flow delivered mental health and addiction services: Other NGO's

Provider Group	Provider	Organisation	Service Description
Inter District Flow (IDF) **Non Government Organisations - Other**	BizComm NZ Ltd	Manor Park Private Hospital is certified to provide hospital level care for up to 54 psychogeriatric and mental health residents.	Clinical Rehabilitation / Sub-Acute / Extended Care Inpatient Beds. An inpatient recovery-oriented service that enhances the skills and functional independence of service users.
	Care NZ (Est 1954) Limited	Care NZ delivers a range of addiction services across multiple DHBs and Correction in multiple locations such as prisons and probation. They deliver community based alcohol and other services to adults and youth.	Single Point of Entry Community based offenders alcohol and other drug specialist services
	Central Health (previously Te Whatuiapiti Trust)	The service is based in a rural setting in Otane, Hawkes Bay. Approximately every two months there is an intake of 15-17 youths with a maximum number of 6 intakes a year.	Child, Adolescent and Youth Community - accommodation
	Emerge Aotearoa	Emerge Aotearoa provides a wide range of community-based mental health, addiction, disability support and social housing services nationwide	Child, adolescent and youth alcohol and drug community services. A community based assessment and treatment service for children, adolescents and youth with alcohol and or other drug issues and or dependence.
	Nova Trust Board	Nova Trust provides a three to six month residential alcohol and drug rehabilitation programme, offering supported accommodation alongside a skills development programme. Nova has a 67 bed lodge providing 24hr custodial supervision and an in-house nurse available during office hours.	Intensive Residential AOD service. Treatment services for people who have particular requirements that are unable to be met in less structured or supported settings.
	Odyssey House Trust	Odyssey House Trust, Christchurch, provides therapeutic support and education to clients with drug and alcohol addictions. Its mission is to improve the wellbeing (Life quality) of individuals, family and community affected by addiction, mental health and related issues.	Intensive Residential AOD service. Treatment services for people who have particular requirements that are unable to be met in less structured or supported settings.

Provider Group	Provider	Organisation	Service Description
	Presbyterian Support Northern (Lifeline Aotearoa)	Lifeline Auckland was established in the mid 1960s by several churches, and has been an active Lifeline supporter since that time.	Services providing suicide prevention and postvention support, including those under the current Suicide Prevention Action Plan.
	The Salvation Army New Zealand Trust	The Salvation Army New Zealand Trust is a national organisation. The salvation Army provide a safe, integrated, high quality treatment service to people whose lives have been affected by the harmful use of, or dependency on alcohol or drugs	• Community based service to provide an alcohol and other drug day treatment programme for people with alcohol and other drug dependence issues • Intensive Residential AOD service. Treatment services for people who have particular requirements that are unable to be met in less structured or supported settings.
Total Non Government Organisation - Other IDF			

Inter District Flow delivered mental health and addiction services: Other DHB - Top Sliced

Provider Group	Provider	Organisation	Service Description
Inter District Flow (IDF) **Top sliced Forensic and Rehabilitation**	Capital & Coast DHB Provider Arm	Youth Forensic Specialist Community Service	• Youth forensic services are specialist mental health and addiction services that exist to respond to the needs of young people who are or may be severely affected by mental health and or alcohol and other drug (AOD) issues and have seriously offended, or are alleged to have seriously offended. More specifically youth forensic services have a core responsibility to provide in a developmentally and culturally appropriate.
		Adult Forensic Mental Health Community Service	• "Service is facility centered with a range of outreach services delivered in prisons, courts, community based and home-based settings, delivering safe, recovery focused, culturally responsive specialist forensic mental health care including effective assessment, treatment and rehabilitation for people with mental health and or co-existing (mental health and addiction) needs who are currently in the justice system and or who are Special patients: • Mental health patients who are declared to be restricted patients under section 55 of the MH(CAT) Act • Remandees per SS 38/44 CPMIP Act 2003, Section 25s (CCPMIP 2003) or Hybrids i.e., SS 34 i (b) 1 CPMIP 2003 • Clients of General Mental Health Adult Services (GMHAS) that have behaviors that present a high level of risk to others"
Total Forensic Specialist Community Service - Other IDF			

Appendix Four: Service Schedule

Service Gaps

Service Cluster	Recommend #	Service Issue	Service Gap Opportunity	Youth 0-18 Yrs	Adult 19-64 Yrs	Older Person 65+	Year 1	Year 2
Increase Access to Community Mental Health and Addiction Treatment	7.	Community Based acute crisis respite	Establish crisis respite beds for specific populations, including the young, the older person and those with particularly complex conditions such as Coexisting Problems (CEP). Services to be provided in the community rather than current delivery model i.e. on hospital grounds.	√	√	√	30 June 2019	30 June 2020
	8.	Community Housing and Recovery Service	Modify the provision of supported residential services to best fit demand including high and complex people under 65 years. This would mean increasing the number of housing and recovery beds		√		30 June 2019	30 June 2020
	9.	Mobile Outreach Services	Resource mental health and addiction community services to be mobile to ensure that services can reach those who need them. Ensure services are available and easily accessible to service users and their family and whānau within each local territories of Wairarapa with decreased waiting times in order to avert future adverse outcomes and improve outcomes.	√	√	√	30 June 2019	30 June 2020
	10.	Flexi funding	Support access to services for those living on the rural and coastal areas, for example by ensuring flexi-funds are available to support people to get to Masterton-based services such as acute crisis respite and managed withdrawal.	√	√	√	30 June 2019	30 June 2020
	11.	Day Activity Service - Adult	Increase limited resources for adult and older people drop-in services to reduce the risks of social isolation and relapse for service users and their family/whānau.		√	√	30 June 2019	30 June 2020

Service Cluster	Recommend #	Service Issue	Service Gap Opportunity	Youth 0-18 Yrs	Adult 19-64 Yrs	Older Person 65+	Year 1	Year 2
Community Services for young people and their family/whānau.	13.	Day Activity Service - Youth	Develop meaningful day activity options for youth to improve their health and wellness, live a self-directed life and strive to reach their full potential.	√			30 June 2019	30 June 2020
	14.	Brief Intervention Options for youth.	Develop a range of brief intervention options (individual and group based) in settings where young people and their families and whānau live, learn and spend their free time. Ensure these options are culturally responsive to Māori. Brief intervention, refers to first responses to young people presenting at lower levels of stepped care. This differs from brief therapy which refers to the targeted, higher intensity interventions that can be delivered at secondary level of care.	√			30 June 2019	30 June 2020
	15.	Youth Rehabilitation Service	Resource a rebalanced mix of rehabilitation options responses across a life course continuum. Ensure services are available and easily accessible to service users and their family and whānau with decreased waiting times in order to avert future adverse outcomes and improve outcomes.	√			30 June 2019	30 June 2020
	16.	Youth Planned Respite Service	Increase access to respite for youth and youth AOD Co-existing Problems (CEP). Note in addition to acute crisis respite service.	√			30 June 2019	30 June 2020
Community Address community services for Māori	18.	Marae-based programmes	Develop marae-based programmes to meet the needs of Māori based on best practice approaches. Consider whānau ora or healthy families' service continuum approach, which builds on the strengths of whānau and encourages whānau development. Engage Māori and families/whānau in any re-design and development. Health services are provided for the improvement of health outcomes and reduction of health inequalities for Māori who use services	√	√	√	30 June 2019	30 June 2020

Service Cluster	Recommend #	Service Issue	Service Gap Opportunity	Youth 0-18 Yrs	Adult 19-64 Yrs	Older Person 65+	Year 1	Year 2
Addiction (Alcohol and Other Drugs	19.	Mixed DHB/NGO addiction service delivery model	Develop a mixed DHB/NGO addiction service delivery model for the Wairarapa Population. Resource skilled staffing in the Wairarapa DHB Provider Arm secondary to include Community Based Alcohol and other Drug Treatment Services and clinical support to service users for Opioid Substitution Treatment (OST).		√	√	30 June 2019	
	20.	Respite (Step up and step down) Residential	Establish access to Addiction Step up-Stepdown service when the person is ready to enter treatment and lack of follow up and support increased the chances of continued addiction and return to use.		√	√	31 December 2018	
	22.	Addiction Residential Service (hub)	Establish a small locally provided multi-purpose residential service (hub) that provides a mix of options needed for addiction treatment and not currently provided locally in Wairarapa, including social residential managed withdrawal (social detox) care and supported accommodation beds for people who have alcohol and other drug dependency for a period of stability for service users to cement gains post treatment.		√	√	30 June 2019	30 June 2020
	23.	Addiction Packages of Care (APOC)	Expand the scope/models used in community services to include outreach components i.e. Packages of Care (APOC) to provide capacity to those who need addiction treatment. Addiction Packages of Care (APOC) are available but difficult to access for the provision of individually tailored packages of care/treatment for youth and adults who are experiencing an acute episode of alcohol and other drug abuse. The packages of care can include Intensive Home Treatment (IHT) as a rapid response service provided to people in their own home.	√	√	√	30 June 2019	

Service Cluster	Recommend #	Service Issue	Service Gap Opportunity	Youth 0-18 Yrs	Adult 19-64 Yrs	Older Person 65+	Year 1	Year 2
Workforce	26.	Workforce Development Plan	Develop a sub-regional (Wairarapa, Hutt Valley and Capital and Coast) Workforce Development Plan that is designed to address the core component of future changes/service improvement initiatives	√	√	√	30 June 2019	30 June 2020
	27.	Mobile Specialist Teams	Develop mobile mental health and addiction specialist resources which are capable of operating across the entire Wairarapa district and which serve primarily to support the effective delivery of services through locality based teams.	√	√	√	30 June 2019	30 June 2020
	29.	Māori workforce	Identify priority areas and develop strategies for increasing Māori workforce (including clinical and community based workers). In particular: examine options for career pathways and development; develop closer training links with other sectors to diversify the existing skill based of the Māori workforce; and evaluate recruitment and retention policies for Māori workforce.	√	√	√	30 June 2019	30 June 2020
	33.	Workforce Strategy (3DHB)	Develop a sub-regional (Wairarapa, Hutt Valley and Capital and Cost DHB) workforce strategy for both mental health and addiction as a core component of future change/service improvement initiatives	√	√	√	30 June 2019	30 June 2020
Integration and Collaboration	34.	Intake and Assessment	Revise intake and assessment arrangements to remove the requirement for separate intake and assessment pathways for service users to address the inter-agency service coordination requirements of service users including young people and the homeless.	√	√	√	30 June 2019	

Service Cluster	Recommend #	Service Issue	Service Gap Opportunity	Youth 0-18 Yrs	Adult 19-64 Yrs	Older Person 65+	Year 1	Year 2
	38.	Integration with Partner Agencies	Working partnership with Oranga Tamariki, Ministry of Social Development, Education and Justice organised through a lead entity for influencing the pathways through high risk mental health, care and protection, and justice services.	√	√	√	30 June 2019	30 June 2020
Prevention and Early Intervention	41.	Multi-disciplinary approach to Mental Health in schools	Undertake a multi-disciplinary approach to tackle mental health issues in schools, including coordination between: a social worker, adolescent psychologist, general practitioner, and drug and alcohol counselling available on-site at school.	√			30 June 2019	30 June 2019
	42.	Counselling Sessions	Increased flexibility of counselling sessions. Information to be provided to the sector to explain the basis for the funding addiction counselling sessions.	√	√	√	30 June 2019	30 June 2019
	43.	Prevention Intervention	Resource services and programmes that intervene earlier in the life course where there is strong evidence for effective interventions that reduce the burden and cost of mental health and addiction – with at risk families, children and adolescents.	√			30 June 2019	30 June 2019
	44.	Stigma and Discrimination	Increase stigma and discrimination resource to enable service users to gain support, protection and redress if they are discriminated against.	√	√	√	30 June 2019	30 June 2020
	45.	Suicide Postvention	Review suicide postvention governance and clearly delineate roles and accountabilities for the co-ordination and integration of suicide prevention activities and other suicide prevention programs across all levels of providers in the Wairarapa.	√	√	√	30 June 2019	

Service Cluster	Recommend #	Service Issue	Service Gap Opportunity	Youth 0-18 Yrs	Adult 19-64 Yrs	Older Person 65+	Year 1	Year 2
Health Information and Education	46.	Service Mapping	Develop a mental health and addiction service map aimed at informing people in the community of the range of services available.	√	√	√	30 June 2019	
	47.	Information and Education	Develop information and education programmes appropriate to the service user, their family/whānau and the community at large including out of hours –quality of information provided to families. Services to be designed to improve a person's health literacy, including improving knowledge, and developing life skills which are available and easily accessible to service users and their family and whānau.	√	√	√	30 June 2019	30 June 2020
	48.	Marketing of Mental Health and Addiction	Undertake a community sponsored marketing and information campaign promoting awareness of mental health and addiction services and how these are accessed.	√	√	√	30 June 2019	30 June 2020

Service Cluster	Recommend #	Service Issue	Service Gap Opportunity	Youth 0-18 Yrs	Adult 19-64 Yrs	Older Person 65+	Year 1	Year 2
Quality, Process and Procedures	49.	Clinical Governance	Develop a clinical governance structure to support the work of all clinicians in the sub-regional mental health and addiction service This includes supporting and monitoring services to be integrated, flexible and responsive; a high performing network of people and agencies.	√	√	√	30 June 2019	30 June 2020
	50.	Process and Procedures Guidelines	Guidelines developed to promote good practice in relation to the development of 'joined-up' mental health and addiction service planning for people with multiple service needs including homeless people	√	√	√	30 June 2019	30 June 2020
	51.	Improved Triage Systems	Effective triage systems, providing more group programmes, ensuring robust systems are in place for prioritising need and monitoring demand and delivery.	√	√	√	30 June 2019	30 June 2020
	52.	Clinical Leadership	Clinical guidelines and standards are developed or updated and maintained for improving high standards of care (clinical and non-clinical.	√	√	√	30 June 2019	
	53.	Responsibility and Accountability	Transparent responsibility and accountability for those standards for the delivery of care to the people who use the mental health and addiction services, their family/whānau.	√	√	√	30 June 2019	
	56.	Family/ whānau engagement	Develop guidelines for engagement with family/whānau in the service user's recovery plan. This includes knowing who should be contacted, when a service users does not want family involved, and/or there is not the time or inclination to engage with family/whānau.	√	√	√	30 June 2019	
Collaborative Leadership Group	59.	Leadership	Review the Terms of Reference (TOR) for the collaborative mental health addiction leadership group to maximise positive outcomes for people experiencing mental health and addiction issues and their families and whānau.	√	√	√	30 June 2019	

Improve Model of Care

Service Cluster	Recommend #	Service Issue	Model of Care Opportunity	Youth 0-18 Yrs	Adult 19-64 Yrs	Older Person 65+	Year 1	Year 2	Year 3
Increase Access to Community Mental Health and Addiction Treatment	1.	Integrated Referral Pathway	Develop a Referral Pathway and access criteria for secondary mental health and addiction services which provides clear service and program pathways for increasing access and streamlining the treatment pathway. Services would be delivered around clinical care pathways with a focus on recovery and address unmet needs that are the single greatest contributor to poor health and social outcomes at an individual, family and population level.	√	√	√	30 June 2019	30 June 2020	30 June 2021
	2.	Older person Funding Model	Develop mental health funding model adapted to the needs of the older person with mental health/physical health issues.			√	30 June 2019	30 June 2020	
	3.	Older Person Assessment Pathway	Development of new assessment pathway that meets the particular needs of older people with mental health and addiction issues which is essential to help prevent admission and promote early discharge.			√	30 June 2019	30 June 2020	
	4.	Family/whānau	Build on the trend towards family and whānau inclusive practice and ensure that there is clear provision for family/whānau to be offered treatment and support as people in their own right. This could include individual sessions, family education and support groups and multi-family treatment groups.	√	√	√	30 June 2019	30 June 2020	30 June 2021

	5.	Older Person	Proactively managing the impact of mental health services for the older person by increasing access to interventions that enable older people to retain or recover functioning, avoiding or delaying the need for more intensive and costly support.			√	30 June 2019	30 June 2020	30 June 2021
	6.	Flexible Funding Models	Develop funding models which enable flexible application to fund brief intervention support for service user and family/whānau-focused and tailored service provision	√	√	√	30 June 2019	30 June 2020	30 June 2021
Community Services for young people and their family/whānau	12.	Youth AOD MST	Review the purpose of Youth AOD Multi Systemic Therapy Service. Consider redeployment of resources for young people who lack secondary and primary level support particularly under 12 year olds. Overall there is limited community services available to youth.	√			30 June 2019		
Address Community services for Māori	17.	Multicultural Mental Health and Addiction Service for Māori	Establish a multicultural Mental Health and Addiction Service for Māori. Services that focus on the drivers of inequalities in mental health and addiction burden and outcomes that affect Māori in particular as well as other high needs populations. Consider a re-design of the mental health and addiction service delivery to address service gaps for Māori; this could include options such as re-locating the service into a marae community setting, developing programmes that are more explicitly holistic and reflective of Māori approaches, settings and governance.	√	√	√	30 June 2019	30 June 2020	30 June 2021

Service Cluster	Recommend #	Service Issue	Model of Care Opportunity	Youth 0-18 Yrs	Adult 19-64 Yrs	Older Person 65+	Year 1	Year 2	Year 3
Addiction	21.	Managed Withdrawal service	Establish a district-wide model of managed withdrawal which includes integrated community supported residential options and ensure equity of access across the district.		√	√	30 June 2019		
	24.	Methamphetamine Treatment Pathway	Develop a tailored treatment pathway for those who are dependent on methamphetamine and their families and whānau to ensure an effective treatment response is available, in the context of partnerships with other stakeholders and preferably as part of a community wide response to methamphetamine related problems. The pathway to be linked to national treatment provisions (available out of district and region) i.e., methamphetamine packages of care which includes residential treatment.	√	√	√	30 June 2019	30 June 2020	
	25.	Addiction Education and Information	Partner with key agencies and providers across sectors to develop a comprehensive plan to support delivery of community addiction education (as related to other key issues such as family violence, vulnerable children, mental health, crime etc.) which identifies the objectives, mechanisms, responsibilities, evaluation methods and resources required for delivery	√	√	√	30 June 2019	30 June 2020	30 June 2021

Service Cluster	Recommend #	Service Issue	Model of Care Opportunity	Youth 0-18 Yrs	Adult 19-64 Yrs	Older Person 65+	Year 1	Year 2	Year 3
Workforce	28.	Workforce Capacity and Capability	Build the capacity and capability of all service providers to work in partnership with the service users through supporting and strengthening knowledge, experience and expertise of health workforce to mitigate the loss of experienced workforce.	√	√	√	30 June 2019	30 June 2020	30 June 2021
	30.	Community Support Worker (including Peer Support) Mental Health and Addiction Services	Identify priority areas to grow the Community Support workforce. This includes development of peer support roles within the mental health and addiction teams as a further consideration Note: Peer service user support in Addiction is an emergent discipline and has experienced rapid growth over the last few years. It is increasingly recognised as a valuable component of addiction service delivery.	√	√	√	30 June 2019	30 June 2020	30 June 2021
	31.	Consumer Advisor	Establish Advisor role/s (Adult Consumer Advisors, Youth Advisors, and/or Family Advisors) in the Wairarapa DHB Provider Arm	√	√	√	30 June 2019	30 June 2020	
	32.	Leadership	Leadership and development of the workforce. Support a diverse workforce that is recovery focused, fosters independence and is well connected, to ensure we build trust, respect and confidence. This includes continued development of the community support workforce. A focused development of capacity and capability across the spectrum of support including enabling e-therapies, self-care/whānau care and peer support.	√	√	√	30 June 2019	30 June 2020	30 June 2021

Service Cluster	Recommend #	Service Issue	Model of Care Opportunity	Youth 0-18 Yrs	Adult 19-64 Yrs	Older Person 65+	Year 1	Year 2	Year 3
Integration and Collaboration	35.	Integrated Service Modules for service users with Co-Existing Problems (CEP)	Develop new or revise current service programmes enabling integrated service modules for service users with Co-Existing Problems (CEP) with the aim of reducing siloed service provision between sectors for people with CEP.	√	√	√	30 June 2019	30 June 2020	30 June 2021
	36.	Integrated Service Delivery	Provide an environment that supports integration and collaborative practice across service delivery boundaries to ensure 'any door is the right door' and mental health and addiction sector builds the capacity and capability to respond to the needs of service user and their family/ whānau.	√	√	√	30 June 2019	30 June 2020	30 June 2021
	37.	Intra and Intersectorial Relationships	Take a whole of person approach by ensuring strong intra and intersectorial relationships to ensure people access the range of support available to achieve recovery and optimal outcomes	√	√	√	30 June 2019	30 June 2020	30 June 2021
Prevention and Early Intervention	39.	Inter-generational Issues	Consider the inter-generational perspective for improving mental health and addictions with the view to decreasing the incidence of health issues in future generations. This is thought to be due to the limited services funded for early intervention and strengthening primary-specialist-community (including social) integration.	√	√	√	30 June 2019	30 June 2020	30 June 2021
	40.	Continuum of Early Interventions	Develop a continuum of early interventions which range from broad population based, targeted mental health and addiction related promotion and prevention initiatives; early (and most often brief) interventions in a variety of community and primary care settings including schools.	√			30 June 2019	30 June 2020	

Service Cluster	Recommend #	Service Issue	Model of Care Opportunity	Youth 0-18 Yrs	Adult 19-64 Yrs	Older Person 65+	Year 1	Year 2	Year 3
Quality, Process and Procedures	54.	Mental Health and Addiction Outcome Framework	The mental health and addiction service should be outcomes focussed (that is, have in place a routine outcome monitoring programme) and the outcomes should link to agreed clinical and service performance measures. Consider the use of Mental Health and Addiction Outcome Framework.	√	√	√		30 June 2020	
	55.	Price Parity	Undertake a review of prices being provided for one service category which is disproportionate to the price for other services. Develop equitable prices relative with the expected resources/costs of delivery.	√	√	√	30 June 2019	30 June 2020	
	57.	Monitoring and Performance	Systems for monitoring outcomes to ensure services are sufficiently resourced, developed or in place to report on service delivery expectations which should be clear and consistent as part of a Service Framework for each service cluster.	√	√	√		30 June 2020	30 June 2021
	58.	Consumer Feedback system	Ensure robust service user feedback complaint/feedback systems are in place	√	√	√	30 June 2019	30 June 2020	30 June 2021

Appendix Five: Stakeholder Engagement

Stakeholder Group	Stakeholder Attendees
Wairarapa DHB personnel involved in delivering secondary and community mental health services:	• Adult Community Mental Health Team members: 20 CMHT in attendance • Child Adolescent Mental Health Team: 15 CAMHS in attendance
Five (5) NGO providers' key personnel delivering and/or managing MHA services	• Mental Health Solutions Ltd (Pathways Health Limited) • King Street Artworks Inc. • Oasis Network Inc. • Supporting Families Wairarapa • Te Hauora Runanga o Wairarapa
Māori Hui	• Wairarapa DHB Māori Relationship Board. • Te Kura Kaupapa Māori o Wairarapa Board member • Wairarapa DHB Consumer Council • Maraeroa Marae Health Centre Inc. • Supporting Families Wairarapa • Te Hauora Runanga o Wairarapa • Whānau member • Māori Mental Health Support Worker, WAIRARAPA DHB • Kaimahi @ Whaiora and Whānau representative • Māori Mental Health Professional @ TE R.A.M.A CAMHS • Clinical Psychologist @ TE R.A.M.A CAMHS
Consumer Hui: 20 Service users in attendance	Hosted by King Street Artworks.
Family Hui 15 Family members in attendance	Hosted by Supporting Families Wairarapa. In attendance 15 Family members
Primary and Secondary schools Hui	• Rathkeale College • Fernridge School • Kahutara School • Greytown School • Makoura College • Kuranui College (3 people)
Primary Care Hui	• Featherston Medical Centre • Masterton Medical (4 people) • Compass Health (7 people) • Carterton Medical Practice • Pathways/CMC
Suicide Postvention Hui	• Lifeline Aotearoa • Open Home Foundation • Supporting Families Wairarapa • Victim Support • Masterton Medical • Supporting Families Wairarapa

Stakeholder Group	Stakeholder Attendees
	• Wairarapa DHB • Changeability • Rural Support Trust
Emergency Department (ED)	4 in attendance: Dr Norman Gray and 3 clinical staff
31 Individual interviews:	• Senior Medical Officers, • Clinical staff, • Wairarapa DHB senior personnel involved in strategy and planning activities, • Family members, • DHB Mental Health and/or Addiction clinicians who services are provided to the Wairarapa population via Inter District Flow arrangement.

Appendix Six: Service Description

Service Group	Service Type	Service Description
Adult Mental Health Services	Crisis Services for people in crisis, or at risk of or having an acute episode (especially when their own or someone else's safety is at risk) including:	• Acute services provided within an inpatient setting, such as a specialist psychiatric hospital ward or mental health facility where clinically appropriate (and an efficient use of resources), 24-hour acute intensive home-based treatment and/or alternatives to hospitalisation • Assessment and referral from hospital-based accident and emergency departments (these services may be delivered by visiting community mental health teams or by inpatient liaison teams) • Community-based crisis respite, including a treatment component (services that provide people, including carers, with a break, so crisis can be eased) • Consultation, liaison and collaboration, including with PHOs and other primary health care services, secondary and tertiary services, for people with both addictions and mental health disorders
	Recovery and Resilience services to support people to recover and develop resilience – to enable people with experience of mental illness and addiction to participate in the everyday life of their communities and whānau	• Assessment and brief interventions • A comprehensive range of treatments including, but not limited to, a range of psychotherapeutic and psychosocial options • Liaison and support with education, employment and housing for service users, including service user led recovery services and peer support • Consultation, liaison and collaboration with PHOs, other primary health care services and other social service agencies • Liaison, education and support for carers, family, whānau and significant others • Mental health and addictions education, prevention and mental health promotion, and early intervention skills.
	Long Term Support for people with mental health and/or addictions issuess and/or damage from alcohol and other drug abuse and other causes needing long term support.	• Services to assess a person's needs • Co-ordination services (service to ensure people get the services they need) • Kaupapa Māori services • Social support services (e.g., self-help groups) • Support for carers • Residential support (supports to live in the client's own home), including home support services • Residential care, including hospital rehabilitation • Rehabilitation

		• Information services • Treatment and ongoing illness management and clinical care • Planned respite • Consultation and liaison.
Adult Addiction Services	Addiction (Alcohol and Other Drugs) services for people with alcohol and other drug problems in the context of the mental health and addiction services relates only to alcohol and other drug use and/or problem gambling. It refers to a maladaptive pattern of substance abuse, or problem gambling leading to significant impairment or distress.	• Assessment • Brief and early intervention • Withdrawal management • Treatment including a range of psychosocial interventions • Day programmes and residential treatment • Alcohol and other drug services for people with co-existing mental health or pathological gambling problems • Opioid substitution treatment services • Rehabilitation • Peer support • Consultation, collaboration and liaison, including with PHOs, other primary health care services, secondary and tertiary services and other social service agencies.
Children and Young People Services	Services for children and young people are available up to and including the age of 19 years, and adult services are available from 18 years; this overlap is managed according to the clinical and developmental needs of the consumer. Some flexibility will be allowed to manage the transition between child and youth services and adult services through to 25 years in order to best meet the needs of the young person. Services will promote effective engagement with both the young person and their family and whānau (when appropriate).	• Inpatient care • Provision of specialist advice to crisis services • Specialist consultation and liaison services to other professionals working with children and young people who require mental health services – including Ministry of Education, Ministry of Social Development (Child, Youth and Family), youth justice, other health services in the primary care, secondary and tertiary sectors, and other agencies • Participation in interagency processes such as Strengthening Families, Family Group Conferences, and high and complex needs case management • Education, prevention and early intervention activities for children and young people, and for families, whānau, carers and others affected • Liaison, support and respite care for families, whānau, carers and others affected • Youth Court liaison services and liaison with the Department of Corrections, the Ministry of Justice and the Ministry of Social Development (Child, Youth and Family).

Forensic and Rehabilitation and Extended Care Service	Services tailored to the needs of specific groups. Services for offenders in the criminal justice system and alleged offenders with mental illness and addictions as follows:	• Inpatient treatment in secure settings • A secure unit for people needing long-term care • Regionally based community forensic teams • Monitoring and management of special patients and restricted patients as defined by the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health (CAT) Act 1992) • Court liaison services and liaison with the Department of Corrections and Ministry of Justice • Consultation and liaison services to community services provided by the Department of Corrections and Ministry of Justice in each region
Suicide Prevention	Suicide Prevention. Coordinate suicide prevention activities.	• This includes implementing a district suicide prevention plan, facilitating and enhancing cross-agency collaboration in respect of suicide prevention and, when necessary, implementing a suicide postvention plan and a coordinated response to suicide clusters/contagion.
Primary Mental Health Services	Primary Mental Health Services. Primary mental health and addiction services provide interventions for people presenting with mild to moderate mental health and addiction problems. In addition to the general primary care response to the needs of people of any age, access to primary mental health interventions is funded for the following specific population groups:	• Primary mental health interventions are based on a stepped care model with interventions matched to service user needs in terms of level of intensity • The enrolled adult population focused on Māori, Pacific and/or low income. The expected outcome is increased access to psychological and psychosocial interventions for these at-risk groups. • Youth primary mental health services, available to all youth in the 12 to 19 year age group (regardless of PHO enrolment) who require such a service. The expected outcomes are to enable early identification of developing mental health and/or addiction issues and better access to timely and appropriate treatment and follow up.
Perinatal and maternal mental health	It is known that women with mental health problems – particularly women with a history of bipolar disorder, psychosis or postnatal/severe depression – are at risk of an escalation of symptoms during the pregnancy and postnatal period.	• Women who are identified as needing mental health services when pregnant or in the period after birth will be able to access appropriate services to meet their needs and keep themselves and their babies safe. • It is expected that all women will have access to perinatal and maternal mental health services.

Older people (65 plus years)	Older people should have access to the same range of mental health and addiction services as other eligible people provided in a manner and setting that are safe and age appropriate. Older people with a mental illness and/or an addiction are also eligible for the range of specific health services for older people. Current adult specialist service users over 65 years will remain with their current specialist service provider unless their needs change. They will not be excluded from specialist services due to age.	• Specialist services for older adults with serious mental health disorders, including serious behavioural and psychological symptoms of dementia (BPSD) • Specialist consultation and liaison services from other professionals working with older people who require mental health services – including the older persons services, community-based support and advocacy services, PHOs, other primary health care services and other social agencies.

Appendix Seven: Theme/Sub-theme Definition

Theme Kaupapa	Definition	Sub Theme	Definition: Whakamaramatanga
Access - *Tuwheratanga*	Services are available and easily accessible to Service users and their family and whānau with decreased waiting times in order to avert future adverse outcomes and improve outcomes	Referral Pathway	Timely access, safe, effective high quality care for people in mental health crisis to reduce inappropriate conveyance to emergency departments.
		Acute Response	Getting the right response 24/7 for people experiencing a mental health crisis.
		Community-based acute support	Services adequately resourced to offer intensive home like treatment (including Crisis respite facilities) as an alternative to an acute inpatient admission.
		Distance	Arrangements that ensure the people in their geographical area have access to mental health and addiction services at a local level.
		Equity	Health outcome disparities are addressed including social and economic factors such as income, poverty, employment, education and housing.
Recovery and resilience - *Te Ta Ora me Te Tu Kaha*	People improve their health and wellness, live a self-directed life and strive to reach their full potential.	Community-based clinical treatment and therapy services	Responsive services focus on recovery, reflect relevant models and take into account the clinical and cultural needs of people affected by mental illness and addiction. Services working together to ensure adequate referrals between mainstream services and those developed to meet the unique needs of specific population groups.
		Community support promote resilience, recovery and connectedness	Services that support individuals to live as independently as possible within the context of their treatment and support needs, and in an environment that is consistent with their goals and the wishes of their family/whānau.
		Respectful engagement and partnerships with service users	A respectful process where Service users of mental health and addiction services are encouraged and empowered to actively participate in decisions about the treatment, services and care they need and receive.

		Family/whānau	Family and whānau play a key role in the Service users road to recovery when providing mental health and addiction services in a family inclusive way. Services need to listen to family and whānau and respond to their specific needs, including providing education on recovery and referral of family and whānau to appropriate support services.
Reducing disparities for Māori - *Te whakaore I ngā mate e panei Ki a Ngai Māori*	Mental Health and Addiction services are provided for the improvement of health outcomes and reduction of health inequalities for Māori who use services.	Response to Māori	Response to Māori is strengthened by relationships, networks and cross agency working. Services take into account the needs, values, and beliefs of Māori including gender and geographical inequalities important areas for action.
		Family/whānau	More awareness for family/whānau and keeping the focus on person-/family/whānau centred care.
Workforce - *Kaimahi*	Building the capacity and capability of the Service providers to work in partnership with the Service users through supporting and strengthening knowledge, experience and expertise of health workforce.	Capability	Workforce development needs to be part of the focus for every service to build the capabilities required to deliver high-quality, evidence-based and person-centred care. This involves building the capacity and capability of all Service providers to work in partnership with the Service users.
		Training and Development	Investment in the training and development of the mental health and addiction workforce is key to ensuring the delivery of effective services. Integrated care and treatment will be achieved through a competent workforce appropriately trained to recognise and respond to mental health and addiction issues.
		Retention and recruitment	Career pathways for retention and recruitment of the required clinical and non-clinical expertise.
		Culturally appropriate workforce	Māori cultural competencies needed and merged with other clinical competencies reflecting what is described as a 'holistic view on life'.

Communication and relationship - *Te hononga Korero me te Whakawhānaunga tanga*	Collaborative communication which supports and strengthens positive relationships	Interagency	Improved relationships to ensure a greater ability to respond to mental health and addiction local needs through open and clear communication.
		Wairarapa Providers	Improved relationships and communications to address local needs ensuring strong collaboration between NGO and DHB mental health and addiction services.
Integration and collaboration - Te Mahi ngātahi	Providing an environment that supports integration and collaborative practice across service delivery boundaries to ensure 'any door is the right door' and mental health and addiction sector builds the capacity and capability to respond to co-existing disorders.	Integration and service delivery	Mental health and addiction service users often access other services. Services to work together in a shared care arrangements that best meet the service user's needs for those with a mental illness and/or addiction. This includes their physical health needs met.
		Leadership	Strong leadership to share innovative ideas, solve problems and improve access to services and provide co-ordinated support to people affected by mental illness and/or addiction.
		Funding approaches	Innovative funding streams for mental health sand addiction service availability for priority population groups i.e. children and youth and/or older people.
Physical health and wellbeing - *Te Ora a-Tinana a-wairua a-hinengaro*	Improving service user access services required for improving physical health needs for overall physical, mental, and social wellbeing.	Physical health	Mental Health and Addiction services addressing physical health issues by collaborating with general health services to address people's physical health needs.
Prevention and Early Intervention - *Hei Rongoa*	Preventing illness and promoting health to reduce the need for secondary or tertiary health care.	Early intervention	Increased emphasis on early intervention by focusing attention on early intervention and strengthening primary–specialist integration.
		Stigma and Discrimination	Continuing national efforts to reduce stigma by informing others who would stigmatise or discriminate against people who use mental health and addiction services. In this way Wairarapa can create inclusive communities that play their part in supporting recovery.

		Suicide Postvention	Collectively implement plans to decrease the incidence of suicide among those people known to mental health and addiction services, and have systems and processes in place to respond effectively to suicide clusters when they emerge.
		Health Promotion	Provide evidence-informed, culturally appropriate mental health promotion for family/whānau. The aim will be to increase awareness of how to recognise and respond to mental health and addiction issues.
Health information and education - *Matauranga Hauora*	Providing health information and education designed to improve a person's health literacy, including improving knowledge, and developing life skills which are available and easily accessible to service users and their family and whānau.	Health Information	Difficult to know who you need to contact in mental health and addiction services. Information and resources to help guide the service user, family/whānau and the community find mental illness and addiction services i.e. a list of helplines and access other resources to help you find services, where to go and how to do it.
		Health education	Education Program works with consumers, family member's awareness and promote understanding of mental health and mental illness. This includes better mental health and addiction education in schools.
Quality, process and procedures - *Tikanga*	Accepted clinical guidelines and standards are maintained for improving high standards of care (clinical and non-clinical), transparent responsibility and accountability for those standards for the delivery of care to the people who use the mental health and addiction services, their family/whānau.	Clinical Governance	Clinical governance required to deliver seamless, well-integrated service. This would include integrated guidelines, protocol and standards and allocating responsibility and accountability for those standards.
		Technology Support Tools	Increase uptake of e-therapy programmes that are culturally appropriate, evidence-informed and aimed at enhancing self-help skills for preventing or managing mild to moderate mental health and addiction problems.
		Leadership	Clinical leadership needs to play a greater role in the delivery of seamless mental health and addiction services to deliver a well-integrated suite of mental health and addiction services across primary and secondary care.

Appendix Eight: National Strategy and Policy

Nationwide Service Framework (Mental health and addiction	Mental Health and Addiction service specifications cover specialist mental health and addiction services targeted at those most severely affected by mental illness or addiction. However, it is recognised that a focus on early intervention and integration between specialist, primary and community services will lead to increased access for those who may be more at risk of developing mental health or addiction issues. Primary mental health services provide a general primary care response to the needs of people of any age with mild or moderate illness. The national expectations are outlined.
Commissioning Framework	The mental health and addiction sector is shaped by what is purchased and how these are purchased. We need innovative and integrated responses that are better matched to those who need them. The development of the Ministry of Health (2016) Commissioning Framework is an action from Rising to the Challenge, the Mental Health and Addiction Service Development Plan 2012-2017 (Rising to the Challenge). The Commissioning Framework proposes a clear agenda of people-centred commissioning of Mental Health and Addiction with a focus on achieving equitable outcomes "wherever people live and whatever their circumstances". To provide the least intensive means of achieving the best possible clear and accessible pathways between specialist and NGO services the Commissioning Framework takes into account the social determinants of health by taking a much broader health and wellbeing approach. This approach provides a nationally consistent approach to commissioning and supports innovative commissioning practices, supports the re-focusing of resource to achieve the goals of delivering care closer to home, provides a national infrastructure that supports new and innovative ways of working, ensures accountability for public funds and continuous quality improvement to improve outcomes for investment.
Population Outcome Framework	The mandate for developing the Mental Health Population Outcome Framework came from Rising to the Challenge and its clear aim is transformative; to put people and equity at the centre of what we do and to improve results for people. The high level purpose of the framework is: *"Through the framework is to know and acknowledge the population groups that experience inequity in outcomes, help orient services to meet the needs of these population groups and to demonstrate and measure the difference we are making to these people."* The seven broad key result areas in which the framework will measure change: Healthy, safe and secure homes; Financial security; Employment, education and participation; Social, cultural and spiritual connection; Wellbeing and respect; Mental distress, illness and Addiction and Physical health. Four macro-population targets that need to be considered: all people in New Zealand, people experiencing challenges to their wellbeing, people who are experiencing ill-health and/or addictions (tāngata whaiora), and the family, friends and whānau of tāngata whaiora.

T e Hau Mārire: Addiction Workforce Strategic Framework (2015-2025)	The Government's expectation for Māori health is whānau ora: Māori families supported to achieve their maximum health and wellbeing (Ministry of Health, 2002). Rising to the Challenge (Ministry of Health, 2012) also promotes a whānau ora approach. To meet the expectations of Rising to the Challenge and beyond, Te Hau Mārire: Māori Addiction Workforce Strategy 2015-2025targets the workforce required to minimise addiction-related harm for Māori. Effectively minimising the harm associated with substance misuse and problem gambling requires that workforce across a range of sectors have the knowledge and skills, within the context of whānau-centred practice, to identify addiction-related issues and, where appropriate, be part of an integrated response towards the desired outcome of whānau ora.
Kaupapa Māori Mental Health and Addiction Services: Best Practice Framework	Kaupapa Māori Mental Health and Addiction Services are well established indigenous solutions to addressing Māori mental health and addiction needs. The Kaupapa Māori Mental Health and Addiction Services: Best Practice Framework has been developed from the evidence available to support the effectiveness of Kaupapa Māori Mental Health and Addiction Models of care and service delivery. Intended as a resource to guide best practice, the Best Practice Framework identifies six core dimensions, and the associated descriptions, exemplars and implications. Central to each dimension is the identification of what is required for Kaupapa Māori Mental Health and Addiction Services to realise optimum outcomes for tangata whaiora and their whānau.
Suicide Prevention Outcome Framework	Every year over 500 people die by suicide in New Zealand. This has a devastating impact on the lives of the people involved and impacts all of us in some way. The New Zealand Suicide Prevention Strategy 2006–2016, which has guided suicide prevention activity in New Zealand since 2006, has come to an end. 'A Strategy to Prevent Suicide in New Zealand: Draft for public consultation' outlines a framework for how we can work together to reduce suicidal behaviour in New Zealand. It also identifies a set of priority areas for action. The Suicide Prevention Outcome framework was developed for the Ministry of Health in 2015 using a population-based outcome framework methodology. The suicide prevention outcome framework has been designed to support a coordinated nationwide response across the health, social and justice sectors to reduce the rate and incidence of suicide in Aotearoa/New Zealand and draws from and supports the New Zealand Suicide Prevention Strategy 2006–2016 and the New Zealand Suicide Prevention Action Plan 2013–2016.
Better, Sooner, More Convenient Policy	The development of Government's better, sooner, more convenient policy position in 2009 focuses on keeping people healthier in the community for longer. For mental health and addictions this means DHBs will need to develop community-based health services. This would include ensuring mental health and addiction services have the capacity to deliver more intense and more frequent services as an alternative to inpatient admission, and to enable the person to receive effective treatment in their own home

National Drug Policy 2015 – 2020	The addiction landscape continues to evolve, and new evidence will continue to emerge about the issues that need to be addressed and the effectiveness of the interventions aimed at addressing them. The National Drug Policy 2020 outlines the government's objectives: • Delaying the uptake of AOD by young people. • Reducing illness and injury from AOD. • Reducing hazardous drinking of alcohol. • Shifting our attitudes towards AOD This Policy makes a commitment to an initial set of actions, and these will be reviewed and updated by the end of 2017.
Substance Addiction Compulsory Assessment and Treatment (SACAT) Act (2017)	Developments in the Alcoholism and Drug Addiction Act (1966) as outlined in the Substance Addiction Compulsory Assessment and Treatment (SACAT) Act (2017) will generate changes in the role of compulsory treatment as part of a treatment pathway for addiction and increased demand for this pathway. Changes to the Act will impact across the Addiction service continuum. Tentative estimates suggest that approximately 200 - 300 people per year nationally, compared with the current 70 - 80 people, could become subject to the proposed new compulsory treatment regime. Under the Act the focus is on restoring a person's capacity to make informed decisions about treatment. The duration of compulsory treatment, therefore, is limited to the length of time required to enable the individual to gain the capacity to consent to participate in ongoing treatment.
Like Minds, Like Mine 2017	Like Minds Like Mine is a New Zealand wide programme to counter stigma and was released on www.gets.govt.nz on 1 August 2017. Submissions were for the next three years and include approaches to increase leadership by people with experience of mental illness; to reducing stigma both internal and external; to provide evidence based education and training and for specific counter discrimination and stigma initiatives for Māori and Pacific people.
Workforce Action Plan	The Ministry of Health's Mental Health and Addiction Workforce Action Plan 2017–2021 (the Action Plan)62 identifies the priority areas and actions required to develop an integrated, competent, capable, high-quality and motivated workforce focused on improving health and wellbeing. It will guide decisions about investment and resourcing for the next five years to ensure the workforce continues to develop and grow. The Action Plan recognises the importance of a combined effort to address the social determinants of health by working across health, justice and social sectors to ensure equitable positive outcomes for all New Zealanders. It includes actions to develop a workforce with the right skills, knowledge, competencies and attitudes needed to design and deliver integrated and innovative responses

[62] Available at: *https://www.health.govt.nz/publication/mental-health-and-addiction-workforce-action-plan-2017-2021*

Appendix Nine: Glossary

Acronyms that have special meanings are set out below. The following acronyms are used in this document.

AOD	Alcohol and other drugs
Addiction	Addiction is the repeated involvement with a substance or activity, despite the substantial harm it now causes, because that involvement was (and may continue to be) pleasurable and/or valuable.
BI	Brief Interventions
CADS	Community Alcohol and Drug Services
Carers	People who support users of mental health and addiction services when they are unwell
Case Management	A team approach to psychiatric care in the community. The team may include a Social Worker, Mental Health Nurse, Psychiatrist, Clinical Psychologists; Community Agencies (e.g. voluntary organizing dealing with mental illness such as SF). Family members may also be included
CEP	Co-existing problems, refers to when an individual has both substance use and mental health issues occurring at the same time, (CEP does not necessarily require threshold of clinical diagnosis to be reached).
CAMHS	Child and Adolescent Mental Health Services
Central Region	Geographical area covering, Palmerston North, Whanganui, in the middle Hawkes Bay in the east, Wellington region in the south including Kapiti, Porirua, Wellington central, Hutt Valley and the Wairarapa.
CMHT	District Health Board Secondary Service.
CRS	Crisis Resolution Team
DHB	District Health Board
DHB Domicile	The District Health Board area in which the client resided at the time of contact with the mental health service or health event.
Funding DHB	The DHB funding the mental health/AoD service provided
GP	General Practitioner
HBT	Home Based Treatment
LOS	Length of Stay
Māori / Pacific cultural workers	Help mainstream services provide culturally respectful services for Māori / Pacific Island peoples
Mental Health	The Mental Health Foundation defines mental health as the capacity to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual wellbeing that respects the importance of culture, equity, social justice and personal dignity. The World Health Organisation defines mental health as being a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Mental health and addiction sector	Includes mental health and/or addiction service providers, consumer and carer organisations, public health service providers active in mental health and primary care providers.
Mental Health Service	Organisations whose primary function is the provision of care, treatment, and support and education for recovery to people with mental illness, or mental health problems
Mental health support worker	Non-clinicians who work with people with mental illness. The mental health support workforce is mainly employed in the non-government community support services sector. They provide support and practical assistance and deliver rehabilitation services or programmes that facilitate the recovery process for people experiencing serious mental illness or emotional distress.
MHAIDS	Mental Health, Addictions and Intellectual Disability Service (3DHB) providing services across Wellington, Porirua, Kapiti, the Hutt Valley and the Wairarapa, as well as some central region and national services.
MST	Multi Systemic Therapy is an intensive family and community based treatment that addresses the multiple determinants of serious antisocial behaviour in young people. MST is trademarked and provided under an exclusive license granted by MST New Zealand, which is part of a parent company based in a university in the USA.
NGO	Non-governmental organisation. A group or organisation contracted by a DHB to provide treatment or support services to individuals and their families.
Peer Support Worker	Work alongside individuals and groups who experience addiction or mental distress to nurture hope and personal power and to inspire them to move forward with their lives. Someone who has experienced their own journey or difficulties in the area they work. Peer support worker is an umbrella term for several other roles and job titles with similar functions, such as peer navigator, peer recovery coach, peer recovery guide, peer mentor, voice worker or peer support specialist.
PHO	Primary Health Organisation
PRIMHD	Data (Programme for the Integration of Mental Health. PRIMHD) provided by the Ministry of Health. The database does not include any data related to primary mental health care such as that provided by general practitioners; nor does it contain any information on unmet need – those with a mental illness and/or addiction who do not access care and/or face unsurmountable barriers to the delivery of care.
Provider Arm	DHB Provider Arm delivering predominately hospital services, however it also includes community services, public health services, and assessment, treatment and rehabilitation services.
Responsible clinician	This is usually a psychiatrist and is the person responsible for a person's treatment while they are under the Mental Health Act.
Stigma and discrimination	A mark or sign of shame, disgrace or disapproval.
Service User	A person who experiences or has experienced mental illness, and who uses or has used mental health services. Also refers to consumer, survivor, patient, resident, and client, tangata whaiora.
SMO	Senior Medical Officer, sometimes referred to as a consultant.
3DHB	Wairarapa, Hutt Valley and Capital & Coast District Health Boards
SACAT	Substance Addiction (Compulsory Assessment and Treatment) Act
Whānau	Extended family, family group, a familiar term of address to a number of people, close.