

DISABILITY SERVICES ADVISORY COMMITTEE

PUBLIC Agenda

18 June 2018, 10.00am to 12.30pm

Board Room, Pilmuir House, Hutt Valley District Health Board



	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS						
1.1	Karakia				10am	
1.2	Apologies	RECORD	F Wilde			
1.3	Continuous Disclosure - Conflict of Interest	ACCEPT	F Wilde			2
1.4	Confirmation of Draft Minutes from 19 March 2018	APPROVE	F Wilde			5
1.5	Matters Arising	NOTE	F Wilde			
1.6	Action List	NOTE	F Wilde			10
1.7	Terms of Reference	APPROVE	F Wilde			12
2 INFORMATION						
2.1	Mental Health Inquiry Submissions One and Two		R Haggerty / N Fairley			14
2.2	Disability Strategy Update		R Haggerty / E Hickson			16
3 DISCUSSION						
3.1	Reporting Progress over the Last Year on the Mental Health and Addiction Work Programme at Hutt Valley DHB		H Carbonatto			19
3.2	Wairarapa DHB Mental Health and Addiction Services Review		N Broom			24
3.3	Progressing a 3DHB Addictions Model of Care in the 2018/19 Financial Year		R Haggerty			28
3.4	Supported Housing Initiative CCDHB		R Haggerty			30
4 OTHER						
4.1	Resolution to exclude the public		F Wilde			32
DATE OF NEXT MEETING 10 SEPTEMBER – LEVEL 11, BOARDROOM, GRACE NEILL BLOCK WELLINGTON REGIONAL HOSPITAL						
APPENDICES						
2.1.1	Mental Health Inquiry Pacific Feedback					33
2.1.2	Final Submission made to MH Inquiry					35


DISABILITY SERVICE ADVISORY COMMITTEE
Conflicts & Declarations of Interest Register

UPDATED AS AT JUNE 2018

Name	Interest
Dame Fran Wilde <i>Chairperson</i>	<ul style="list-style-type: none"> • Ambassador Cancer Society Hope Fellowship • Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims • Chair, Remuneration Authority • Chair Wellington Lifelines Group • Chair National Military Heritage Trust • Deputy Chair, Capital & Coast District Health Board • Deputy Chair NZ Transport Agency • Director Museum of NZ Te Papa Tongarewa • Director Frequency Projects Ltd • Member Whitireia-Weltec Council
Mr Andrew Blair <i>Member</i>	<ul style="list-style-type: none"> • Chair, Hutt Valley District Health Board (from 5 December 2016) • Advisor to the Board, Forte Health Limited, Christchurch • Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector • Former Member of the Hawkes Bay District Health Board (2013-2016) • Former Chair, Cancer Control (2014-2015) • Former CEO Acurity Health Group Limited
Ms Sue Kedgley <i>Member</i>	<ul style="list-style-type: none"> • Member, Capital & Coast District Health Board • Member, CCDHB CPHAC/DSAC committee • Member, Greater Wellington Regional Council • Member, Consumer New Zealand Board • Deputy Chair, Consumer New Zealand • Environment spokesperson and Chair of Environment committee, Wellington Regional Council • Step son works in middle management of Fletcher Steel
Dr Roger Blakeley <i>Member</i>	<ul style="list-style-type: none"> • Member of Capital and Coast District Health Board • Deputy Chair, Wellington Regional Strategy Committee • Councillor, Greater Wellington Regional Council • Director, Port Investments Ltd • Director, Greater Wellington Rail Ltd • Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council • Member, Harkness Fellowships Trust Board • Independent Consultant • Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland

Name	Interest
	<ul style="list-style-type: none"> • Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington • Invited to join the Board of the Wesley Community Action Group • Member of the Regional Steering Group, Warm Healthy Homes
<p>Ms 'Ana Coffey <i>Member</i></p>	<ul style="list-style-type: none"> • Member of Capital & Coast District Health Board • Councillor, Porirua City Council • Director, Dunstan Lake District Limited • Trustee, Whitireia Foundation • Brother is Team Coach for Pathways and Real Youth Counties Manukau District Health Board • Father is Acting Director in the Office for Disability Issues, Ministry of Social Development
<p>Ms Eileen Brown <i>Member</i></p>	<ul style="list-style-type: none"> • Member of Capital & Coast District Health Board • Board member (until Feb. 2017), Newtown Union Health Service Board • Employee of New Zealand Council of Trade Unions • Senior Policy Analyst at the Council of Trade Unions (CTU). CTU affiliated members include NZNO, PSA, E tū, ASMS, MERAS and First Union • Executive Committee Member of Healthcare Aotearoa
<p>Ms Sue Driver <i>Member</i></p>	<ul style="list-style-type: none"> • Community representative, Australian and NZ College of Anaesthetists • Board Member of Kaibosh • Daughter, Policy Advisor, College of Physicians • Former Chair, Robinson Seismic (Base isolators, Wgtn Hospital) • Advisor to various NGOs
<p>Mr Fa'amatuainu Tino Pereira <i>Member</i></p>	<ul style="list-style-type: none"> • Managing Director Niu Vision Group Ltd (NVG) • Chair 3DHB Sub-Regional Pacific Strategic Health Group (SPSHG) • Chair Pacific Business Trust • Chair Pacific Advisory Group (PAG) MSD • Chair Central Pacific Group (CPC) • Chair, Pasefika Healthy Home Trust • Establishment Chair Council of Pacific Collectives • Chair, Pacific Panel for Vulnerable Children • Member, 3DHB CPHAC/DSAC
<p>Dr Tristram Ingham <i>Member</i></p>	<ul style="list-style-type: none"> • Senior Research Fellow, University of Otago Wellington • Member, Capital & Coast DHB Māori Partnership Board • Member, Scientific Advisory Board – Asthma Foundation of NZ • Chair, Te Ao Mārama Māori Disability Advisory Group • Councillor at Large – National Council of the Muscular Dystrophy Association • Member, Executive Committee Wellington Branch MDA NZ, Inc. • Trustee, Neuromuscular Research Foundation Trust • Member, Wellington City Council Accessibility Advisory Group • Member, 3DHB Sub-Regional Disability Advisory Group • Professional Member – Royal Society of New Zealand • Member, Institute of Directors

Name	Interest
	<ul style="list-style-type: none">• Member, Health Research Council College of Experts• Member, European Respiratory Society• Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association)• Director, Miramar Enterprises Limited (Property Investment Company)• Wife, Research Fellow, University of Otago Wellington



3DHB DSAC Meeting Minutes

DATE:	19 March 2018	TIME:	10am – 12.30pm
VENUE:	Level 11, Board Room, Grace Neill Block, Wellington Regional Hospital		
PRESENT:	Dame Fran Wilde (Chair), Eileen Brown, Sue Driver, Sue Kedgley, Prue Lamason, Kim Smith, Bob Francis, Dr Tristram Ingham, Jane Hopkirk, John Terris, Derek Milne		
APOLOGIES:	Andrew Blair, Lisa Bridson, Alan Shirley, Yvette Grace, 'Ana Coffey, Tino Pereira, Jane Hopkirk and Kim Smith		
IN ATTENDANCE:	Ashley Bloomfield, Adri Isbister, Dale Oliff, Rachel Haggerty, Helene Carbonatto, Nigel Broom,		
PUBLIC	One member of public present.		
PRESENTERS	<p>Mental Health and Addiction: Joint work Programme Update Arawhetu Gray, Director, Mental Health and Addiction, Capital and Coast DHB (CCDHB)</p> <p>Report on UK Research Trip: Citizen Led Social Care and NHS Transformation Pauline Boyles, Director, Disability Strategy and Performance (CCDHB)</p> <p>Update on Implementation of Disability Strategy Pauline Boyles, Director, Disability Strategy and Performance (CCDHB)</p>		



	Agenda Item	Discussion	Action Required And by Whom
1	PROCEDURAL BUSINESS		
1.1	KARAKIA	Dr Tristram Ingham led Karakia. Committee Chair, Dame Fran Wilde, welcomed members and DHB staff	
1.2	APOLOGIES	Received from Andrew Blair, Lisa Bridson, Alan Shirley, Yvette Grace, 'Ana Coffey, Tino Pereira, Jane Hopkirk and Kim Smith	
1.3	INTEREST REGISTER	The Committee notes conflicts from Tristram and Eileen. Tristram and Eileen will provide their updated information to Catherine.	
1.4	Confirmation of previous minutes	Otherwise, minutes were accepted as true and correct. Fran notes that the minutes need to record the times of people leaving the meeting (attending in person or video).	
1.5	Matters arising	No matters arising	
1.6	Terms of Reference	The three Chief Executives (CEs) have agreed to the Terms of Reference (TOR) and the TOR have had legal review. Tristram requested an amendment to the definition of a Quorum to reflect at least one co-opted member from each of the advisory groups or their nominated alternate. Moved Tristram Ingham seconded by Sue Driver	Rachel to amend the Quorum as follows: A quorum of is a majority of Committee members, and must include at least one member from each Board and at least one co-opted member from each of the Sub-Regional Disability Advisory Group (SRDAG), Sub-Regional Pacific



		<p>Fran noted that if there is an important decision to be made, the CEs would have consulted the advisory groups for their views. The Committee noted that DSAC is an advisory committee and not a decision-making committee.</p> <p>Fran suggested to add another bullet point under Objectives and Accountabilities, “inform and engage with each advisory group on all issues”</p> <p>The Committee endorsed the Terms of Reference with the recommended amendments.</p>	<p>Advisory Group (SRPAG) and Maori Partnership Board(s) (MPB) or their nominated alternates.</p> <p>Rachel to add an additional bullet point under Objectives and Accountabilities, as a fifth row from the bottom:</p> <p>Ensure that this Committee is appropriately engaged with, and informed by, the other advisory groups of each DHB.</p>
2	PRESENTATION		
2.1	<p>Approach to DSAC Fran Wilde Rachel Haggerty Helene Carbonatto Nigel Broom</p>	<p>Prior to presentation, Derek noted that he would also like the minutes to show that it is important that the CEs use their best judgement in determining how and when the three Boards of Capital & Coast, Hutt Valley and Wairarapa are brought together to work together on key strategic issues.</p> <p>Note the importance of focusing on mental health and addictions.</p> <p>The Committee noted the discussion paper.</p>	<p>The CEs have been advised.</p>
2.2	<p>Mental Health and Addiction: Joint work Programme Update Arawhetu Gray, Director, Mental Health and Addiction, Capital and Coast DHB (CCDHB) Nigel Fairley, Waiatamai Tamehana,</p>	<p>Arawhetu and team presented the work programme that covers the key priorities that ensure the improvement of mental health and wellbeing outcomes across the 3DHBs.</p> <p>Fran asked Nigel where we are doing well for MHAIDS Integration and areas where we need to focus on.</p>	<p>The executive to report on highlights on Mental Health & Addictions Integration in the next meeting.</p>



	<p>Sandra Murray, Rod Bartling Nigel Broom, Marion Thomas</p> <p><i>Adri dropped off from VC at approx. 11.20am</i></p>	<p>Eileen asked to be provided with a staff engagement process that is with the workforce representatives.</p> <p>Fran asked to share the Consumer Leadership presentation with the 3DHB Consumer Advisory Groups and Citizens Health Council (CHC) and obtain their feedback on how it fits with CHC's framework and recommendations.</p> <p>Fran said with less than a month to the Mental Health inquiry, there is insufficient time to arrange for a discussion meeting between DHBs to align messages.</p> <p>Fran noted that the Inquiry will not be combative in nature, so there is no need for messaging to employees.</p> <p>Fran also noted that until a combined 3DHBs response becomes a formal submission, there is no need to go to governance level for endorsement.</p> <p>The Committee noted the presentation.</p>	<p>The executive to provide an overall picture of the tertiary, secondary and primary mental health services in the next meeting.</p> <p>Deferred with Citizens Health Council established.</p>
3	DECISION		
<p>3.1</p>	<p>Report on UK Research Trip: Citizen Led Social Care and NHS Transformation Pauline Boyles, Director, Disability Strategy and Performance (CCDHB)</p>	<p>Pauline reported on her recent study trip to the UK to examine the value of citizen led initiatives to strengthen health and social wellbeing and also to seek endorsement on further development work on Community Circles.</p> <p>There was support for the concept of Community Circles. Fran noted the proposal should be further developed to identify how each DHB can implement the approach.</p> <p>Derek noted that programmes such as Healthcare Homes are being funded by the 3DHBs and we should investigate how they can be connected up with Community Circles and who will take the lead.</p>	<p>The Executive to develop proposals to identify how each DHB can implement the approach.</p> <p>CCDHB is leading a trial on Community Circles with a</p>



	<i>Member from the public left the meeting at approx. 11.55am</i>	<p>Tristram offered endorsement but cautions on resourcing challenges and leadership hazards.</p> <p>Eileen recognised the work done by Pauline and her team and she thanked them.</p> <p>The Committee noted the paper and presentation.</p>	specific focus on disability and ageing in 2018/19.
4.0	DISCUSSION		
4.1	Update on Implementation of Disability Strategy Pauline Boyles, Director, Disability Strategy and Performance (CCDHB)	<p>Pauline gave an update on the progress against the Disability Strategy to meet the goals of 2017/18 Annual Plan.</p> <p>Derek and Fran noted that informed consent is undergoing further revision and welcome the suggested rewording that the research is noted with a focus on developing resources and investments.</p> <p>The Committee noted the paper with the amendment.</p> <p>Moved Prue Lamason seconded by Derek Milne</p>	
	General Business	<p>Fran requested a DSAC report to the Board with the minutes.</p> <p>Fran noted the TOR will be reported with changes.</p> <p>The Executive will report on the Mental Health Integration Project and the Mental Health Inquiry.</p> <p>Tristram closed the meeting.</p>	

Next meeting is 18 June 2018 at Hutt Valley DHB.

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

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
DSAC Public Meeting 18 March 2018					
2.2	Mental Health and Addiction: Joint Work Programme Update	<p>The executive to report on highlights on Mental Health & Addictions Integration in the next meeting and to provide an overall picture of the tertiary, secondary and primary mental health services in the next meeting.</p> <p>Sharing the Consumer Leadership presentation with the 3DHB Consumer Advisory Groups and Citizens Health Council (CHC) and obtain their feedback on how it fits with CHC's framework and recommendations.</p>	<p>SIP</p> <p>SIP</p>	<p>Papers to be presented in June's DSAC meeting. Included in the Mental Health Inquiry response.</p> <p>Deferred with CHC established.</p>	18 June
3.1	Report on UK Research Trip: Citizen Led Social Care and NHS Transformation	The Executive to develop proposals to identify how each DHB can implement the Community Circles approach.	SIP	<p>CCDHB is leading a trial on Community Circles with a specific focus on disability and ageing in 2018/19.</p> <p>The findings will be shared across the DHBs.</p>	

Closed since last meeting – 18 March

AP No:	Topic:	Action:	Responsible:	How Dealt With:	Delivery Date:
DSAC Public Meeting 18 May 2018					
1.3	Register of Interests	Changes to Eileen Brown and Tristram Ingram's conflicts.	Committee Secretary	Conflicts of Interest updated.	March
1.6	Terms of Reference	<p>Amend the Quorum as follows:</p> <p>A quorum of is a majority of Committee members, and must include at least one member from each Board and at least one co-opted member from each of the Sub-Regional Disability Advisory Group (SRDAG), Sub-Regional Pacific Advisory Group (SRPAG) and Maori Partnership Board(s) (MPB) or their nominated alternates.</p> <p>Add an additional bullet point under Objectives and Accountabilities, as a fifth row from the bottom:</p> <p>Ensure that this Committee is appropriately engaged with, and informed by, the other advisory groups of each DHB.</p>	Committee Secretary	Terms of Reference updated.	March
2.1	Approach to DSAC	CEs use their best judgement in determining how and when the three Boards of Capital & Coast, Hutt Valley and Wairarapa are brought together to work together on key strategic issues.	Committee Secretary	CEs have been advised.	March



Terms of Reference




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

March 2018

<p>Compliance</p>	<p>In accordance with section 35 of the New Zealand Public Health and Disability Act 2000, the Boards shall establish a Disability Support Advisory Committee (hereinafter called “The Committee”) whose members and chairperson shall be as determined by the Boards from time to time.</p> <p>The Committee shall comply with the New Zealand Public Health and Disability Act 2000. The terms of reference of the Committee shall be to do the following in a manner not inconsistent with the New Zealand Health Strategy.</p> <p>The Committee shall comply with the Boards’ Standing Orders for Statutory Committees.</p> <p>These Terms of Reference:</p> <ul style="list-style-type: none"> • are supplementary to the provisions of the Act and Schedule 4 to the Act; • supersede the previous Terms of Reference dated 30 July 2017; • are effective from March 2018.
<p>Functions of the Committee</p>	<p>The functions of this Committee are to give the advice to the full Board of each DHB on:</p> <ul style="list-style-type: none"> • the needs, and the factors that may affect the mental health and addiction, and disability status, of the residents of the DHB; • the mental health and addiction, and disability support needs of the resident population of the DHB; • priorities for the use of mental health and addiction, and disability support funding. <p>The aim of the Committee’s advice is to ensure that each DHB maximise the independence of the people with mental health and addiction, and disability support needs within the DHBs resident population through:</p> <ul style="list-style-type: none"> • the range of disability support and mental health and addiction, services the DHB has provided or funded or could provide or fund for those people; • the service interventions the DHB has provided or funded or could provide or fund for the population; • policies the DHB has adopted or could adopt for those people. <p>The Committee’s advice will be consistent with the New Zealand Health Strategy.</p> <p>The Committee shall present its findings and recommendations to the Boards for their consideration.</p>
<p>Objectives and Accountability</p>	<p>The Committee shall:</p> <ul style="list-style-type: none"> • monitor the disability support and mental health and addiction, needs of each DHB resident population providing advice to each Board; • provide advice to each Board on the implications of mental health and addiction, and disability related needs and status for planning and funding of nation-wide and sector-wide system improvement goals ; • provide advice to each Board on policies, strategies and commissioning (planning and funding) to support improved health and wellbeing outcomes for the target population in each district;

	<ul style="list-style-type: none"> • provide advice to each Board on priorities for improvement and independence of people experiencing mental health and addiction, and disability as part of the strategic and annual planning process to improve wellness outcomes and independence within each district; • provide advice to each Board on strategies to achieve equity in modifiable mental health and addiction, and disability status amongst the population of each DHB including but not limited to Māori, Pacific, people living in high deprivation, people with mental health and addiction, and addiction conditions and people with disabilities; • monitor and advise each Board on the impact and effectiveness of disability support and mental health and addiction services being provided for the resident population of each DHB; • provide advice to each Board on the delivery of health services accessed by people with mental health and addiction, and disabilities including how it can effectively meet its responsibilities towards the government’s vision and strategies for both populations; • identify issues and opportunities in relation to the provision of mental health and addiction, and disability services that the Committee considers may warrant further investigation and advise the Board accordingly; • ensure that this Committee is appropriately engaged with, and informed by, the other advisory groups of each DHB; • identify when ‘expert’ assistance will be required in order for the Committee to fulfill its obligations, and achieve its annual work plan by co-opting experience when required; • report regularly to each Board on the Committee’s findings (generally the minutes of each meeting will be placed on the agenda of the next Board meeting); • collaborate as required with Committees of other district health boards in the interests of providing optimum, economical and efficient services; • perform any other functions as directed by the respective DHB Boards.
Authorities and Access	<p>The following authorities are delegated to the Committee to:</p> <ul style="list-style-type: none"> • require the Chief Executive Officers and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request; • interface with any other Committee(s) that may be formed from time to time.
Meetings	<p>The Committee shall hold no less than four meetings per annum, but may determine to meet more often if considered necessary by the Committee or upon that instruction of the Boards.</p>
Quorum	<p>A quorum is a majority of Committee members, and must include at least one member from each Board and one co-opted member from each of the Sub-Regional Disability Advisory Group (SRDAG), Sub-Regional Pacific Advisory Group (SRPAG) and Maori Partnership Board(s) (MPB) or their nominated alternates.</p>
Membership	<p>Membership of the Committee shall be as directed by the Boards. The Committee has the ability to co-opt expert advisors as required.</p>
Procedure	<p>Schedule 4 of the New Zealand Public Health and Disability Act will apply to the business and procedure of the Committee.</p>

PUBLIC EXCLUDED

  		DSAC INFORMATION
		Date: 6th June 2018
Author	Trish Davis, National Operations Manager, ID Services (seconded to Inquiry project)	
Endorsed by	Rachel Haggerty, Executive Director, Strategy, Innovation and Performance CCDHB Nigel Fairley, General Manager, Mental Health Addiction & Intellectual Disability Services 3DHB	
Subject	Mental Health and Addiction Inquiry Update	
RECOMMENDATIONS It is recommended that DSAC: <ol style="list-style-type: none"> NOTE the Inquiry consultation process and feedback from the Pacific attendees; NOTE the feedback for the Mental Health Inquiry from the MHAIDs workforce; and NOTE the final submission made to the Inquiry by Wairarapa, Hutt Valley and Capital and Coast District Health Boards 		
APPENDICES <ol style="list-style-type: none"> Feedback from the Mental Health Inquiry from Pacific attendees Government Inquiry into Mental Health and Addictions – Final 3DHB response 		

1. BACKGROUND

The Government's Inquiry into mental health and addiction visited the Wellington, Hutt Valley and Wairarapa regions on May 17, 18 and 22. In May we advised you that a 3DHB approach was adopted in regard engaging with the Mental Health Inquiry (Inquiry).

Two joint written submissions were made and meetings with the Inquiry panel were coordinated across the three DHBs to ensure opportunity for consumers, the community and NGO sector, the workforce and the MHAIDS provider to make representation to the Inquiry panel.

2. 3DHB SUBMISSIONS

The 3DHBs have submitted two written submissions; two presentations from the panel meeting with senior executives and feedback from MHAIDS staff. The initial submission and presentations were made available to the Board via Board books. The final response and staff feedback are attached as appendix 2 and 3.

2.1 Initial responses

The initial response and stocktake was submitted to the Inquiry on 4th May 2018. This response outlined the DHBs' insights into this area, a stocktake of programmes/services, challenges and potential solutions. This 3DHB response recommended the following seven key solutions:

- Addressing equity issues for those populations with greatest need including Māori, youth, Pacific,
- Broadening service scope to mental health and mental distress with emphasis on prevention and early intervention,

- Increasing access to talk therapies,
- Workforce development,
- Creating multi-disciplinary therapeutic hubs around clusters of schools,
- Increasing integration across primary/community and specialist mental health services by developing community wellbeing networks, and
- Commissioning integrated services.

2.2 Final written submission

The final submission, submitted on 5 June 2018, focused on the importance of prevention and early intervention and DHBs using commissioning for populations and outcomes. It acknowledges DHBs have a significant contribution to make to improving mental health and wellbeing, outlining approaches to change.

At the same time it reiterates that change is important but disinvesting from the secondary mental health and addiction services to reinvest in other areas is an unsuccessful approach in the current funding constrained environment.

3. MEETINGS WITH THE MENTAL HEALTH INQUIRY PANEL

Engagement with the panel members occurred on **May 17, 18 and 22**. The Inquiry panel met with senior DHB leadership, the public and consumers, provider stakeholders and the workforce.

The team met with the chief executives from the three DHBs, 3DHB senior leaders, and senior clinical and management staff from MHAIDS. The range of presentations gave the Inquiry panel insights into current mental health and addiction services, challenges and possible solutions for the future.

The public meeting held in Porirua on 17th May was attended by approximately 118 people. Many family members spoke about their individual circumstances and what had worked or not worked well for them. Key themes emerged about the lack of early supports for people with mental distress; families/whānau seeking more involvement in the support processes for their family member; the impact of methamphetamine in the community and the need for an increased range of supports for Māori and Pacific.

Eleven stakeholder meetings were held with the following groups: consumers, Māori, Pacific, NGOs (mental health and addiction), community, Te Ara Pai collective, PHOs and GPs. Out of the eleven meetings, three were dedicated for MHAIDS staff working in Capital and Coast and Hutt Valley areas.

The general feedback we received was that everyone was grateful for the opportunity to be able to talk about their areas, the challenges they were facing and they submitted a range of solutions for change. (See appendix 3.2.1 for the feedback from the Pacific attendees who met with the Inquiry panel on 18th May 2018).

PUBLIC

		DISABILITY SERVICES ADVISORY COMMITTEE INFORMATION PAPER 7 June 2018
From:	Emma Hickson, Acting Disability Strategy and Performance Directorate (DSPD), Capital and Coast DHB (CCDHB)	
Endorsed by:	Rachel Haggerty, Director, Strategy, Innovation and Performance, CCDHB Helene Carbonatto, General Manager, Strategy, Planning and Outcomes, Hutt Valley DHB (HVDHB) Nigel Broom, Executive Leader, Planning and Performance, Wairarapa DHB (WRDHB)	
Subject	Update on the implementation of Disability Strategy	
<p>It is recommended that the Disability Advisory Committee:</p> <ul style="list-style-type: none"> ▪ Note the review of education planning and the training in the United Nations Convention of the Rights of the Disabled Person. ▪ Note progress on the New Zealand Sign Language (NZSL) Plan ▪ Note the strategic issues arising: Interim Clinical Governance Group (ICG), CCDHB and HVDHB ▪ Note the update on Annual Planning priorities 		

1. PURPOSE

This paper is to provide a brief update DSAC members on progress against the Disability Strategy on three specific areas of work to meet the goals of the 17/18 Annual Plan and planning for 2018/19

- Implementing the Disability Strategy
- Delivering against the actions of the 2017/2018 Annual plan
- Update DSAC on 2018/2019 Annual Plan
- Review of work plan and prioritisation of activities for 2018/19 against the Disability Strategy

2. UPDATE ON PROGRESS AGAINST THE DISABILITY STRATEGY (2017-22)

2.1. Review of Education Planning

Progress on the employment of a disability educator based at CCDHB is underway. Planning is ongoing to ensure consistent delivery of key messages and use of resources across the 3DHBs that align to the sub-regional Disability Strategy “Enabling Partnerships” (sections 1.6 and 4.4).

The disability team is receiving training from Paul Gibson (former human right commissioner) on the *United Nations Convention on the Rights of a Persons with Disability* to ensure a rights based approach provides a strong foundation for all the work within the disability team as outlined in the Sub-Regional Disability Strategy.

2.2. Progress on the New Zealand Sign Language (NZSL) Plan

A collection of useful information for the deaf community and health/DHB staff is now available on CCDHB's website. This information will be publicised as widely with focus on primary health and the community. It is envisioned this page will become a hub for the deaf community and health workers when seeking information. Work is underway to get this information replicated on the HVDHB and WDHB websites.

CCDHB recently enabled access to Skype, allowing the use of video remote interpreting (VRI) within CCDHB. VRI uses a NZSL interpreter remotely via a device between 8am – 8pm and is free of charge. The disability strategy, and performance team has purchased 5 iPads that will be housed in the Emergency departments within Wellington, Kenepuru, Hutt Valley and Wairarapa hospitals. This resource will allow immediate access to a NZSL interpreter in emergency or unplanned situations between 8am – 8pm. NZVRI and the DHB will work in partnership to promote the use of VRI within the primary and community sector.

The 'NZSL in Health Task Force' (Deaf Community Advisory Group) met in February to prioritize the 5 year plan of work and identified deaf mental health and wellbeing as a priority area. Discussions have begun with the Ministry of Health (MoH) around their proposal of a national Deaf Mental Health Advisory Group. The MoH have shown significant interest in the research 'Deaf New Zealand Sign Language users' access to healthcare' published by Witko et al. (2017) in the NZ Medical Journal. There will be a presentation of this information at the MoH to a cross ministry group involved with mental health and addictions work.

Deaf responsiveness education in 2018 is being targeted towards high user areas such as new born hearing screeners, audiology and MHAIDs. In partnership with Deaf Aotearoa, CCDHB and HVDHB are hosting 'stir it up' coffee classes where DHB staff can learn or practice their NZSL with a deaf person over coffee. These have been held monthly alternating between CCDHB and HVDHB.

2.3. Strategic issues arising: Interim Clinical Governance Group (ICG), CCDHB and HVDHB

The Interim Clinical Governance Group was established in January 2017 to address the increasing number of people using hospital services for whom there are challenges in agreeing appropriate service pathways due to the complexity of their clinical care and disability support needs. The Group is chaired by the HVDHB or the CCDHB Chief Medical Officer and the Director of Disability, Strategy and Performance. The group has been largely successful in helping staff and people using services achieve a resolution in a shorter time period. The group has evolved and expanded since its inception to include addressing unmet need and funding gaps for complex community patients across all sectors.

Referrals since the group's inception have been audited to identify key themes and demographics and to understand where the gaps or blocks are in agreeing appropriate and timely solutions from a person centred approach. Work is underway to clarify referral pathways and criteria to the group, and to build on and improve the information available for future cases. In addition, themes and trends are being tracked to ensure an appropriate response in developing service pathways in line with the Sub-Regional Disability Strategy.

The data gathered from the ICG meetings is also being used to inform the Whole of Life NASC project group. The two groups are linked to ensure a consistent understanding and to enable an integrated work programme to address key issues encountered.

A key theme continues to be the needs of bariatric patients. There are a group of patients who do not meet Disability Support Services criteria for equipment or housing modifications relating to bariatric needs for whom this has a significant negative impact on health and wellbeing. A review of equipment provision policy and practice guidelines, along with discussion with stakeholders is taking place to find solutions for this group of patients and to agree a pathway and flowchart for clinicians to follow.

3. DELIVERING AGAINST THE ACTIONS OF THE 2017/2018 ANNUAL PLAN

3.1. Workforce development

The disability, strategy and performance team are covering the vacant role of the CCDHB Disability Educator, bringing in people with lived experience of disabilities to be involved in training. Disability responsiveness training has begun on ward 6 north, Wellington Hospital in response to patient feedback and with the

support of the Hutt DHB educator. Future plans include using data to determine where training should be targeted.

Disability Responsiveness education has continued to expand throughout Hutt Valley DHB with coverage now including the plastics department. This expansion will also include disability responsiveness being a part of all orientation programmes that occur in at Hutt Hospital (house surgeons, registrars, nurses, anaesthetic technicians, midwives and foundation training day).

The Wairarapa education has included undergraduate nurses, generic orientation and in specific clinical areas.

3.2. Dashboard of indicators

An initial quality review of the disability alerts has been completed across CCDHB and HVDHB. The team are currently reviewing these outcomes to determine future plans with regards to the disability responsiveness education plan. This work and a review of the CCDHB dashboard will inform what changes are needed to be made to develop a similar disability dashboard for the Hutt Valley. Wairarapa DHB currently do not have disability alerts enabled in their system. Planning is underway for the coming year, after which time a dashboard would be feasible.

3.3. Service access for people with a learning disability

Progression on informed consent for people with learning disability is waiting for the CCDHB informed consent policy. Further development is reliant on the development of an electronic application for the health passport.

4. UPDATE DSAC ON 2018/2019 ANNUAL PLAN

Annual plan expectations from the MoH included the development of e-learning training for frontline staff and clinicians with reports on % of staff that have completed training. The DSPD, having already developed e-learning with associated reports, will review the current e-learning content with a specific regard to its Maori and Pacific focus.

4.1. E-Learning tool

The E-Learning Tool is in place to improve decision making within clinical situations. For 2018/19 the current 3DHB e-learning tool will be reviewed, including usage, Māori & Pacific focus and outcomes.

4.2. CCDHBs educator role

Re-establish CCDHB's disability educator role within Capability and Development, to work with local and wider disability and other teams.

4.3. Disability Alerts – Quality


CCDHB aims to reduce unsafe longer admissions for disabled people by improving information given to clinicians by patients. People who have disabilities and/or chronic health conditions are invited and supported to complete Disability Support Solutions Forms to engage clinical staff in proactive well-informed care. For 2018/19, CCDHB will establish a view of the current quality of the Disability Alerts. Develop education in line with the e-Learning review (5.1) and the educators' work programme and priorities (5.2)

4.4. Disability Alerts – Equity

Work with CCDHB's Māori and Pacific Directorates to support the uptake of Disability Alerts for Māori and Pacific populations.

5. REVIEW OF WORK PLAN AND PRIORITISATION OF ACTIVITIES FOR 2018/19 AGAINST THE DISABILITY STRATEGY

The Disability Strategy and Performance team are currently reviewing their work plan and prioritising their activities for the 2018/19 year. A document will be developed to guide activities for the next financial year.

		DSAC DISCUSSION PAPER
		Date: 31 May 2018
Author	Rod Bartling, Director of Mental Health Service Improvement	
Endorsed by	Helene Carbonatto, General Manager Strategy Planning and Outcomes	
Reviewed/approved by	The Executive Leadership Team (reviewed on 9 May 2018)	
Subject	Reporting Progress Over the Last Year on the Mental Health and Addiction Work Programme at Hutt Valley DHB	
<p>RECOMMENDATIONS</p> <p>It is recommended that DSAC:</p> <ol style="list-style-type: none"> Note that a mental health and addiction programme of work was established in early 2017 after a stocktake of current activity was undertaken; Note that two additional staff were employed to support this programme of work and to manage the commissioning activity related to functions undertaken by Capital & Coast DHB being transferred to Hutt Valley DHB; Note that in June 2017 the Board approved ongoing annual funding of \$1,394,400 to help address service gaps that became obvious as the work programme advanced; Note the considerable progress made across the breadth of the work programme. Note the areas of the work programme that did not advance as well as possible or planned; 		

1. PURPOSE

The purpose of this paper is to provide the Board with an overview of progress made over the last twelve months on the Mental Health (MH) and Addiction Work Programme impacting Hutt Valley DHB. It also provides feedback on areas that did not advance as well as possible or planned.

The paper groups the work programme into three categories of focus:

- Reviews;
- Service Improvements;
- Commissioning.

The work programme itself reflects the collective effort of people employed within the Strategy Planning and Outcomes Team (SPO), the DHB, the Mental Health Addiction and Intellectual Disability Services (MHAIDS) and the Strategy Innovation and Planning Team (SIP) at Capital & Coast DHB.

2. BACKGROUND

In late 2016, the Chief Executive commissioned a stocktake of MH activity that impacted the Hutt Valley catchment area. In January 2017, this stocktake resulted in the establishment of a twelve-month temporary role to oversee and support the delivery of MH service improvements.

A subsequent decision was taken in mid-2017 to relocate on an interim basis, the Hutt Valley DHB commissioning functions then delivered by the Capital & Coast DHB SIP team, to the SPO team at Hutt Valley DHB. This necessitated the establishment of two new roles initially for a 24 months period within the SPO team. One of these roles replaced the initial role established in January 2017.

Several service gaps became obvious as the work programme advanced and the Board subsequently approved \$1,394,400 of additional ongoing annual mental health funding to help address those service gaps.

Over the last year, considerable collective effort has resulted in the advancement of a comprehensive MH work programme. Most progress has been extremely positive but like any work programme, there are always areas that on reflection could have advanced better.

3. PROGRESS ON REVIEWS

Two significant reviews have been undertaken during the last twelve months and progress is outlined below. Two further structural reviews are noted further in the paper.

3.1 Infant, Child, Adolescent and Family Service (ICAFS)

The ICAFS wait times had been some of the longest across the country and despite effort by MHAIDS leadership stepped improvement was not achieved. A decision was made to commission an independent review that resulted in several actions including a formal review of the ICAFS structure.

There have been several resulting service improvement activities and a new ICAFS structure was implemented on 30 April 2018. This structure has been developed in a thorough co-design process with the ICAFS team and is well-supported within the service. Additionally, as the new improvement activities have been introduced, there has been a corresponding improvement in wait times.

3.2 Te Whare Ahuru (TWA)

Hutt Valley DHB's current acute inpatient service, TWA, is not fit for purpose and poses several barriers to clients achieving optimal health outcomes. A decision was undertaken to invest in a programme of work that would develop a new model of care for TWA and the intent to subsequently advance a refurbishment project.

Sapere Research Limited was commissioned to develop the model of care and progress has included several forums with key stakeholders to gain input, a comprehensive data analysis exercise, a literature review and visits to other DHBs with similar recent experience.

This material is currently being collated and a final report from Sapere is due in late June 2018. Board approval will then be sought to proceed to architectural design.

4. SERVICE IMPROVEMENTS

Several significant service improvement exercises have been undertaken, some of which are outlined below.

4.1 Community Team Caseload Review

Community Team caseloads in the Hutt Valley are considerably higher than like services in the wider Wellington region. This is despite very comparable referral rates. A working hypothesis was developed that people were staying linked to the service much longer than needed, and that their MH needs were more appropriately managed within primary care practice. These high caseloads have a critical impact on secondary care services and result in people with more acute needs not experiencing the service they should.

The Executive Leadership Team (ELT) approved an Innovation Fund bid to conduct a thorough review of those caseloads. This review identified that over 20 percent (up to 300 people), could and should be transferred to general practice. A collaboration is underway with Te Awakairangi Health Network to ensure the safe and appropriate transfer of client care. This will take several months to achieve and during that time a portion of those people identified may remain in secondary service care. It has also been identified that up to another 150 people could have their care transferred with more intensive support.

4.2 Youth Alcohol and Other Drug Co-Existing Problems Consult-Liaison Services (AODCEP)

The region's Youth Alcohol and other Drug (AOD) Strategic Plan identified a need to improve the youth AODCEP capability within specialist and community-based services. Board approval was gained in December 2017 to invest in this space, and as a result a small Capital & Coast and Hutt Valley DHBs consult-liaison team has been established with vacancies currently under recruitment.

Additionally, all three of the catchment areas Youth One Stop Shops (YOSS) are currently being contracted to employ their own specialist staff. These staff will be capable of both providing direct service to people and assisting the building of capability within community settings.

4.3 Building Community Capacity

A collaboration with local council and the local Labour Minister of Parliament's Office has been focused on helping better equip a diverse range of people within community settings to engage with people experiencing mental health difficulties. This work has seen the DHB engage Blueprint to deliver Mental Health 101 training to these workers. The first course is scheduled to be delivered in July 2018 with the council providing logistical co-ordination and support.

4.4 Suicide Prevention and Postvention Services

Regional Public Health (RPH) deliver postvention services for Capital & Coast and Hutt Valley DHBs, and Lifeline Aotearoa are contracted to deliver prevention services across the sub-region. A substantial programme of activity has occurred over the last twelve months in both prevention and postvention and more recently a new draft strategy has been developed.

The 3DHBs are currently considering how to make a strong impact within this critical space and this will inform the finalisation of the strategy. Delays in the provision of a whole of government National Suicide Prevention and Postvention Strategy have caused some uncertainty in terms of expectations on various agencies and organisations.

4.5 Client Pathways and Shared Care Records

An independent and formal review of several tragic events impacting consumers across the sub-region identified the need for better information sharing across services and with general practice. This resulted in a 3DHB MHAIDS-led project to introduce a shared electronic record.

Phase one of this project went live in March 2018 and now there is a far more robust and consistent capability to share information. Phase two is currently being scoped to further enhance that capability.

4.6 Substance Abuse Compulsory Assessment and Treatment Act (SACAT)

This new piece of legislation was enacted in February 2018. It provides stronger support for those extremely acute consumers who require intervention and treatment. The legislation has been implemented across the sub-region without incident, but further work is required to develop service options to support those people placed under the legislation.

5. COMMISSIONING

The SPO team have either led or been intricately involved in several commissioning local, sub-regional and regional exercises, some of which are outlined below.

5.1 Youth Respite Services

It was identified there were inadequate Youth Respite Services (YRS) across the Hutt Valley and Capital & Coast DHBs catchment areas. A detailed exercise was undertaken to analyse need, benchmark across several DHBs and ultimately manage an open tender process for the provision of new YRS.

A preferred provider has been identified and a co-design process is currently underway as contract paperwork is also finalised. It is anticipated new services will be in place in the third quarter of 2018.

5.2 Regional Alcohol and Other Drug (AOD) Acute Residential Services

The region's AOD DHB and Planning services identified that the current configuration of residential services was no longer fit for purpose, economically sound or optimal for client outcomes. A comprehensive review was undertaken and a five DHB procurement process undertaken.

This procurement process is now at a point where proposals are being evaluated with a plan for the new configuration of services to be in place by November 2018. It is essential that a separate exercise is undertaken to consider the appropriateness of local step-down and step-up AOD services.

5.3 Local commissioning activity

Several local commissioning activities are underway. This activity will or has already enhanced current service provision including:

- Hutt Women's Centre having extended opening hours to assist support women with mental health needs including a new maternal mental health capability;
- The first dedicated housing co-ordination resource being in place to assist people with MH needs overcome housing issues;
- The first dedicated vocational support role that will both help build MHAIDS staff focus on employment and directly aide individual consumer's connection with the workforce.

5.4 Investment Planning

Commissioning progress over the last year has been focused on addressing what were seen as obvious gaps. These gaps were or are being mainly addressed through the additional funding the Board approved in June 2017.

It is critical that management analyse how existing investment is performing in MH and intelligently identify where focus needs to go over the coming years. Management have therefore contracted work to develop a MH Investment Strategy and it is expected that work to be completed in June 2018.

6. AREAS NOT PROGRESSING AS PLANNED OR FOCUS NEEDED

Overall progress has been extremely positive and given the limited resource applied to such a broad work programme, some challenges are to be expected. Below are some of those challenges.

6.1 Review of the MHAIDS Crisis Response Service

This review commenced in 2016 and although the service is fully functional, there have been a few challenges experienced through the review. A final report is imminent that is expected to identify any residual areas of need. This will need to include how management continues to support improvements in the interface between MHAIDS and broader DHB services.

6.2 Integration agenda

The recent appointment of a Programme Manager to coordinate a new mental health network is already achieving dividends in progressing a comprehensive local integration agenda in parallel with Capital & Coast DHBs efforts to do the same. Progress prior to this has been slower than optimal but this was primarily a resourcing issue.


6.3 3DHB Mental Health and Addiction Strategy

Considerable effort was undertaken with a broad range of key stakeholders in 2016 to develop a draft 3DHB Mental Health and Addiction Strategy. This strategy has remained in draft mainly due to the changing structure of strategy and planning functions within each of the 3DHBs.

Recent effort led by the SIP team at Capital & Coast DHB has seen a review of the draft and a recommendation being developed on how to best finalise it. Management expect to report back to the DSAC shortly regarding this.

7. SUMMARY

Excellent progress has been made during the last year months improving MH service provision within the Hutt Valley. There is still much to be done but we are well on our way to establishing a robust work programme.

 Wairarapa DHB <small>Wairarapa District Health Board</small> <small>Te Pori Houora a-rohe o Wairarapa</small>		DSAC DISCUSSION
		Date: 5 June 2018
Author	Pauline Morrison, Project Leader, Wairarapa Mental Health & Addiction Services Review	
Endorsed by	Nigel Broom, Executive Leader Planning & Performance Wairarapa DHB	
Subject	Wairarapa DHB Mental Health and Addiction Services Review	
<p>RECOMMENDATIONS</p> <p>It is recommended that DSAC:</p> <ul style="list-style-type: none"> a) NOTE that that in February 2018 the Wairarapa DHB Board approved the Wairarapa Mental Health and Addiction Services Review; b) NOTE the progress to date on the Review as per this report. 		

1. PURPOSE

The purpose of this paper is to provide the Committee with an overview of progress made on the Wairarapa District Health Board (**WrDHB**) Mental Health and Addiction Services Review.

2. BACKGROUND

Wairarapa DHB funds a mix of mental health and addictions hospital in-patient services and community-based services.

Until 2009, the Wairarapa 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 through the partnership alliance of the Wairarapa Community Primary Health Organisation (WCPHO) and the Wairarapa District Health Board (WrDHB) as part of the Tihei Wairarapa business case, a Wairarapa-wide initiative which explored how all services could integrate more closely to provide better and more holistic health care..

A new service model was subsequently developed as part of the mental health and addiction component of Tihei Wairarapa. The Tihei Wairarapa business case 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.

In February 2018, in order to ensure the best possible care and outcomes for the population of Wairarapa, the WrDHB initiated a review to examine its existing mental health and addiction services and programmes for their population. The aim of the review was to develop a clear and considered view of the needs of the people of Wairarapa who are experiencing harm related to mental health and addiction issues.

The scope of the review included all Wairarapa DHB 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.

2.1 Government Inquiry Mental Health and Addiction

On 31 January 2018 the Government established an inquiry into mental health and addiction 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 on 22nd May 2018. The Wairarapa DHB's TOR are very similar to the Government Inquiry TOR for Mental Health and Addiction who wants 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 the findings of the local Wairarapa Review.

3. PROCESS TO DATE

The review has been undertaken between the period March 2018 to May 2018, through an extensive process of engaging with stakeholders who have an active interest in improved mental health and AOD services for individuals, family, whānau, hapū and iwi living in the Wairarapa District. The stakeholder engagement is described in detail below.

Other key processes have included a review of relevant national and local documents including Wairarapa DHB's Annual Plan, a stocktake of funded mental health and addiction treatment and support services for young people, adults and older people and an analysis of utilisation data (where available). The five key strategic themes from the New Zealand Health Strategy (2016) have provided a frame of reference for consideration of the review findings.

3.1 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 options for future service delivery, scheduled for submission to the Board in June 2018.

The DHB asked Stakeholders seven (7) questions:

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

The engagement process to date has been very dynamic and has included a greater number of Stakeholder hui/interview, where for some stakeholder groups, the DHB has needed to seek a more direct stakeholder input. The level of Stakeholder engagement has been substantial. The benefit of the increased engagement has seen the DHB strengthening and building of new relationships with stakeholders which has led to more interactive and effective engagement.

Stakeholder engagement has included the following hui and individual interviews:

- WrDHB personnel involved in delivering secondary and community mental health services:
- Adult Community Mental Health Team Hui
- Child Adolescent Mental Health Team Hui
- Five (5) NGO providers' key personnel delivering and/or managing MHA services
- Maori Hui
- Consumer Hui
- Family Hui
- School Hui
- Primary Care Hui
- Suicide Postvention Hui
- Emergency Department (ED)
- 31 Individual interviews:
- Senior Medical Officers,
- Clinical staff,
- WrDHB 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.

Over 135 people have been included in the stakeholder engagement process and over more than 1,700 individual responses recorded.

A "Closing the Loop" hui was held at the Copthorne Solway Park on Tuesday 29 May at which the ten reoccurring themes (see below) noted through the stakeholder engagement process were fed back to the stakeholders to ensure they had been captured correctly. Participants also workshopped their top three opportunities for the future.

4. REOCCURRING THEMES

On the basis of the stakeholder engagement, the following 10 Reoccurring Themes of what is needed were identified:


1. **Access:** 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
2. **Recovery and Resilience:** People improve their health and wellness, live a self-directed life and strive to reach their full potential.
3. **Reducing disparities for Māori:** Mental Health and Addiction services are provided for the improvement of health outcomes and reduction of health inequalities for Māori who use services.
4. **Workforce:** 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.

5. **Communication and relationship:** Collaborative communication which supports and strengthens positive relationships
6. **Integration and collaboration:** 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.
7. **Physical health and wellbeing:** Improving Service User access to services required for improving physical health needs for overall physical, mental, and social wellbeing.
8. **Prevention and Early Intervention:** Preventing illness and promoting health to reduce the need for secondary or tertiary health care
9. **Health information and education:** 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.
10. **Quality, process and procedures:** 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.

5. NEXT STEPS

Excellent progress has been made. Next steps are:

- Wairarapa DHB Mental Health and Addiction Review Report due to the DHB Board June 2018.
- Government Inquiry into Mental Health Report due October 2018.
- A co-design phase from November 2018 onwards.

 Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA		DSAC DISCUSSION
		Date: 18 June 2018
Author	Sandra Murray, Project Manager-mental health and Addictions	
Endorsed by	Rachel Haggerty, Director - Strategy, Innovation & Performance	
Subject	Progressing a 3DHB Addictions Model of Care in the 2018/19 Financial Year	
RECOMMENDATION		
It is recommended that DSAC:		
<ol style="list-style-type: none"> a) Note the proposed project to develop a 3DHB Addictions' Model of Care; and b) Endorse the inclusion of this project on the 2018/19 Annual Plan 		
APPENDICES		
<ol style="list-style-type: none"> 1. Intensive Supported Housing Multi-Agency Initiative 		

1. PURPOSE

This paper gives the Disability Support Advisory Committee (DSAC) an overview of a project proposed to be progressed in the 2018/19 financial year and seeks their endorsement for it to be included in the 2018/19 Annual Plan.

2. BACKGROUND

Implementation of the new Substance Addiction Compulsory Assessment Treatment Act (SACATA) 2017 identified that across the 3 DHBs there is no consistent Model of Care for Addictions' Services and that there is a potential gap in services. This poses a risk to the DHBs and their ability to not only provide a duty of care related to SACATA but to meet the needs of their populations. It was noted during implementation that nationally this was an issue. This is a priority initiative as it will provide a framework for existing and planned addiction related projects to be prioritised against and wiser investment decisions made.

In the Minister's Letter of Expectations for DHBs the Minister identified a specific focus on mental health and addictions and called out the need for action in relation to implementing models of care for addiction treatment, with particular reference to the commencement of SACATA.

3. PROPOSED PROJECT – CO-CREATE AN ADDICTIONS' MODEL OF CARE

In May 2018 the 3DHB Mental Health and Addiction Oversight Group collectively endorsed the need for a 3DHB Addictions Model of Care.

A co-created 3 DHB Addictions Model of Care would take into consideration:

- Confirmation of outcomes sought, philosophy/ principles driving service approach and provision.
- Populations intended to reach (e.g. just people with high/ complex needs or inclusive of moderate needs and ability to provide preventive/ educational responses, services tailored to youth and supports to whanau).

- Service delivery model/s - e.g. range/ nature of services/ ability to step up/ step down and be delivered as close as possible to communities people live in (locality based models).
- Client pathways and service pathways (and associated eligibility rules).
- Workforce – e.g. ethos, skill sets and organisation/ delivery structure.
- Infrastructure – e.g. best location of services, use of technology.
- Local delivery approaches that will be effective in different communities.

In creating an Addictions Model of Care it would enable the following:

- A better understanding of population need.
- A shared understanding of what is currently available and how well it works.
- Consideration of best practice treatment options –nationally and internationally.
- A thorough look at current care and treatment options available and their effectiveness.
- Provision of a shared understanding of the gap between needs and available care and treatment and what is needed to address this.
- Mechanisms to drive investment decision making.
- Assist provide a framework to monitor and evaluate performance and outcomes.


4. PROJECT DELIVERABLES AND TIMELINES

The project will facilitate the co creation of a draft 3DHB Addictions Model of Care and have this completed by quarter three of the 2018/19 financial year.

The project will also develop a short, medium and long term roadmap and investment plan to guide implementation- from what we currently have to having a fully implemented Addictions Model of Care.

5. RESOURCE IMPLICATIONS

A project manager will be required to plan, co-ordinate, facilitate co-design processes and write up the Addictions Model of Care and Implementation and Investment Roadmaps. Clinical leadership will be essential to research best practice treatment and service options.

 Capital & Coast District Health Board <small>ŪROKO KI TE URU HAUIORA</small>		DSAC DISCUSSION
		Date: 18 June 2018
Author	Sandra Murray, Project Manager-mental health and Addictions	
Endorsed by	Rachel Haggerty, Director - Strategy, Innovation & Performance	
Subject	Progressing a 3DHB Addictions Model of Care in the 2018/19 Financial Year	
RECOMMENDATION		
It is recommended that DSAC:		
<ul style="list-style-type: none"> • Note the update on the multi-agency initiative to create a supported housing initiative. • Endorse the direction of the multiple agencies working together, especially Housing New Zealand as they go through their public consultation process. • Endorse CCDHB services providing support to this initiative. • Note that additional funding maybe required for additional staff in the intensive outreach programme (Te Roopu Aramuka Wharoaroa) but at this time this is unclear. 		

1. PURPOSE

The purpose of this document is to update the Board on a multiagency initiative and to seek their endorsement to publicly support the project and make an indicative commitment to extend an existing service to better meet the health needs of a complex group of people.

2. BACKGROUND

Housing New Zealand are looking to develop a community social housing solution in inner city Wellington. A target audience for the social housing solution will be people who have complex social and health needs and predominantly 'fall through cracks' across multiple agencies and do not get their needs met. Typically this group has a history of being homeless for a long period of time as well as a history of alcohol dependency, trauma and physical health needs (for example nutritional deficits, diabetes, liver/kidney disease, dental decay).

They may also have mental health needs, a cognitive impairment, a physical disability and impaired daily living skills. They are a vulnerable population prone to being victims of predatory behaviors. Their health needs are not at the level where they need 24 hour residential health services.

3. CURRENT IMPACT ON CCDHB SERVICES

Due to this group's complex needs, eligibility criteria that often exclude them, gaps in appropriate services, and service coordination, this group draw extensively on our most intensive health services that react/ respond to an urgent need or crisis. From a health perspective this is especially seen in the Emergency Department, long term (6+ months) hospital admissions where they bed block as there are no alternative solutions and mental health addiction services where they cycle through services. A case study over two years indicated that one person accessed the Emergency Department 28 times of which 7 resulted in hospital admissions.

However, over the last nine years CCDHB, initially with assistance from Ministry of Health Primary Care innovations Funding, trialed and developed a small intensive outreach programme (Te Roopu Aramuka Wharoaroa) that supports people who are homeless and provides virtual case management to coordinate housing and health care solutions. This programme is making a difference and is reducing the impact on costly hospital based services.

4. FUTURE OPPORTUNITY FOR CHANGE

With Housing New Zealand looking to develop a social housing solution in Wellington there is an opportunity for multiple agencies to work together to provide housing, social and health solutions in a way that proactively and more sustainably meets this group of people's needs and reduces the draw on intensive services such as the emergency department, hospital bed admissions, Police, emergency accommodation and ambulance services.

4.1 Multi-Agency Partnership:

The concept model proposed for people identified with the most intensive need incorporates Housing New Zealand, Ministry of Social Development, Wellington City Council, Primary Care and Capital Coast DHB. The indicative interagency concept model looks like:

- Housing New Zealand (HNZ) develop a housing solution for people who have complex social, addiction and health needs. This would be people's home and they would be a tenant and pay rent. HNZ have indicated that they would look to be the landlord initially to assist the initiative to be successfully embedded. The housing solution would include individual bed sits with bathrooms and communal living spaces that include wet (spaces where alcohol can be consumed) and dry (spaces where no alcohol can be consumed).
- The Ministry of Social Development procure a Housing First Provider that would be procured to meet the unique needs for this group of people in a way that would provide a level of supported accommodation that included creating a safe environment, ensuring basic needs were met such as meals, managing dynamics and behaviors. It is envisaged that 24/7 staff cover will be needed. Housing First principles are:
 - Immediate access to housing with no housing readiness conditions
 - Consumer choice and self-determination
 - A harm reduction and recovery-orientation approach
 - Individualised and person-driven supports
 - Social and community integration
- Capital Coast DHB with support from primary care extend and/or reshape their existing Te Roopu Aramuka Wharoaroa service and potentially team up with MSD to provide a homebased virtual case management model to provides wrap around supports, resources and services to best meet each individuals health and social needs. This may require an investment in 2-3 more staff.
- Wellington City Council provide discretionary support and funding to assist the initiative be successful and provide access to community wellbeing programmes run in the wider social housing complex.

5. TIMEFRAMES

It is anticipated that the facility will not be fully constructed until at least 2020 so no imminent investment is required for 2018/19.

PUBLIC

 Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA		HSC DECISION
		Date: 18 June 2018
Author	Fran Wilde, CPHAC Chair	
Subject	RESOLUTION TO EXCLUDE THE PUBLIC	
RECOMMENDATION It is recommended that the Committee: a) Agree that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:		

SUBJECT	REASON	REFERENCE
Public Excluded Minutes	For the reasons set out in the respective public excluded papers	
Public Excluded Matters Arising from previous Public Excluded meeting	For the reasons set out in respective public excluded papers	
Development of a work plan for CPHAC	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	9(2)(b)(i)(j)

* Official Information Act 1982.

APPENDIX 1

Pacific Fono: Mental Health Inquiry Feedback**1 PACIFIC ISLAND ENGAGEMENT WITH THE MENTAL HEALTH INQUIRY**

Approximately 30 members of the Pacific Island community across Capital and Coast, and Hutt Valley DHBs attended the Pacific fono. The Pacific members of the Mental Health Inquiry panel To'oa Dr Jemaima Tiatia and Josiah Tualamaleali'i met with Pacific leaders and consumers to listen to their views and experiences of mental health services.

Prior to presenting their issues, Pacific leaders and consumers expressed their appreciation for the opportunity to be engaged in the Mental Health Inquiry. A follow up Pacific focussed consultation has been arranged for the 5th July in Wellington of which details will be disseminated to participants and those leaders and consumers who could not attend.

Participants reinforced that their ultimate goal was to see Pacific families and communities flourish by establishing strong connections to their cultural identity, heritage and language, and achieving the dreams and aspirations for their aiga / families.

Across the board, participants felt that the barriers to progression are systemic and attitudinal. Participants expressed grave concerns about the current state of mental health services and have made a call to the Mental Health inquiry for immediate action to curb the significant risk and danger posed on consumers, their families and communities;

The following feedback was provided:

1.1 Service delivery, utilisation and integration

- Pacific leaders expressed concerned that the data available does not define a clear problem definition and as a consequence, the investments in services does not accurately reflect the needs of Pacific consumers and their families;
- There is a sense that mental health services are fragmented, lack alignment, and collaboration within secondary and primary mental health services, making access and utilisation of services challenging for Pacific people;
- The services for Pacific people do not cater for co-morbidities across mental and physical health, e.g. Pacific people with mental health who have diabetes, obesity and long term conditions;
- There is a lack of integration between Pacific providers across community and secondary services. This issue is a reflection of the funding models and lack an understanding of Pacific consumers needs to have a seamless service from being discharged from acute / secondary services to community, and that avoids readmission;
- As much as possible, services need to be based and delivered within the communities and across the NGO sector.ⁱⁱⁱ

1.2 Models of care

- Pacific populations are evolving yet the current models are poorly equipped to deal with the growing challenges being experienced by Pacific communities in particular young Pacific people in society today;
- Cultural assessment frameworks are still relevant for Pacific consumers yet they are not readily available, developed or reviewed for practitioners to utilise nor is appropriate training responsiveness programmes available;

- There is a lack of cultural assessment frameworks supporting wellbeing of Pacific consumers being integrated in service deliveryⁱⁱⁱ;

1.3 Workforce

- Despite the efforts to grow the Pacific mental health workforce in CCDHB and HVDHB, and the significant investment by organisations like Le Va, Te Pou, and the DHBs, the Pacific workforce continues to be under-represented in the clinical, management and leadership areas, across CCDHB and HVDHB.
- Pacific people appear to be over-represented within entry level roles such as support workers and front line roles in NGOs such as navigators with little understanding of how Pacific people can progress into clinical / management roles;
- There is no leadership pipeline to support senior clinicians and staff in leadership roles within Mental health services and the NGO sector^{iv};

1.4 By Pacific for Pacific

- Pacific participants continue to be concerned about the perceived ‘taker-over’ of Pacific providers and services by mainstream services without due consideration of the relevance of by Pacific for Pacific services.^v

ⁱ Pacific Perspectives (2011) Primary Care for Pacific People: A Pacific and Health Systems View. Wellington: Pacific Perspectives.

ⁱⁱ “Inequity is built into health systems...” (Starfield, 2011) and equity is achieved only by good policy and managing to that policy (Sheridan, 2011).

ⁱⁱⁱ Tiatia J. 2008. *Pacific Cultural Competencies: A literature review*. Wellington: Ministry of Health. Published in February 2008 by the Ministry of Health PO Box 5013 Wellington, New Zealand

^{iv} Betancourt, J.R., Green, A.R., Carrillo, J.E., Ananeh-Firempong II, O. (2003) Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports* 118(4): 293-302

^v Ryan, D., Beckford, N., & Fitzsimons, M. (unpublished, 2010) *Lalaga: Pacific providers making a difference*. Wellington: Ministry of Health

APPENDIX 2



June 5 2018

Professor Ron Patterson
Chair
Government Inquiry into Mental Health and Addiction
mentalhealthinquiry@dia.govt.nz

Dear Ron

3DHB final submission to Government Inquiry into Mental Health and Addiction

Background to submission development

This letter forms our final submission to the Government Inquiry into Mental Health and Addiction. In addition to this letter, please also refer to the following:

- The initial response and stocktake on behalf of the 3 DHBs as funders, and MHAIDS as the 3DHB provider arm of mental health and addiction services in our area, sent to the Inquiry on **Friday May 4**.
- Engagement with the panel members on **May 17, 18 and 22**, including the two presentations provided by the 3 CEs and the 3DHB senior leadership team.

District Health Boards (DHBs) have a contribution to make. Approaches need to change, and leadership from the centre of the system needs to support us to take the initiative in that change.

We acknowledge our mental health and addiction services play an important role in the provision of services and require appropriate funding to support ongoing service development and delivery. Our service provision and investment is dominated by specialist mental health services. With significant funding pressure investment in prevention, early intervention and support for mental distress and trauma is very limited.

However; the major changes have to take place outside of services, at a societal level, if services are able to respond differently to need and have the space required to focus on the recovery and wellbeing of their clients and their families.

From the perspective of a services provider, the combined DHBs would like to see a society where wellbeing and freedom from addictions are supported in our society and issues affecting mental health and wellbeing are recognised and acted upon ***before they require an intensive (and expensive) health system response.***

Furthermore, internationally there is wide discussion on a population health approach prevention and promotion of mental health and wellbeing. The World Health Organisation, along with others have promoted these approaches. In our New Zealand context we have the learnings of whānau ora to

inform our approach to approaches, programmes and partnerships that will support mental health, wellbeing and freedom from addictions. Critically, ensuring the relevant government agencies are on board and the right systems, budget appropriations and capability are in place is essential to this transformational change.

The issue of funding streams that support mental health and wellbeing is also a critical discussion. As we verbally outlined; disinvesting to reinvest remains an unsuccessful approach in a funding constrained environments with significant competing demands; that redirecting increases in population based funding streams is possible (and the current focus of Capital and Coast DHB) is possible but will be slow to achieve the change we need, and finally the development of a focused investment for mental health and wellbeing could be the most effective model of funding.

Specific contributions from DHBs to the change required

In our earlier responses we had listed integrated commissioning as the seventh in a list of possible solutions. The process of engaging with the panel has helped us refine our ideas: we see that addressing commissioning is the fastest lever by which New Zealand as a whole can address the issues outlined in this submission, and our earlier responses and presentations.

MOH published a commissioning framework for Mental Health and Addiction in 2016. It also commenced the development of a population based approach to outcomes that recognises that diversity requires differing responses to support mental health and wellbeing. Neither of these frameworks have been implemented consistently nationally¹.

In addition to tackling commissioning, DHBs have other significant contributions to make in effecting the systemic change described earlier in this letter. These are strategic level solutions, and complement the practical solutions we provided in our earlier response and presentations. They include ensuring that:

- Accountability mechanisms to the Crown/MOH for mental health and freedom from addiction reflect drivers of wellbeing and facilitate investment in wellbeing models;
- DHB commissioning models that focus on the mental health and freedom from addictions of ethnographically identifies population groups, requiring integration of health services across the life course;
- Services for those who are experiencing illness are also focused on achieving wellbeing and specifically focusing on removing risk based approaches;
- Clinical expertise is focused on supporting wellness through focusing on life outcomes as well as clinical results.
- Workforce development focuses on delivery of redesigned models of care that are specific and not general.

¹ See last paragraph, p 4, *Commissioning Framework for Mental Health and Addiction: A New Zealand guide*, 2016

In addition to the last point above on workforce, our May 4 response inadvertently missed addressing the registered nursing workforce, easily the largest group of our staff. We recognise better workforce planning is required for this vital group, including creating a 3DHB approach, significantly increasing the new entry to specialist practice (NESP) intake and take practical approaches to address the gender and cultural imbalances.

Conclusion

In conclusion, a future society will still need a strong, capable and committed mental health sector that can help individuals in greatest need, and it is essential that we do not disinvest in that sector in order to reinvest elsewhere. But we stand a far greater chance of success if the current flood tide can be stemmed by a society that gives **greater priority to managing the determinants of mental health**.

As DHBs, we have a contribution to make to implementing recommendations for a cohesive mental health and addiction approach for Aotearoa, New Zealand, an anticipated outcome of this Inquiry.

We believe we are at a point of opening the door to a very different approach with our community partners – embarking on deliberate, transformational change. We trust the panel will recognise the system-level changes required to enable this to happen in a meaningful way.

We thank you again for the opportunity to make our submission. Please let us know if you have any questions.

Yours sincerely

Adri Isbister
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Wairarapa DHB

Dale Oliff
Acting CEO
Hutt Valley DHB

Ashley Bloomfield
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