**Waikato Mental Health and Addictions Systems Review**

Tēnā koutou katoa,
Me mihi ki ngā mate o te wā. Rātou ki a rātou. E te Kingi me te Makau Ariki, koutou te Whare o te Kahui Ariki. Pai maririe ki a rātou
Mihi hoki ki ngā puipuiaki o te Waikato. Mihi whakaute ki a koutou, ki a rātou katoa.

Mental Health and Addiction Services (MH&AS) in the Waikato provide care to approximately 5000 people each week. It is a core service which contributes significantly to the wellbeing of our community and supporting people across all stages of life to achieve their full health potential.

Waikato DHB has recorded a sharp increase in demand for MH&AS in recent years, particularly for whaiora with high and complex needs and methamphetamine use. Although this is by no means unique to the Waikato, the effects have been particularly pronounced as the region has experienced unprecedented population growth.

In response to this growing need, hospital services have expanded over a number of years, as has the community-based provider network and the level of dedicated MH&AS funding (up 45% since 2011/12).

Although there has been considerable effort to meet growing demand, as service expansion and additions have occurred over a number of years, the result has been a system and structure which was not designed 'as one' with the level of interconnectedness and service options which best reflect the needs of our Waikato community today.

We are fortunate to have an outstanding group of people in our MH&AS team, and a highly skilled and dedicated group of partners in our community providers. The DHB has commissioned this independent report to inform our pathway forward.

What is recommended is a pathway of connected services along which there are multiple opportunities for whaiora to receive care and support at an earlier stage to enhance wellbeing and prevent the need for acute admission.

There have been previous reviews of MH&AS which have tended to focus on a specific service area. The intent of this review is different. We have asked an independent team with considerable expertise and experience to consider the full range of services and practices, from primary care in the community through to our acute services, strategy and funding, and governance – a true 'system' review.

It is intended that this review will help to shape our MH&AS system in a way which better supports our staff and enhances the quality, equity and access to care for all whaiora.

On behalf Waikato DHB I wish to thank Dr David Chaplow and the Review Group for their work and recommendations. We are also grateful to all those who have contributed to this review by sharing their time and knowledge.

Acknowledging the importance of the review, the commissioners have requested that a report be provided in April which includes priorities and a timetable for addressing the Review Group's recommendations.

Nō reira, tēnā koutou katoa

Dame Karen Poutasi
Commissioner
Waikato DHB

# WAIKATO MENTAL HEALTH AND ADDICTIONS SYSTEMS REVIEW

2020

*"IF THINGS STAY THE SAME, WE ALL BECOME PART OF THE PROBLEM*

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# WAIKATO MENTAL HEALTH AND ADDICTIONS SYSTEMS REVIEW

## *"IF THINGS STAY THE SAME, WE ALL BECOME PART OF THE PROBLEM"*

**Foreword**

The Waikato Mental Health and Addiction System Review 2020 was commissioned to report on the performance of the current Mental Health and Addiction system ("MH&AS") within the Waikato District Health Board ("Waikato DHB"). It is integral to the success of the MH&AS that the population of the WDHB rohe (area) can have confidence in their MH&AS when accessing services in the community and as an inpatient. It is noted that many of the issues and challenges identified in this Waikato DHB review are also experienced by other District Health Boards across Aotearoa.

This review is not merely a platform to report on deficiencies of a system, it is an opportunity. It is an opportunity to build on all that has gone before and take a look back to map out the future. It is an opportunity to take stock of progress and state what needs to happen to achieve the key priorities identified in Me Kōrero Tātou and in the DHB's strategic plans and priorities. It is an opportunity to ensure the health and safety of tāngata whaiora ("whaiora").[1]

We thank the DHB for the privilege of serving on this review. We acknowledge the many whaiora, whānau, kaimahi, individuals and organisations associated with the MH&AS across the Waikato rohe who generously shared their experiences and suggestions to enhance and improve services. They have made significant contributions to our findings and recommendations.

**Review team members**

1. Dr. David Chaplow – Chair
2. Charles Joe, JP
3. Gail Goodfellow
4. Joanna Price
5. Sherida Davy
6. Sheryl Matenga
7. Wi Keelan
8. Dr Maria Baker

Professor Ron Paterson provided expert advice. Carolyne Grainger was Executive Coordinator for the review, and Nicola Birch assisted in writing the report.

The review team reported to Waikato DHB's executive team via Riki Nia Nia, Executive Director Māori, Equity and Health Improvement.

[1] People with experience of mental illness, who are seeking wellness or recovery of self.

**Review Process**

The review team members met on a weekly basis, 2-3 days per week, from the end of September 2020 through to mid-December 2020. During this time, the team met with key services and individuals throughout the MH&AS and met as a panel to discuss findings.

On the commencement of the review, key individuals, groups, and resources were identified and subsequently engaged in interviews. During the initial interviews, based on the information gathered, the list of those that needed to be interview evolved. Over 180 persons and groups were interviewed as part of the review process, across both the provider arm and the associate community providers. A full list of those interviewed is appended to this report.[2]

A draft indicative report was presented to the Executive Leadership Team (ELT) on 23 December 2020

**Approach**

At the review team's powhiri, the expectation was set that the team needed to be candid about their findings and that these findings were to reflect reality. This has been a key driver in our approach to this review. Our aim has been to ensure a safe, efficient, effective and accessible environment for whaiora. With that in mind, we considered it our responsibility to present the MH&AS with transformational recommendations to ensure Waikato's mental health and addiction services (MH&AS) were fit for purpose.

To investigate the current way of "doing things" was to confront systems, practices and processes within the MH&AS domain. It is important to note that MH&A does not operate in isolation. It operates in a system. It was essential therefore to review other areas that directly affect MH&AS, such as Strategy and Funding, how MH&AS connects with other medical services and other community mental health providers (such as primary services).

Essentially, this holistic approach to the review has meant the net was cast widely in who was included when undertaking interviews. This approach has allowed identification and acknowledgement of the many successes within the realm of MH&AS. However, it has revealed gaps within the MH&AS, some requiring immediate action.

Engagement of tāngata whaiora (whaiora) and whānau was central to the approach taken in carrying out the review and writing of this report. This report seeks to express the views of whaiora, whānau and the lived experience workforce who helped the reviewers to understand the issues and what is needed within the Waikato DHB mental health and addiction system.

**Terms of Reference**

The Terms of Reference ("TOR") were fashioned by the DHB Executive Leadership Team (ELT) and after several iterations were approved.

TOR 1-4 refer to interrelated system issues: processes of Strategy and Funding; 'system delivery' both in the provider arm and across the community; clinical and cultural governance; and application of Māori methodology and practices. These four TOR are part of a continuum

[2] Appendix 2 – List of interviewees

to ensure adequate and appropriate needs are met for whaiora. If there is a failure in the continuum, the needs of whaiora are not met.

Statements 5 and 6 in the TOR concern the important procedural elements key to effective and respectful practice as they relate to leave protocols and procedures for whaiora, and communication with whaiora, family and whānau.

There is overlap between some of the TOR statements and their findings. However, for the sake of clarity and comprehensiveness, the discussion, findings and recommendations for each TOR are set out separately.

**Background**

The Waikato District Health Board region covers a land mass of more than 21,000km and services an estimated 425,836 people in the region. Waikato has a higher proportion of Māori than the national average with 23% of the population identifying as Māori, and a lower proportion of Pacific people with 3% identifying as Pacific peoples. Of the Mental Health population, Māori are significantly over-represented, making up approximately 40% of the whaiora that access the system.

Over the last decade, there has been a series of reviews, reports and inquiries that have examined the Mental Health system, at both a National and a District Health Board level. These reports provided essential background material to the findings and recommendations of this report.

He Ara Oranga (2018) is the report of the Government Inquiry into Mental Health and Addiction. From this inquiry emerged consensus that for many parts of New Zealand society, there was a readiness for the need for change and a new direction. "An emphasis on wellbeing and community, with more treatment options, close to home, whānau and community based responses and cross government action". He Ara Oranga proposed major changes to current policies and laws, and made 40 recommendations, 38 of which the Government accepted.
The Health and Disability System Review (2020) was charged with "recommending system level changes that would be sustainable, lead to better more equitable outcomes for all New Zealanders and shift the balance from treatment towards health and wellbeing". The review report, Pūrongo Whakamutunga, identified four key themes:

- Ensuring whaiora, whānau and communities are at the heart of the system
- Culture change and more focused leadership
- Developing more effective Te Tiriti based partnerships with health and disability and creating a system that works more effectively for Māori
- Ensuring the system is integrated and deliberately plans ahead with a longer-term focus.

**Preliminary Comments**

**Mental Health and Wellbeing**

Mental Health is often defined as the absence of illness. Mental Health Services are set up to assess and treat illness in whaiora, the majority who then progress to wellness.

Wellbeing is a distinct concept. It often concerns cultural and spiritual alignment enshrined in the meaning of existence (the components of existing or being human).

Clearly, mental health and wellbeing are intricately linked. Clinicians need to consider wellbeing issues and do this by understanding the whaiora narrative, known as 'formulation'. However, many people who are not unwell also have wellbeing issues: issues of loss; concerns with self-identity; displacement; cultural dissonance; worth and belonging. As well as personal and whānau supports, a range of community agencies and institutions (clubs, churches, welfare, counselling organisations), may assist in meeting the wellbeing needs of an individual and/or whānau. Hence, mental health services often fail unless connected to other agency providers. 'Interagency' cooperation is important to any health system dealing holistically with a person or whānau.

It is in this context that 'Whānau Ora' was developed as a navigation philosophy to assist individuals and whānau access disparate agencies and, in doing so, reduce inequities.

**Inequality and inequity**

Inequality and inequity are terms that are closely related. They have different meanings and implications. Inequality refers to groups not being treated equally. Inequity refers to the unfairness that may lead to poorer outcomes for some groups. Essentially inequities for individuals involve gaps, often driven by social determinants such as education, housing, employment/income and deprivation that result in a lack of access to necessities that are technically available to everyone.

Inequity occurs in a complex web of circumstance; if a person doesn't have the appropriate education that leads to gainful employment this directly affects access to housing, employment and income. This leads to inability to access services that a person has a right to access. However, if petrol is unaffordable, or indeed a car, a person is negatively impacted if to access something requires travel. Hence, services that are equally available for a given community cannot be accessed by those suffering inequities. One of the major obstacles to accessing adequate mental health and wellbeing are existing inequities. A Māori outcome indicator is given[3].

[3] Equity outcome for Māori means "restoration of mauri, maintenance of mana, reciprocation of manaakitanga, establishment of mana motuhake"

**The 'system'**

**Epidemiological studies** in NZ indicate that approximately 50% of people will suffer from a mental disorder in their lifetime; 20% over the previous 12-months. Ethnic disparities are noted as well as comorbid illnesses in 40% of cases. Other studies demonstrate that about 7% of sufferers initially access their primary providers and about 4% access secondary MH&A services because of the need for specialist care.

**Strategy and Funding** is a division of the DHB. Money is allocated by the government on an annual basis. The DHB has two 'arms': 'Strategy and Funding', and 'Provision of Specialist Services'. Funding for MH&A services occur across both the provider arm and across the community. Current funding split for mental health and addiction services between provider arm and community is in favour of the provider arm (56:44%) noting an increase in investment in the system of almost 45% over the past decade, exceeding 'ring-fenced' expectations for 2020/21.[4]

**Primary mental health** Services include GP practices, Primary Health Organisations (PHOs) including Māori-led PHOs and other agencies that deliver primary care. These are funded differently from secondary and tertiary services; by 'capitation' (the government paying an amount for every whaiora registered) and by fee for service, in addition. Primary services are often 'first contact' services though those with inequity issues experience barriers to care due to cultural attitudes, cost and comorbidities.

**Secondary mental health** includes the provider arm of the DHB who are funded for age-related mental health[5] and related services as well as community-based services, mainly NGOs[6] (set up as non-profit charitable services to support whaiora).

**Addiction Services** were historically separate services from MH services but were brought within the ambit of MH in the 1990's (hence the current 'MH&A services') due to the comorbidities that often exist in respective whaiora and due to management efficiencies and in an endeavour to 'professionalise' the addiction services. The importance of these services highlights the challenges that encompass the amount of alcohol consumed by our society and the rampant illicit drug use, currently prevalent, and, in rangatahi, the devastating adverse effect on the maturing brain, on behaviour and on relationships. Different types of addiction services are provided in both the provider arm and in the community.

**Te Tiriti o Waitangi and Mana Motuhake**

In 1840 an accord signed between Māori and the Crown came to certain agreements. These are often simplistically summed up as 'the three P's' (Partnership, Participation and Protection). This understanding is outdated and the Ministry of Health's new Treaty

[4] Report to Finance Risk and Audit Committee 18 Nov 2020.

[5] General adult, inpatient and community; consultation-liaison, eating disorders, dual diagnosis, Intellectual disability, infant, child and adolescent, forensic services and mental health services for older persons.

[6] NGOs referred to by the Review Team as 'Associate Community Providers'.

Framework[7] sets the government direction to improve health outcome and inequity for Māori over the next 5-years. The more important agreement (Article II) was to have Māori aegis over Māori 'taonga', the ability to manage their own affairs, often referred to as 'Mana Motuhake'.

[7] Whakamaua: Māori Health Action plan 2020-2025.

**Themes**

A number of key themes emerged in our discussions and are reflected in our findings and recommendations.

**Theme 1 – Structure:**

***The Waikato DHB structure must embrace Te Tiriti o Waitangi***

Te Tiriti o Waitangi provides the framework for how the Board and iwi Māori may meet their obligations for Māori self-determination (mana motuhake) in the design, delivery and monitoring of health and disability services. The vision of iwi Māori is that Te Tiriti o Waitangi will be embedded and enacted in all systems of Waikato DHB. The DHB has committed, through the creation and publication of Te Pae Tawhiti 2018-2030 (The Framework for Change) to the principles of Partnership, Participation and Protection which should underpin engagement with Māori to develop Māori responsiveness. These principles need updating to reflect current understanding of these obligations. To embrace a Te Tiriti o Waitangi framework will ensure that Waikato DHB is working in a safe, culturally competent and equitable health and disability service environment.

As part of the review, the review team considered the Waikato DHB organisational leadership structure. The most senior Māori position in Waikato DHB is the Executive Director: Māori, Equity and Improvement of Health. This position is a direct report to the Chief Executive. The Executive Director: Māori, Equity and Improvement of Health leads the Public Health Unit , Pacific Health Unit (a new unit) and Te Puna Oranga.

Te Puna Oranga is the Waikato DHB's Māori Health Services, and provides a service that reaches across all levels within the Waikato DHB and into the Waikato communities. It is a kaupapa Māori led service that provides strategic, as well as Mātauranga Māori, services. Included in the services provided are the Kaitakawaenga (Māori cultural workers), who provide a Māori specific service of cultural care and guidance to whaiora in the mental health system.

Other groups are part of the structure, some at a governance level and some at an advisory level. Of interest to the review panel was the Iwi Māori Council (IMC), the Oversight Group and Mental Health and Addictions Service (provider arm) Clinical Governance Forum.
The review team understood that the IMC is involved in some Waikato DHB operational meetings; they are present or represented at meetings held by Te Puna Oranga, the provider arm Clinical Governance Forum and the Oversight Group.

The Oversight Group, created to provide (community) sector governance, leadership and direction, and to oversee Waikato DHB Mental Health Sector investment, is not functioning according to its initial vision. This was reflected in written and oral reports to the review panel, which variously described the Oversight Group as *'Fragmented; lacking collaboration between the Waikato DHB and NGOs; highly political; and struggling to convene the NGO providers'.* This group needs to be disbanded or be reconstituted and work differently; it needs to provide, and work within, a clinical structure in which community providers can meet according to their respective common interests (i.e. child and adolescent, addiction, Pacific,

kaupapa Māori services). As a general conclusion, the review panel noted that there is a lack of trust within the group.

The provider arm Mental Health Clinical Governance Forum operates effectively over the 'provider arm' Mental Health Services at a high level, monitoring the consistently high and rising demand for mental health and addictions services within the Waikato region. Proposals have been developed to mitigate the significant risks identified. This has led to additional funding being allocated. It is recognised that further work and funding will be required to fully mitigate risks.

**Theme 2 – Māori and Mental Health**

***Equity outcome for Māori means "restoration of mauri, maintenance of mana, reciprocation of manaakitanga, establishment of mana motuhake"***

As identified above, the structure of Waikato DHB needs to be wrapped in a Te Tiriti o Waitangi framework; so too must the MH&AS be grounded in the same framework as expressed in Whakamaua: Māori Health Acton Plan 2020-2025. To ensure an effective and successful model of care for Māori, Mental Health need to focus on: Te Tiriti o Waitangi; Equity; kaitakawaenga; Me Kōrero Tātou; and Mātauranga Māori.

Māori, although 23% of the overall Waikato rohe population, are only 9% of the Waikato DHB MHAS staff population. This needs to increase over time to ensure there are staff who can be the champions of 'tikanga' and 'Mātauranga Māori '. There is also the issue of equity. Persistent inequity of health outcomes experienced by Māori whaiora and their whānau are a concern. This inequity is symbolised in the over representation of Māori being coercively managed via Section 29,[8] by being subject to disproportionate seclusion events and by the unenviable high death rate by suicide. Furthermore, Māori are more likely to be admitted in the weekend when there is no kaitakawaenga service available.

Throughout the review, the kaitakawaenga team received uniform acceptance and praise for the service they provide. However, with only 7 Full Time Equivalents (FTE) available, all of whom sit in the provider arm, the kaitakawaenga has insufficient FTE to resource the current demand. To give full effect to the cultural importance of the kaitakawaenga, their reach needs to extend past the provider arm and should not be limited to "office hours". The cultural guidance provided by kaitakawaenga is essential to whaiora and whānau well-being and directly aligns with the aspirations outlined in Me Kōrero Tātou.

Me Korero Tātou represents the community Māori voice and clearly defines iwi aspirations for Māori. The iwi voice is to move deliberatively to 'Mana Motuhake'; the enablement of Māori to be Māori and exercise authority over their own lives (inclusive health services) according to their needs, values and traditions. The review team was informed that disappointment was expressed by iwi that no immediate feedback to them occurred as to what action would follow by Waikato DHB following Me Kōrero Tātou's release.

Mātauranga Māori, the knowledge of Māori, needs to be recognised and applied within the Mental Health system. There is immense value in Mātauranga Māori approaches and Te Ao

[8] Mental Health (Compulsory Assessment and Treatment) Act 1992.

Māori traditional healing practice, including the use of 'Rongoa' as effective interventions for Māori whaiora and their whānau. There is strong evidence that effective Mātauranga Māori cultural intervention programmes can reduce inequity and increase health outcomes for Māori in the MH&AS. The 'medical model' approach to medicine can easily dismiss the cultural importance to well-being. To successfully implement Mātauranga Māori approaches there needs to be recognition and education of different cultural approaches. These approaches must also recognise the importance of staff working collaboratively with tangata whaiora and their whānau in their own treatment. MH&AS must ensure that whaiora and whānau are active partners not only in their own treatment but also within service and organisational processes i.e. the whaiora leave process.

**Theme 3 – Action through planning**
***"Many services; one system"***

Of concern was the repeated comment throughout the review process that there are simply *"no plans"* (to action the vision set out in the various documents).

The review team were not clear whether this was entirely accurate. The S&F team, previously titled the 'Planning and Funding' team, is impacted by the fact that there appears to be no focused planning when looking at how to allocate funds. Strategy and planning is everyone's business. Funding and contracting is a specialist area. Despite the creation of a number of strategic and visionary documents, including: Creating our Futures; Iwi Māori Health Strategy; Ki Taumata o Pae Ora; Waikato Health System Plan Te Korowai Waiora; Mental Health and Addictions Te Pae Tawhiti; and Me Kōrero Tātou – Let's Talk, clinicians are keen to see operational planning. A clinical service's plan for mental Health will be completed in advance of the Final Business Case in the current financial year. Strategizing and planning should be a conjoint effort between S&F and senior clinical personnel. These documents have identified a number of at-risk areas that require attention, and highlighted specific issues for Māori that need addressing, all of which can only be addressed if specifically, and adequately funded. The omission of planning in this area has meant that funding is not being allocated to what should be priority areas. Without the appropriate planning to create conjoint, time-framed implemented action plans for the visions and strategies outlined in the aforementioned documents, the vision lies dormant and remains merely a "dream". This challenge is at the door of all DHBs

Demand for services within the Waikato DHB has increased dramatically over recent years. The review team heard that mental health services should be sited within communities, or close to them. Acknowledgement of this statement is a start; planning for this issue has begun.

The lack of focussed planning also highlights the limited connection between and across all mental health services, including between the provider arm and associate community providers (NGOs), and between the respective associate community providers. The rationale of this 'dated' contracting lies in history when a competitive business model was promoted in order to encourage efficiencies. Instead, we find a provider arm, 'capability rich' but 'capacity poor' and a community sector struggling to access capability when required and having unused capacity because of inflexibility in interpreting contracts. The provider arm and

associate community providers (NGOs) require (re)-planning and purchasing as unified and connected services.

**Theme 4 – Funding and Relationships**

***"Investment in successfully proven initiatives is required to expand access and choice for whaiora and whānau"***

Over time demand has outstripped supply in MH&AS. This has had a negative impact on MH&AS relationship managers who, in interviews, stated they feel frustrated. This impact has partially contributed to the turnover of staff who have held the relationship manager position (four relationship managers in three years).The situation has also resulted in frustration for the NGO/ACP's and provider arm management who felt powerless to seek solutions when demand for service was overwhelming them.

As indicated above, a competitive model of health care was brought in during the 1990's which resulted in tension between providers and a lack of partnership between them. Although there has been a movement away from this type of model of health, consequences of this model design are still influencing the sector today. The competitive approach of funding splits providers from a "joined up" partnership approach across all services as one system. The system needs to move to a 'many providers, one service' system approach; however, this approach can only be achieved through meaningful, trusting relationships. Years of poor management and governance has seen the introduction of Commissioners to the WDHB with a new approach.

With 44% of mental health users identifying as Māori, the current model of funding struggles with Māori inequity. The investment focus must be on moving whaiora from illness to wellness and ultimately to 'wellbeing'. The change in approach, which needs to result in a strong shift away from the competitive model of care, must be supported by a sound MH&AS Strategy and Funding (S&F). It will require S&F to undertake appropriate planning, implementation of service development, and investment logic mapping. The development and use of a funding framework with a clear plan of actions, along with reconfiguration of services that meets current and future needs of the populations of Waikato as a whole, is also required. Strategy requires 'partnership'.

The Commissioning Framework for Mental Health and Addiction Services (2016) is a government created and endorsed outcome focused approach for funding that provides national guidance to enable the measurement of outcomes that make a real difference for people.[9] Strategy and Funding could benefit greatly by implementing the commissioning framework. This framework can support and provide the structure for WDHB to support a new way of working.

Inequities in pricing existed between WDHB provider arm services and NGO/ACPs and between NGO/ACPs. This had led to mistrust and unhelpful competition between providers. There needs to be accountability and transparency across the sector particularly in terms of pricing public funding. Agreements, between two parties (MOH and providers) were

[9] https://www.health.govt.nz/publication/commissioning-framework-mental-health-and-addiction-new-zealand-guide .

effectively not a partnership as ACPs did not believe they had the necessary input into the agreements e.g., service delivery mission, vision, philosophy, model of care and flexibility clauses were not included in the "provider specific terms and conditions" section of the agreements.

**Theme 5 – Management frameworks and Governance**
***"Governance: accounting for cultural, fiscal and clinical issues"***

Governance, concerning cultural, fiscal and clinical issues begins with a genuine, power-sharing partnership. Partnership within the Waikato DHB requires Waikato DHB, Māori and 'mainstream services' to work collaboratively in the governance, design, delivery and monitoring of services. Māori must co-design the health system with Waikato DHB to ensure the best outcomes for Māori. It is essential that Māori have a say in how Waikato DHB, and essentially the Government, can exercise effective and appropriate stewardship over the health and disability system for all. To achieve this, stronger and more visible Māori leadership is required. Genuine iwi Māori partnership for developing Mātauranga Māori and Te Ao Māori approaches need to be embedded in Waikato DHB. Change is needed to minimise the impact, towards both staff and patients, of conscious and unconscious bias towards Māori.

Governance around funding decisions has been problematic. At the time of the review the Commissioners provided governance oversight for WDHB. Delegations of Authority across the provider arm services were strictly managed as a result of the significant WDHB deficit. Historically, funding decisions have been made via S&F with input from the CE and SFO at funding meetings. Presently, the funding decisions are made by the following roles who make up the Executive Leadership Team (ELT): CE; Chief Medical Officer; Chief Nursing and Midwifery Advisor; Chief Advisor Allied Health; Executive Director Māori, Equity and Health Improvement; Executive Director Strategy and Funding; Executive Director Organisational Support; Executive Director Digital Enabling; Executive Director Hospital and Community Services, Executive Director Finance, Procurement and Supply Chain.

The review team noted that while the provider arm is clinically 'capability rich' and 'capacity poor', the associate community providers (NGOs) tended to have clinical capability commensurate with their contracts. Recently, the acute units had in excess of seventeen (17) over their contracted beds, yet the community had a similar number of vacancies that could not be filled because of alleged contractual specification. (There is also a view that NGO providers could have been more flexible)

In regard to governance, the provider arm MHAS has a well-honed governance structure. The community providers each have governance (as demanded of Charitable Trusts) but are relatively isolated with little communication between related services and difficulty accessing capability when needed.

**Theme 6 – Unique challenges to the service**
***"We are at breaking point."***

It is near impossible to review mental health in isolation; every part of the system is interrelated and either positively or negatively impacts the other parts. This creates unique and specific challenges to the services. Challenges faced include, but are not limited to:

capacity issues in acute services; whaiora presenting with complex needs; addiction services; and ICAMHS (infant, child and adolescent mental health services). Issues affecting these services will be expanded on in the report below.

During this review, it was reported on several occasions that the onsite acute adult inpatient facility was not just at capacity, but had exceeded capacity, with more acute patients than beds available. Added to this has been increase in demand for services. There is a general lack of community triage and short-term treatments available in the primary sector and in the secondary community sector, thereby pushing whaiora into the acute system.

Service design is also an issue due to separate 'strategy, planning and funding' for hospital services as distinct from community services. The two areas must be considered as two aspects of the single, continuous service.

The number of whaiora ,with high and complex needs, living in the inpatient wards has grown over time. Since deinstitutionalization in the 1990's, the Midland Region has discussed the need for a regional 'high and complex' service yet nothing concrete has eventuated. Numerous reviews and papers have been written and discussions have occurred at executive levels. Each DHB region in Midland is also trying to grapple with the challenges faced in managing acute inpatient beds when whaiora are effectively living in the wards.

The Waikato DHB MH&A services are experiencing high numbers of: complex presentations (including dual diagnosis, head injury, homelessness, addictions, antisocial personalities and mental illness). These presentations have a negative impact on the availability of acute beds and staffing. At the time of the review, thirty (30) whaiora presenting with high and complex needs were effectively living in the acute and forensic wards and were unable to be placed. The 'opportunity cost' of this situation is vast.

Addiction services across Waikato DHB, in the provider arm and across the community, lack both a framework and collective governance across providers. The consequence of this is that services are not integrated and necessities such as detoxification are deemed wholly inadequate.

Having a significant impact on the system are whaiora under the influence of methamphetamine. Anecdotally, they are the mental health patients most likely to be placed in seclusion, albeit usually with shorter admissions. It raises the issue of where whaiora can be safely managed while under the influence of methamphetamine in a clinically safe environment. These admissions place added pressure on staff due to the potential aggression and higher assault risk. This also results in additional staff needed for the care and management of these whaiora.

Lastly, it is imperative that a discussion occurs regarding infant, child and adolescent mental health (ICAMHS), as this area has been in crisis alert since 2015, despite reviews occurring in 2017 and 2019 the focus tends to be on the service, yet it is essential that the focus shifts to the child. The service, with waiting lists for psychological services as high as 12 months, is unacceptable. In spite of over 60% of the 2019 recommendation having been completed, the services continue to struggle.

## Discussion of Terms of Reference

**Terms of Reference (i):** ***Review the configuration of Mental Health and Addictions Services (MH&AS), what is purchased and whether that meets the District population needs, especially its Māori population***

The Waikato District Health Board (Waikato DHB) Strategy, Planning and Funding procure parallel mainstream and Māori Kaupapa (Hauora Waikato) hospital and community clinical Mental Health and Addiction Services (MH&AS) for the region. Associate providers (NGOs) – mainstream and kaupapa – provide a suite of mainly support services along with clinical services e.g. Adult Addiction and other Substances (AOS) Services.

The configuration of services purchased requires change to ensure the services can meet the burgeoning demand on MH&AS and AOS services currently and into the future. The population of the Waikato is 425,806 (Waikato DHB Annual Report 2020) and increasing. However, a change in the configuration of services needs to be planned and informed by the Māori Equity Report (not available to the reviewers at the time of the review); be based on the Waikato DHB strategic documents, research evidence and best practice; and be future proofed for the coming years. A case in point is Mental Health Services for Older Persons (MHSOP) with an ever increasing older population with the number of New Zealanders diagnosed with dementia being expected to triple in the coming years. Yet investment in MHSOP has remained relatively static for the past ten years. The whaiora group with 'high and complex' needs is increasing the demand for long-term clinical rehabilitation and care and as a result this cohort are effectively "living" in the inpatient units.

AOS funding has not kept pace with the increasing negative impacts of alcohol, methamphetamine and synthetic cannabis misuse. INTACT Youth/Rangatahi AOD Services development delivered across the region has been successfully planned, funded and implemented well. This approach could be replicated for Adult AOD Services to improve access to service.

A significant percentage of people presenting acutely to MH&AS do not have a major mental illness but they do have wellbeing and social issues that require addressing. To meet this need the Waikato DHB MH&AS clinical services have been funded 1FTE as well as Whanau Pai 42 new staff (Primary Health Care), both via the Ministry of Health. This is a limited resource given the increase in demand for services and the numbers of people presenting with wellbeing issues.

Strategy and Funding (S&F) is made up of a range of divisions including the Finance and Enterprise Portfolio Office (EPO) in charge of investments; Analysts who review data; Senior Funding Managers including the Director of Māori Health and Equity; Māori Service Development Manager and Relationship Managers who have the direct relationship with the Associate Providers (NGOs). The separate sections of S&F

personnel makes it difficult for providers to negotiate with S&F, particularly when issues arise

Procurement and agreement management is an area of frustration particularly for Associate Providers (NGOs) with a practice of "rolling contracts over" for many years, instead of ensuring review of agreements every three years with new base agreements and variations being utilised for increases in funding during that period. This approach would provide time for planning and investment in the future services for both parties.

**Strategy and Funding**

Strategy and Funding are responsible for the distribution of New Zealand Vote Health funds including the allocation of funding for MH&AS and AOS.

The S&F roles are complex and poorly understood by providers of services. Staff in S&F are required to have a broad range of knowledge, requiring an understanding of the following, however not limited to:

- population health assessment frameworks
- needs analysis
- research evidence (qualitative and quantitative)
- strategy, planning, accountability and legal frameworks
- current legislation
- agreement management
- commissioning frameworks
- procurement practise
- service specifications tiers
- auditing requirements and processes
- funding and payment processes, including budget management across the sector
- change management along with risk management processes
- reporting
- actual service delivery expectations, models of service delivery and expectations of the populations served.

Staff include:

- Three analysts with high level analytical expertise who utilised structure to manage data effectively utilising algorithmic procedures to reach output information and inform development. *Process funding mapping was underway using equity algorithms with an equity focus for allocation to ICAMHS, AOD, MHSOP, Adult OST services. Algorithms provided automatic decision-making processes used by computer programmes to identify patterns in data. These algorithms can be used to help government better understand New Zealand and New Zealanders. This knowledge means government can make good decisions and deliver services that are more effective and efficient.* Quarterly Performance Monitoring Reporting (PMRs) undertaken by ACP's and sent to MOH sector services were loaded onto the MOH Health Information Network (HIN) platform that analysts were able

to access to inform planning. PRIMHD reporting was also utilised by analysts as part of monitoring qualitative and quantitative data.

- The MH&AS Senior Funding and Relationship Manager, an experienced (11 Years) DHB MH&AS Accountant, planner and funder who had oversight of the PVS: part of the way in which District Health Boards inform the Ministry of Health about their expenditure and activity plans to meet local demand for services and government priorities for the provision of health care services for provider arm clinical services. In December 2020 the staff member was seconded into the role of Director of Funder and Provider Relationships (Interim). A Māori Health, Mental Health & Addictions Funding Relationship Manager had oversight and a commissioning role (the process of procuring health through population needs assessment, planning of services to meet those needs and securing services on a limited budget, then monitoring the services procured) for the ACP's. The staff member was relatively new to health and had worked in their current role for two months at the time of the review. Both staff identified as accountants.

- The Director of Māori Health and Equity (DMH&E) had more than 20 years working in WDHB MH&AS planning and funding roles. The DMH&E was providing orientation and mentoring to the new Funding Relationship Manager through introductions to the ACPs in the community during the review.

- An experienced Māori Service Development Manager (SDM) MH&AS S&F had been in their role for more than a year working on MH&AS initiatives. The SDM who had credibility in the sector had worked in clinical and senior management roles. One of the developments that the SDM had been involved was Awhi Mai – Awhi Atu (Our Model of Wellbeing – Our Solution) a mental health community based acute alternative to admission service.

Despite the vast knowledge required to work in S&F, there is a general lack of any national strategy and funding training that supports the development of S&F staff. Senior staff expressed an interest in teaching new staff however they are restricted by the pressures of their roles and are limited in the support that they can offer. The consequence of limited training means that staff come under unnecessary pressures.

**Enterprise Portfolio Office**

The Finance and Enterprise Portfolio Office (EPO) also has a part to play in the allocating of funds. Their role is to monitor, report on and prioritise all investments. Types of investments include "Change the Business" Investments, and "Run the Business" Investments with budgets over $500k. All other "Run the Business" investments, with budgets under $500k, fall within the respective Executive Director's DFA (Delegations of Financial Authority) to track and deliver the investment. The EPO offers a prioritisation process for any investment in new services. Other aspects of the EPO role included operating expenses (OPEX) and management of capital expense (CAPEX). Cost benefit analysis was embedded into the work activity. A guideline for health benefits drivers was also utilised by the EPO. Delegations and process for investment prioritisation usually sit hand in hand.

However, the EPO activities are either not known or poorly understood across the MH&AS and AOS sectors

**Accountability and Governance: Who approves funding?**
S&F are often seen as the only decision makers for funding. At the time of the review the Commissioners provided governance oversight for WDHB. Delegations of Authority across the provider arm services were strictly managed as a result of the significant WDHB deficit and to bring spending under control. Historically, funding decisions would be made via S&F with input from the CE and SFO at funding meetings. Presently, the funding decisions are made by the following roles who make up Executive Leadership Team (ELT): CE; Chief Medical Officer; Chief Nursing and Midwifery; Chief Advisor Allied Health; Executive Director Māori, Equity and Health Improvement; Executive Director Strategy and Funding; Executive Director Organisational Support; Executive Director Hospital and Community Services; Executive Director Digital Enabling; Executive Director Finance, Procurement and Supply Chain. funding decisions.

**Ministry of Health**
There was a limited understanding across the sector of the Ministry of Health (MOH) responsibility for funding, monitoring, sector compliance along with accountability expectations and reporting responsibilities that S&F are required to meet and report through to the MOH.

MOH accountability documents that planning and funding teams are expected to work within include:

- Crown Funding Agreement (CFA) https://nsfl.health.govt.nz/accountability/crown-funding-agreement
- Annual Plan and Statement of Intent (SOI) Guidelines
- Operational Policy Framework (OPF) https://nsfl.health.govt.nz/accountability/operational-policy-framework-0
- Service Coverage Schedule (SCS)
- DHB Reporting Requirements
- Health Needs Assessment (HNA) plus a range of other requirements such as e.g.:
    - Financial Standards and guidelines https://nsfl.health.govt.nz/accountability/financial-standards-and-guidelines
    - Annual planning package requirements https://nsfl.health.govt.nz/dhb-planning-package and Equity Action Plans
    - Legislative timeframes and statement of performance https://nsfl.health.govt.nz/dhb-planning-package/legislative-timeframes-submission-201920-dhb-statements-performance

NB: The above is not an exhaustive list of MOH requirements of DHBs.
Although those working in the MH&AOS service sector do not need an intimate knowledge of the MOH accountability and related planning, legislation and financial requirements of S&F, it is important for them to understand that public funding accountabilities are paramount given the Health Vote spend in the Waikato.

**Current Commissioning Framework**

A competitive model of purchasing health care was brought in during the 1990's and resulted in tension between providers and a lack of partnership between them. Although there has been a movement away from this type of model of purchasing, consequences of this model design are still influencing the MH&A sector today. It should be noted however that the current situation has been as much due to poor system management and poor governance. The competitive approach of funding splits providers. There needs to be a "joined up" partnership approach across all services as one system. The system needs to move to a many owners one service system approach. This approach can only be achieved through meaningful, trusting relationships.

Despite the creation of a number of strategic and visionary documents, including: Creating our Futures; Iwi Māori Health Strategy; Ki Taumata o Pae Ora; Waikato Health System Plan Te Korowai Waiora; Mental Health and Addictions Te Pae Tawhiti; and Me Kōrero Tātou – Let's Talk, the decision to action the findings and objectives of these documents through operational planning has been slow. Instead, there is the impression from the sector that funding is ad hoc and not based on evidence.

A change in approach needs to result in a strong shift away from the competitive model of care and must be supported by a sound MH&AS Strategy, Planning and Funding (S&F). It will require S&F to undertake service development through investment logic mapping and produce action plans that are achievable. The development and use of a funding framework with a clear plan of actions, along with reconfiguration of services that meets current and future needs of the populations of Waikato as a whole, is required. Furthermore, a Te Ao Māori methodology to commissioning, as outlined in "Me Kōrero Tātou – Let's Talk" undertaken with the Waikato Tainui community including iwi Māori and Mātauranga models and approaches, is required.

| | | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020/21** |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | **$ 132,730,164** | **$ 139,038,845** | **$ 146,479,763** | **$ 153,444,382** | **$ 169,673,474** |
| DHB Provider Arm | All MH & A Inpatient & Community Services | $ 84,480,839 | $ 87,547,580 | $ 89,606,422 | $ 91,623,378 | $ 95,762,441 |
| NGO Services | All MH & A Inpatient, Residential & Community Services | $ 45,921,174 | $ 48,474,586 | $ 53,463,616 | $ 58,263,505 | $ 64,814,826 |
| PHOs | Three PHOs | $ 2,328,151 | $ 3,016,678 | $ 3,409,725 | $ 3,557,498 | $ 3,827,031 |
| NGO Providers | Whanau Pai | | | | | $ 4,583,455 |
| NGO Providers | Pasifika Support, | $ - | $ - | $ - | $ - | $ 685,720 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Psychology Services | | | | | |
| | | **$ 132,730,164** | **$ 139,038,845** | **$ 146,479,763** | **$ 153,444,382** | **$ 169,673,474** |
| | | | *$ 6,308,681* | *$ 7,440,918* | *$ 6,964,618* | *$ 16,229,092* |
| | | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020/21** |

It is understood that the investment process is a result of planning and funding decisions. This has been hampered by the deficit, necessary oversight by the Commissioner and turn over by the relationship managers.

Investment challenges have also resulted in frustration for the ACPs/NGOs and provider arm management who felt powerless to seek solutions when demand for service was overwhelming them. It has also driven ACPs/NGOs to seek funding (some successfully) from other ministries instead of health e.g. MSD funding. Several providers reported to the reviewers that they were moving away from delivering MH&AS as commissioning and procurement processes were more robust with other ministries including a longer term (three years) funded agreements enabling them to enact service planning more robustly.

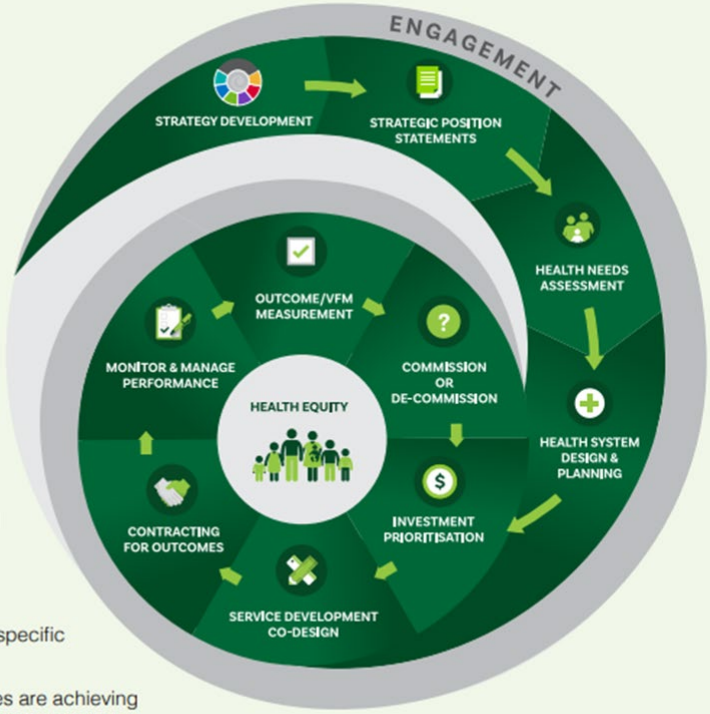
The Commissioning Framework for Mental Health and Addiction Services (2016) set out below is a government created and endorsed outcome focused approach for funding that provides national guidance to enable the measurement of outcomes that make a real difference for people.[10] Strategy and Funding could benefit greatly by implementing the commissioning framework. It should be noted that S&F team have already introduced the 'Commissioning Koru' (see diagram below). This framework can support and provide the structure for WDHB to support a new way of working. For some parts of the sector this change is already occurring, and this framework will support this evolution. For others, this framework will be a revolutionary new way of working, freeing up areas that have previously been more prescriptive and tightening up on results. It will require clear articulation, partnership (co-design), and agreement on the outcomes and results we expect to see and how these will be measured.

[10] https://www.health.govt.nz/publication/commissioning-framework-mental-health-and-addiction-new-zealand-guide .

The Waikato DHB commissioning approach includes the following key activities:

- Developing Waikato DHB's strategic direction and aligning strategic imperatives across different service areas.
- Understanding the health and social needs of specific populations and communities.
- Developing services that respond to the needs. This involves engagement with the community, service users and the wider health sector to agree the desired outcomes and define how services will be delivered.
- Identifying and contracting providers for services and specific outcomes.
- Monitoring how well services are achieving the desired outcomes, managing provider performance and engaging with communities and the sector on improvements.
- Directing resources to services where communities will benefit and value is optimised.

Figure 2: **Waikato DHB commissioning approach**




**MOH: Commissioning Framework for Mental Health and Addiction Services (2016)**


Note: KPIs = key performance indicators

Agreements between two parties (MOH and Providers) were effectively not a partnership as NGO/ACPs did not believe they had the necessary input into the agreements e.g. service

delivery mission, vision, philosophy, model of care and flexibility clauses were not included in the "*provider specifics terms and conditions*" section of the agreements.

NB: The Awhi Mai – Awhi Atu Alternative Acute Bed development agreement utilised the provider specific terms and conditions of the funded agreement to include model of care and relevant expectations of service. This work was led by the Service Development Manager S&F and could be replicated in all funded agreements.

Inequities in pricing existed between WDHB provider arm services, ACPs and between ACPs. This has led to mistrust and unhelpful competition between providers. There needs to be accountability and transparency across the service sector particularly in terms of pricing.

'Wash Up'[11] was considered by the ACPs sector as another pressure particularly when funding was Full Time Equivalent (FTE) based. Recruitment to invest in the right person for the right job often took longer than the three months allowed and incurred costs. While it is sensible to ensure funding is utilised appropriately for services, some leeway allowing for recruitment should be considered. This would alleviate the pressure and allow providers to recruit the right staff and not be forced into recruiting quickly and inappropriately creating performance issues and impacting on care delivery.

Probity: RFP (Request for Proposal) management and decision-making, NGO/ACPs reported, was poorly managed and providers queried that due process was being followed. NGO/ACPs understood that sensitive information must be secure. However, NGO/ACPs submitting RFP's reported that feedback from S&F was spasmodic or absent. They did not have confidence that the process was fair and equitable.

Associate Providers (NGOs) expressed frustration due to agreement management practises of the funder. "Rolling" a contract over on an annual basis as is the current practice, is frustrating and often results in time lags before variations are completed, delaying payment to providers delivering services. This impacts budget management which includes payroll of employed staff delivering services. Whereas agreements for a three year term, including all service lines (PUCs) that meets all the requirements of current legislation, makes agreement management easier for both parties. Variations should only be required in the three year period for increases in the CPI (Consumer Price Increase).

**What is purchased/investment?**
**Overview on Mental Health and Addiction Services funding for 2020/21 November 2020** (provided by Strategy & Funding)

Mental Health (MH) funding is ring fenced and reported on. Waikato DHB's MH ring-fence is set at $158.8 million for 2020/21. The Annual Plan submitted for 2020/21 is forecasting expenditure of $161.1m, which exceeds the ring-fence expectation of $158.8m, by over $2m. The 20/21 planned S&F MH&AS expenditure detailed below:

| ***Service*** | ***Annual $ 20/21*** |
|---|---|
| *DHB Provider arm* | *$94,112,579* |

[11] 'Wash up' is roughly equated to the end of year balancing of the books

| | |
|---|---|
| *NGOs* | *$63,654,822* |
| *Primary Mental Health* | *$3,977,028* |
| ***20/21 Planned Expenditure*** | ***$161,744,429*** |
| ***MH ring-fence expectation*** | ***$158,800,000*** |

A further $3.4 million in MH&AS investment was planned for 20/21. Demographic funding aims to address volume increase associated with population growth. The demographic funding was not specified by MoH, but is deemed to be the difference between funding received for cost pressure increases and the total percentage funding increase received

In addition to the expenditure noted above, the new national investment in Primary Mental Health Services has seen the commencement of 'Access and Choice' services in Waikato DHB, with $4.7 million now contracted with four Māori providers (via Whānau Pai) to deliver a new approach to community and primary care. This funding was not included in the ring-fence expectation.

Investment in Mental Health and Addiction had grown from $111.6 million in 2011/12 to $161.7 million in 20/21; a 44.9% increase. This compared favourably to population growth of 18.7% and general (CPI) inflation of 17.6% over the same period.

***Investments over Recent Years***

| ***FY commenced*** | ***Service*** | ***FTE*** | ***Beds*** | ***Programme*** |
|---|---|---|---|---|
| *2015/16* | *YouthINtact – Youth AOD – expansion of existing services/ new model of care* | *8.65* | | |
| *2016/17* | *Additional adult crisis respite bed nights* | | *Approx. 1.7* | |
| *2016/17* | *Integrated Primary Care packages for People with Long Term Mental Illness* | | | *1* |
| *2017/18* | *Further investment in Youth Forensic Services* | *3.4* | | |
| *2017/18* | *Psychiatrist advisory role in Primary Mental Health* | *1.2* | | |
| *2017/18* | *Community Placement of several high/complex needs individuals* | | *10* | |
| *2018/19* | *Additional minimum secure (Forensic) inpatient beds* | | *8* | |
| *2019/20* | *Awhi Mai acute alternative inpatient facility* | | *10* | |
| *2019/20* | *Clinical Support for Awhi Mai – DHB Provider arm* | *4* | | |
| *2019/20* | *Ahikaroa – Community Support including Housing Co-ordination* | *20* | | |
| *2019/20* | *Additional clinical FTE – DHB Provider arm* | *6* | | |

| | | | | |
|---|---|---|---|---|
| *2019/20* | *Additional whānau support role in Thames Coromandel* | *1* | | |
| *2019/20* | *Regional pricing alignment for AOD residential services* | | *25* | |
| *2020/21* | *Support for additional acute inpatient beds (Henry Bennett Centre)* | | *7* | |

Pay Equity, https://www.health.govt.nz/new-zealand-health-system/pay-equity-settlements/care-and-support-workers-pay-equity-settlement/summary-pay-equity-settlement while funded, had resulted in the WDHB S&F not being able to support Consumer Price Index (CPI) increases in agreements for ACPs while legislative changes had increased costs e.g. Worksafe Act 2015; Vulnerable Children Act 2014.

Contrary to sector opinion, S&F have actively been focused on reducing demand on acute inpatient beds. However, S&F agreed that the development of services over the past decade could be viewed as "tinkering around the edges". Many of the ACPs voiced their concern at lack of planning and implementation of aspirational documents – *"what is the plan and what actions are being taken".*

**Reporting**

A key aspect of accountability is transparency of actions which can be achieved through robust, independent reporting.

There is a belief that the burden of reporting is extensive. Further, NGO/ACPs believed that quarterly Performance Monitoring Reports (PMRs) were not valued by S&F as there was often no feedback or follow-up. A number of providers completed extensive narratives that were time consuming yet they believed no one bothered to read them. Further, the secondary services were providing comprehensive monthly reporting (sighted by the reviewer) through to the WDHB Chief Operating Officer (COO), whose focus was on clear accountability.

Multiple audits for multiple agreements (each agreement must be audited). Large providers experienced 'audit fatigue' as they may have numerous agreements based on the wide range of service provision. One funded agreement for a term of three to five years that includes all funded services lines (PUC) in the base (00) agreement, would reduce the number audits required, be cost effective, less disruptive to the providers and reduce time spent and required by S&F and the provider on audit corrective action plans.

NB: Health Share Ltd does audit collaboratively with the Ministry of Social Development (MSD) audit and compliance team where providers are funded through MSD and Health and where possible attempt to audit a number of agreements held by a provider to reduce audit fatigue.

Associate providers/NGOs reported quarterly via Ministry of Health (MOH) Performance Monitoring Reports (PMR) process. The Programme for Information Mental Health Data (PRIMHD) along with Alcohol and Drug Outcome Measure (ADOM) reporting is extracted electronically and stored on the MOH Health Information Network (HIN) enabling S&F to

monitor the services funded. ACPs/NGOs on the other hand, while they understood that secondary services were required to complete Health of the Nation Outcome Scale (HONOS) and Health of the Nation Outcome Scale Child & Adolescent (HONOSCA) reporting via PRIMHD, were not aware of the separate WDHB accountability reporting frameworks. ACPs/NGOs also believed that the provider arm did not have the same scrutiny or requirements of service delivery as secondary services were funded through a Service Level Agreement (SLA) via a Price Volume Schedule (PVS) and were guaranteed future funding. ACPs/NGOs suggested that the funder and provider arm should be further separated as they were too "close", yet the funder and provider definitely displayed real tensions, although each sector indicated they wanted to work collaboratively with each other.

Misunderstandings between ACPs /NGOs and DHB services related to auditing. All APC/NGOs were routinely audited (three year programme carried out by Healthshare Ltd https://healthshare.health.nz/ ) against the funded agreements, whereas the clinical services were not audited routinely against the services delivered. Further, if issues arose S&F could request an Issued Based Audit (IBA) be carried out. MH&AS inpatient units were required to be certificated via HealthCERT to provide safe and reasonable levels of service for whaiora. The HealthCERT audit was carried out by a Designated Audit Agency. However, ACPs/NGOs whose facilities contained more than five beds were also required to undertake HealthCERT audits. Inpatient units were also subject to the Crimes and Torture Act - Unannounced monitoring of places of detention[12]. Mental health inpatient units were additionally subject to unannounced visits by District Inspectors who provided representation for patients subject to the Mental Health (CAT) Act 1992 or the Intellectual Disability Compulsory Care and Rehabilitation Act 2003 (IDCCR Act.

**Does what is funded meet the need of the district population?**

As outlined above, reporting is inconsistent across the sector therefore it is difficult to ascertain whether what is being purchased meets the needs of the district population. The MH&AOS and Hauora Waikato (Kaupapa Service) provide parallel clinical services (not all district health boards fund parallel Māori and mainstream clinical services) and there are a range of associate community providers who hold Kaupapa funded agreements too.

Generally, the funding allocation does not appear to reflect the current population of the district. Population increases across the region have been unprecedented (populations moving from Auckland; Migrants and New Zealanders returning from overseas particularly since the Covid19 outbreak, many of who have high health and MH&AS needs).

There are persistent equity gaps within mental health system between Māori and non-Māori. Significant equity issues have occurred, (access to GP primary care and medical services, high use of seclusion, limited housing stock, discrimination, limited income) for Māori and those people experiencing a serious mental health and addiction illness.

NB: *People with severe mental disorders on average tend to die earlier than the general population. This is referred to as 'premature mortality'. There is a 10-25 year life expectancy*

[12] Crimes of Torture Act 1989 inspections by the Ombudsman - OPCAT

*reduction in patients with severe mental disorders: World Health Organisation. Life expectancy at birth, by gender, Māori and non-Māori, 1951–2013 [1] in 2013, life expectancy at birth was 73.0 years for Māori males and 77.1 years for Māori females; it was 80.3 years for non-Māori males and 83.9 years for non-Māori females. Statistics NZ* Aug 2, 2018.

Te Pae Tawhiti sets out the direction for MH&A services over the next few years. There will need to be considerable investment in Te Pae Tawhiti to ensure the district has an appropriate system of care that minimises the need for additional inpatient beds above the sixty-five (65) specified in the indicative business case. A roadmap for investment is currently under development and should be presented to FRAC (Finance, Risk and Audit Committee) in early 2021.

The issue of well-being, in contrast to major mental illness/disorder, is problematic. There are limited services in place to address well-being issues. Up to eighty percent of presentations to the crisis team are for well-being issues. The community have expectations that MH&AOS services will address these issues, many of which relate to social issues such as homelessness.

Funding is currently not meeting the high and complex needs of whaiora. There has been an increase in the number of high and complex whaiora living in the inpatient wards. This number appears to have been steadily increasing since the 1990's, which saw the deinstitutionalization of the mental health system. Although a positive step for many, it has left high and complex whaiora in limbo without any regional solutions.

WDHB MH&AS staff reported that associate community providers (NGOs) would not accept whaiora into their services based on their funding agreements. Clinical staff were not privy to the agreements in terms of what service line (Purchase Unit Code) was funded, resulting in thirty (30) (high and complex) whaiora being unable to be placed into the community residential services. As a result, access to acute inpatient care for people with severe mental health and addiction issues has been impacted negatively.

Adult Addiction and other Substances (AOS) Services were not "joined" up across the sector although there was more and more pressure from Corrections, Probation and the Courts for AOS services. For rangatahi/youth, the Youth Intact AOS Services model of service had been refreshing and successful as a joined up model with consistent marketing, leadership (including rangatahi advice) and approaches to care delivery. Rangatahi and whānau spoke highly of the services they received and appreciated the ease of access and expertise of the staff delivering the services. This approach led by S&F could be replicated in Adult AOS services. A range of residential AOS services are funded out of the Midland Region. Consideration needs to be given to moving them back to the Midland/Waikato Region particularly with the proposals set out in Pūrongo Whakamutunga – The Health and Disability System Review 2020 report.

Methamphetamine-dependent whaiora presenting to acute mental health services with a high risk of acute physical (violence) and mental health harms (psychosis) were stretching human resources and roster management of staff. Adding to the stress of this situation is the genuine fear by staff, of being assaulted by whaiora in a drug-induced state. The incident summary for the period August 2020 identified 77 incidents of violence and aggression on

staff; the number one ranking for a twelve month period. NB: There is no national methamphetamine plan in place for MH&AS managing excited delirium often seen in this cohort.

Whaiora, whānau/family found access to services confusing and difficult to navigate. ACPs/NGOs provided harrowing examples of whaiora and whānau being unable to access services when the need was acute. This was exacerbated when people lived rurally. ACPs/NGOs had the same difficulties when trying to access provider arm services.

There is a long wait list time for ICAMHS of 12-months (in order to access psychological services). The ICAMHS clusters particularly in rural South Waikato were unwieldy and were not functioning as planned. This had resulted in one provider mitigating the significant risks they carried by terminating their agreement for services with S&F, in a rural locality. In part this was as a result of the high demand for ICAMHS services and the pressures placed on clinicians in the provider arm services and ACPs/NGOs managing the challenging behaviours resulting in crisis, on a day to day basis with limited clinical input.

Consult Liaison Services funded through the PVS 2.5FTE was inadequate for the population. Consult Liaison is part of a suite of services required for Registrars in training to undertake and is effectively the "shop window" of mental health and addiction and other substances services across all hospital services.

Paediatrics/ICAMHS were unable to access psychology services for traumatised children. Further, the paediatric services had noted an emerging increase in the number of children presenting to services who met the criteria of Fetal Alcohol Spectrum Disorder (FASD).

Psychologists identified that they worked well with mild to moderate mental illness yet the majority were working with whaiora with severe and enduring mental illness. Psychology assessment and psychometric testing was not available per se across the sector. Provider arm psychologists identified access to therapeutic interview rooms was a resource issue impacting the number of people seen. A mixed model of utilising private and employed psychologists would better meet the needs of whaiora and ensure timely access to talking therapies.

Rehabilitation services had lost allocated FTE as the provider arm had reallocated funding within the Price Volume Schedule (PVS) yet this is an important service particularly when supporting the recovery of high and complex cohort of whaiora. Reallocation of FTE within the PVS was achievable when open and transparent conversations occurred between both S&F and provider arm staff.

Health of the Older People: The Mental Health Services for Older Persons (MHSOP) inpatient facility was overstretched and pathways of access limited. Concern was expressed to the reviewers regarding the increasing health needs of older people particularly the increase in the rates of dementia. The rest home sector utilise a business model to fund their services. Provision of dementia care is publicly funded. However, many of the major players in the sector were not interested in the provision of dementia care as it was not viewed as 'profitable'. Concern was expressed at the recent indication by a major rest home provider

that they would exit dementia beds in the Waikato region. S&F were aware and were at the time of writing seeking solutions for MHSOP.

There appears to be minimal investment in technology. There are many advantages to utilising the technical solutions available to the mental health system. Practical rehabilitation services can be strengthened through the use of mental health technologies that can be used by clinicians and support staff as an adjunct to mainstream clinical practices. Technologies such as email, virtual reality, computer programs, blogs, social networks, the telephone, video conferencing, computer games, a variety of applications (i.e. for the management of anxiety, phobias), instant messaging, podcasts and virtual appointments for people in rural communities, could improve mental health and addiction health outcomes for all. They are also likely to be more cost effective. There are number of technology platforms already available. ACPs are successfully utilising technology platforms more effectively while the provider arm services are limited due to in-house Information Services barriers.

Advantages of using technology include:

- Treatment anytime anywhere
- Anonymity assured
- Lower Cost (some apps are free or cost less than traditional processes)
- Treatment via technology for remote areas (Facetime; Skype, Zoom)
- 24 hour service for intervention support
- Ability to collect information quickly.

During the Covid-19 lockdown staff had the ability to work remotely including engaging with whaiora in the community via phone. It was noted that during the period community staff made more contact (telephone) with whaiora and demand on inpatient services decreased.

Technology, in the form of social media, can also have positive outcomes. Social media was utilised by many of the ACP's, very successfully, as a means of contact (messaging) and providing stories of hope. The WDHB has a Facebook account, however, its Facebook page did not feature any MH&AS stories.

There are persistent equity gaps within Mental Health system between Māori and non-Māori. Significant equity issues have occurred (access to GP primary care and medical services, high use of seclusion, limited housing stock, discrimination; limited income) for Māori and those people experiencing a serious mental health and addiction illness.

**Recommendations**

1. Operational planning needs completion and planned actions need to be implemented. It is important for whaiora, whānau, mainstream and iwi to have time-framed, incremental pathways to realise the issues expressed as important to them in documents such as 'Me Kōrero Tātou'.
2. S&F consider utilising the expertise clinicians to explore ways or working and supporting the transition of high and complex whaiora out of the inpatient services into a community service "home for life".

3. Whaiora transition plans be developed with both provider arm and ACPs/NGOs, agreed and implemented incrementally (over many months) to allow whaiora to adapt to their new environment successfully. This will require a package of care funding envelope.
4. Clinicians support ACP/NGO staff to implement behavioural management plans for whaiora, provide oversight, mentoring and supervision to enable staff expertise working with this cohort to grow and develop positively.
5. Waikato DHB consider funding a provider with expertise in delivering high and complex services.
6. That regular, open and transparent, quarterly meetings occur between the Provider arm manager and S&F for the purpose of reporting against the PVS. The process would also be an opportunity for the provider arm management to highlight key achievements e.g. therapeutic "leave" management recently instigated in the inpatient services (reduction in absence without leave / AWOL) and the numerous quality initiatives of merit that were being achieved.
7. Any reconfiguration of FTE be agreed with S&F with a relevant rationale to share and mitigate risk.
8. New service development must include S&F and not be undertaken in a "vacuum".
9. The DHB involve clinicians to a greater degree in service planning
10. Strategy and Funding assist provider arm clinical leadership by supporting co-location opportunities with MH&AS NGO/ACPs (supportive letter to all providers identifying what the clinical leadership were attempting to achieve), particularly in the smaller urban areas and rural communities for closer to home responsive services.
11. ACPs be provided with a template to input their mission, vision and model of care for service delivery along with service expectations and relevant monitoring in the Provider Specifics Terms of Conditions section of the funded agreement and this be included in the new agreements.
12. Utilise the use of flexibility clauses to support whaiora costs e.g. clothing to attend an interview for a job; respite placement. A schedule of the rationale and flexibility spend would need to be sent to S&F by ACPs as agreed, for monitoring within a flexibility (variable) funding envelope for each provider.
13. Review all pricing across the MH&AS sector and agree pricing standards (price by unit) e.g. clinical FTE rates; non -clinical rates; bed rates etc.
14. Agreed pricing rates are transparently shared by S&F with providers to minimise competition and enable trust to grow in the sector.
15. All MH&AS provider service specification by FTE, Bed Day, Programmes are listed on a template and all providers have access to the information. This approach allows staff to identify who provides what service across the system.
16. Longer term funded agreements be renewed every three years to ease payment processes and improve budget efficiencies. This will also reduce demand on staff at the WDHB and MOH managing ad-hoc payments and follow up payments on behalf of providers.
17. Move to PRIMHD reporting for all providers across the sector moving away from Performance Monitoring Reports.
18. Consider a similar accountability reporting framework that is aligned to monthly provider arm reporting to identify value for money and emerging risk analysis. NB: S&F relationship managers would need to actively engage with ACPs regularly for the purpose of communicating any emerging risks to ensure risk is shared and managed.

19. Reconsider Wash Up management as an exception not a rule. However Relationship Managers will need to have regular (four times a years) face to face meetings with NGO/ACPs staff to ensure transparent open communication is ongoing to mitigate relevant risks and implement wash up as required.
20. Audit schedules are provided annually and communicated to all providers. This will reduce the miscommunication across the sector regarding audit activity. One agreement includes all service lines funded to ensure one routine contract audit occurs every three years.
21. Issues Based Audits (IBA) are utilised more often by S&F.
22. S&F seek solutions of support for providers who face challenges e.g. utilising other provider support of staff.
23. Consider including the mandatory Governance Social Sector Accreditation Standard (SSAS) in routine audits and IBAs as a more comprehensive criterion for audit.
24. That feedback is provided to all providers at the conclusion of an RFP process to clarify learnings.
25. EPO activities are profiled and relevant outcome updates are posted on the WDHB Facebook page and communicated by the Relationship Manager to the MH&AS sector
26. RFP processes and outcomes are managed on such a way to ensure transparency
27. Specify provider MH&AS models of care and whaiora outcomes on WDHB Facebook pages on a monthly basis where health outcomes/gains have been identified (provider arm and ACPs).
28. Profile all evaluation of service activity on Facebook as well, to enable providers to learn from each other to facilitate replication of cost-effective treatments and wellbeing outcomes.
29. Each month profile a service (provider arm and ACP) the team, what they do and how they work. With consent, ask whaiora who are willing to share their stories of hope on Facebook/social media.
30. As a publicly funded sector, set up a portal for all MH&AS providers or alternatively utilise the WDHB Facebook page to include all related planning, funding and service development being undertaken.
31. Provide a schedule of services by PUC and provider to all funded services including provider arm staff via email or hardcopy and update this annually.

**Terms of Reference (ii)** ***Review the approach to ensure that services are safe, effective, integrated in a seamless manner across the continuum of care and are adequately resourced, cognisant of both Māori and non-Māori communities and ongoing and persistent inequities that exist for Māori***

The following description of the mental health and addictions system (MH&AS) and accompanying recommendations illustrates that many current services are struggling with capacity issues, lack of specific planning, no common governance over community services, and low morale among staff. As a consequence, some services are not safe or effective and few services are integrated. Serious inequities persist for Māori.

The disconnection between the provider arm and the community (NGO) services is historic and is a major factor of inefficiency. The remedy is for both Strategy and Funding (S&F) with senior MH&AS clinicians and management to strategize and plan for respective services that will enable contracting for connected services.

Connected service contracting across the provider arm /community divide will go a long way to sort the capacity issues that bedevil the acute unit. This will necessitate further community contracting for sub-acute care with clinical capability.

Mention is made of areas needing immediate attention. These include the provision of service for whaiora with 'high and complex' needs and the rationalisation of Infant, Child, and Adolescent Mental Health Services (ICAMHS).

Inequity for Māori is illustrated in the statistic of 23% of Māori in the district with up to 40% of Māori entering MH&AS at any one time. Te Puna Oranga is a key service for Waikato DHB with kaitakawaenga funded by MH&ASs. All those interviewed extolled the value of these workers. However, with a total of 700-800 FTEs in the MH&AS and only 7-FTE kaitakawaenga, the disparity is obvious and needs immediate attention. (More will be said in TOR (iv)).

As noted in the pre-amble there is a conflation between mental illness and crisis of wellbeing. There is a need to re-apportion team members approximate to the need. What is often needed in a well-being crises are counsellors, navigators and kaitakawaenga working alongside clinicians.

Safe,[13] effective,[14] integrated[15] and adequately resourced services are the 'gold standard' that all service management strive for. Waikato MH&AS leaders are no different. The review team found capable and competent management at many levels; people who have withstood challenging circumstances and withering criticism.

[13] Safe practice includes safety for whaiora, staff and community; it includes all the dimensions of life (bio/psycho/social/cultural and spiritual).
[14] 'Successful in producing a desired or intended result'.
[15] 'Different aspects of the whole, linked or coordinated'.

Adult mental health and addiction services (provider arm) include general adult inpatient and community services, specialty adult services (consultation-liaison, eating disorder, dual diagnosis/ID services, infant, child and adolescent services, forensic Services and mental health Services for older persons). In addition, MH&AS are provided in the community by primary health and by some Non-Government Organisations (NGOs)/Associate Community Partners (ACPs). Secondary service provision also occurs via a mix of urban community teams and rural services based in the Thames, Te Awamutu, Te Kuiti Tokoroa and Taumaranui areas. These services are, in some cases, being re-developed according to a negotiated strategy with the target populations.[16]

**Understanding the Whaiora journey**

The beginning of the journey for whaiora, into the Mental Health system, can be via many 'doors'. Access to the 'provider arm' secondary (or specialist services) is often via a primary service; some contacts are direct (from the community) via crisis services or via the Emergency Department. Other sources are via police, courts, prison services. The common methodology that follows an admission entails assessment and triage, noting that a high percentage of referrals to 'crisis' services relate more appropriately to 'wellbeing' issues and services. However, interagency availability and cooperation are associated challenges yet to be fully resolved.

Throughput of whaiora varies, and of a given population cohort, only a minority of whaiora (up to 10%) access specialist in-patient services. To maintain flow, input must be managed carefully, throughput must be efficient, output must be managed with the whaiora and their whānau with available community options, and outcomes must be robust enough to minimise relapse in whaiora. Throughput also involves the work of the whaiora journey. This work ranges from assessment and treatment, depending on the assessed cause. Output encompassed in the whaiora journey involves moving through the services according to need, both in the provider arm and in the community. Whaiora with 'high and complex' needs will be discussed separately.

A significant percentage of whaiora relapse within a specified period (often within 28 days). This signals a challenge in how adequately whaiora are managed while exiting the inpatient service. Those requiring supported care are referred to the NGO/ACP sector, notional extensions of the respective secondary services. The connections between the provider arm and the NGO/ACP community sector need improvement. The need at times is for rapid clinical advice and/or re-assessment. Whaiora under the aegis of the MH Act will continue to have a 'Responsible Clinician[17]' and be seen at regular intervals, via a case manager. However, the majority, not under the Act, should also be able to have easy access to specialist assistance when needed.

Outcomes for whaiora are often mixed. The experience of the unpleasantness of having a mental illness is often conflated with the experience of being in an inpatient unit. Outcomes are measured differently by whaiora, by their whānau and by clinicians. Seclusion is rarely pleasant for whaiora and never therapeutic. It is utilised when risk demands a 'duty of care'

[16] Refer 'Me Kōrero Tātou' and 'Closer to Home' strategy.

[17] Responsible Clinician as defined by the Mental Health (CAT) Act 1992 Section 2.

response. In spite of huge and sustained effort, mixed results regarding lessening the incidence of seclusion have resulted.

Issues present in the system can negatively affect the journey for individual whaiora and contribute to the mixed outcomes. There is a current crisis in capacity of the acute inpatient units illustrated by the systemic nature of flow. The heavy load carried by community clinicians is reflected in the barriers to care preventing whaiora returning to primary providers. These barriers entail the so called 'high and complex' factors seen in many whaiora. As a generality, biomedical treatments predominate in inpatient settings and as whaiora attain wellness, these in-patient settings become increasingly inappropriate. The current MH&AS system lacks the ability to easily decant to subacute community provision; recovering whaiora transferred to a suitable community setting whereby they can access more appropriate treatments. A glaring issue is the 'stasis' in the inpatient units whereby a dozen or so whaiora (with 'high and complex' needs) have been present for lengthy periods, with no ability to move to a contained, supported and supportive setting.

Important to note are recent inpatient trends evident in the mental health service. There has been an increase in: whaiora presenting with comorbid disorders for inpatient care, often complicated by methamphetamine use/abuse; social dislocation (homelessness, poverty, dislocation, relapsing mental disorder); young people presenting with self-harm.

An additional element, albeit indirect, that contributes to the disrupted whaiora journey is the critical function of Strategy and Funding (S&F) where historically, the provider arm and the community have been funded independently.

Waikato DHB has been involved in a number of reviews over the past five years and it is acknowledged that these reviews have produced important findings that have helped shape the current system. They have brought about the beginnings of change through projects and initiatives that have positively influenced the mental health and addictions system. The review found innovation and determination to improve the whaiora journey and experience. However, there have been aspects of safety that have needed improvement (see TOR (v)); the lack of comprehensive planning following envisioning strategies has made some contracts ineffective, and, with few exceptions, services are not integrated. It should be noted that work to sort this is in train.

Safety at an individual level immediately depends upon robust assessment and having the resource options to manage the findings effectively for the whaiora and family. Contextually, capacity is an important factor that allows flexibility of service that in turn contributes to safe practice. Current adult inpatient services are running well above 100% capacity. The ICAMHS waiting lists (of many months) are unacceptable and waiting times to access psychology is now above 12-months. These facts indicate that some services are not safe and are not effective.

The problems that exist demand change. The amelioration of these challenges will entail:

- Viewing the sector, functionally, as one entity, albeit with many providers,

- A new model of care with a management structure across both 'arms' with shared resource (TOR 1 and 3)
- A focus on both whaiora wellness and wellbeing
- An assertive response to capacity challenges
- Both 'arms' (provider and community) being able to share risk.

Further, initiatives to address the recommendations of this review should work within the expected principles outlined below:

- That Treaty articles with translational application operate through all strata of the DHB
- That visible leadership of the DHB are reflecting the principles of safe practice, integrity, trust, integrated systems, and acknowledging primacy of Whaiora and their whānau
- That system culture reflects 'many providers; one system'
- That strategic philosophy must translate to strategic operation that translates to dynamic, specific, time-framed, operational, conjoint planning
- That health and wellbeing are intertwined, and must be reflected in transcultural and interagency approaches and cooperation
- That MH&A issues for an individual whaiora are not uniform and 'treating the cause' must follow an evaluation process and availability of remedial treatments, be they biological, psychological, sociological, cultural or existential, in nature. All are equally important to wellness and wellbeing.

**Strategy and Funding**

The response to whaiora-need begins with the strategy and planning of services. The review team was told that the planning of the new sixty-five (65)-bed build (replacing HRBC units) was largely determined by the fiscal ceiling, not on the assessed need. This is disputable. It was in this context that 'Awhi Mai; Awhi Atu' was established, a valuable but insufficient asset.

A common refrain from many contributors was "there is no 'plan'", referring to discrete planning of all the respective services that constitute MH&AS, over the next period. Planning is not just the preserve of S&F. It involves all interested parties. 'Te Pae Tawhiti', 'Creating our Futures', 'Me Kōrero Tātou' all provide a solid start with consultation and an enunciated vision for desired outcomes. These documents have been augmented with a variety of 'equity' documents. The vision that these plans espouse, however, needs translation, specific planning and integration with the existing operational services, both within the provider arm and within the community. In short, many of these excellent visions lack accompanying specific, time-framed plans, framed in conjunction with targeted populations. This is in hand. Note: A draft Commissioning plan is nearing completion[18]

Further, the review found that there is no 'Framework' of organisational management for MH&AS across the entire system, also reflected in incomplete/inconsistent governance methodology. Governance will be addressed in TOR (iii). It has been clear to the review team that excellent MHAS governance exists in the provider arm. What governance exists over community services is not clear (beside the accountability to the Charities Commission). Each

[18] Personal Communication, Dir. S&F.

service unit (whether in the provider arm or the community) requires an accountability structure encompassing fiscal, clinical and cultural issues.

A common governance structure over common subspecialties would provide some unity. Another factor that accords with a 'one service' approach may be to place an operational management structure across all Waikato DHB MH&AS provision in order to close the divide between the 'arms' and also to enable meaningful support to those who need it. This may possibly occur at the Community MHS level with management accounting to the MH&AS management.

The review team identified that the synergy between S&F and the 'provider arm' MH&AS leadership is minimal. Discussion with the S&F Director[19] agreed that 'churn', work demand, capacity and capability issues were a hindrance to close working synergies with target populations, including with the provider arm.

It was also noted that synergy between the provider arm leadership and the 'community' MH&AS (NGO/ACP's) is lacking. S&F contracts with individual NGOs to supply needed services. These service contracts are generally not widely known by other NGO providers or by the provider arm. There is concern regarding contract monitoring in that it is not uniform, and many contracts are merely rolled over. There were also issues regarding notified problems. It was stated that in the past there has not been any follow-up to notified problems. However, these should always be followed by issue-based audits.

There was an expressed desire for closer working agreements between the provider arm and the NGO sector by a uniting structure across all MH&AS provision that would be to everyone's benefit. Interest was also expressed, for practical reasons, to reorganise Hamilton's community mental health teams from a single site (London Street) and explore a different service model, perhaps encompassing attachment of clinicians and clinical support to the respective hubs with regional visits as necessary.

The review team noted that two 0.6FTE positions have been created to liaise between secondary MH&AS and Primary services. This is an excellent model, though frustrations expressed by those involved speak of fragmentation, 'cherry-picking', and 'lack of ownership' of challenging cases. Integrated care is hampered generally by fiscal issues, multi-morbidity in many whaiora, doctor attitudes (in some instances) and the 'business model' (see below for a full discussion).

**Recommendations**

32. Operational/commissioning planning needs completion. This will be important for Whaiora and Iwi to have a time framed, incremental pathway to realise the issues expressed important to them in documents such as 'Me Kōrero Tātou'.
33. To explore common criteria of service governance across the entire MHAS spectrum
34. To explore a framework of 'management' over the entire spectrum of services

[19] Interview 4/11/20.

35. S&F and the MH&AS explore ways whereby S&F can retain independence while funding for service integration. Likewise, S&F portfolio managers to avail themselves of the opportunity to be part of sector governance.
36. MH&AS leadership explore ways with the community service providers to mutually support services and whaiora when needed
37. Concerted effort to build on the two PT liaison specialists with GPs with improved integration and perhaps mentoring with common governance explored for those dealing with whaiora.

**Capacity**

This review was partially triggered by unacceptable (over)capacity issues in the acute adult inpatient units (Henry Rongomau Bennett Centre). Such a small service carrying the risk for an entire service is untenable and a recipe for 'burnout', high staff turnover and, eventually, risk for the DHB.

The inpatient unit is under the impression of 'doing more and more with less and less'. Waikato MH&AS are funded for around 3.5% access rates to secondary services. Actual rates are 4.6% for adults and 4.1% for Child and Youth.[20] Adult crisis contacts have increased exponentially, and adult inpatient service occupancy has reached the highest recorded (since 2013). *"Unrealistic expectations from the general population regarding access to and response from the DHB sits behind expressed frustration".*[21]

There is a lack of flexibility and capacity in the acute units. This is well enunciated by the Director and Manager MHAS in their submission.[22] Until 'Awhi mai; Awhi atu' community beds came on stream there were few options to safely transfer whaiora who experience subacute symptoms.

Intensifying the issue of capacity is the stasis in throughput due to whaiora with high & complex needs, who appear to have no clear placement options. Currently there are up to thirty plus (30) 'high and complex' whaiora (both in the acute adult and forensic wards) unable to move from the units due to safety concerns. This is a growing cohort in every DHB in New Zealand. The keys to stability and safe management of those with 'high and complex' presentations involve:

- Stable residence
- A drug free environment
- Sustained treatment of mental illness
- Intensive support

There is a general belief that the new build will alleviate capacity problems within the current service. The review team is clear that unless 'sub-acute' services are provided in the community (with associated clinical capability) and unless whaiora with 'high and complex'

[20] Creating our Futures, Waikato Picture.
[21] Personal Communication, Dir. MHAS.
[22] 13 October 2020.

needs have a clinical pathway out of the acute adult and forensic units, the effectiveness of the new build will be severely compromised. This will be address in the 'Clinical Services Plan'.

Concern was expressed around the lack of shared risk by whole of MH&AS system, with risk always defaulting to the inpatient unit. An aspect of 'many providers; one service' could, with a district management framework with common governance, encompass the shared concerns for all whaiora, early recognition of risk and a shared planning approach.

There is also a lack of treatment options in the system. The cry of many whaiora, is to have available 'talking' therapies. There will always be a place for one-to-one psychotherapy. Because of its nature (specialised, lengthy, limited) consideration needs to be given how this precious resource be apportioned. Why this therapeutic modality should be regarded as the preserve of one discipline (psychology) is unclear given the training of all clinical disciplines and other cultural modalities (in therapeutic endeavours).

**Recommendations**

38. With urgency, subacute beds to be contracted in the community, connected (by planning, contracting and by governance) to the inpatient and forensic units
39. Capacity must be created by creating flexibility in the acute adult inpatient services. This may occur in two ways:
    i. Ability to decant to supported community services with clinical capability
    ii. Dealing with the 'high and complex' whaiora.
40. Creation of a small specialist unit dealing with the 'high and complex' whaiora. This would necessitate the involvement of specialist care experienced in dealing with risk, rehabilitation and interagency involvement.
41. Immediate enlargement of the 'active transition team' dedicated to this small but significant group of whaiora with 'high and complex' needs
42. Early interagency involvement in the assessment and triage of whaiora in crisis; a 'Whānau Ora' type navigation model (noting that the majority of whaiora who present in crisis with social needs need assistance other than inpatient admission)
43. There needs to be an insistence on 'diagnostic formulation' and one transferable 'management plan'[23]
44. Careful discharge planning, involving the triangulation of whaiora, whānau and clinician, needs to occur with commensurate managed follow-up.

[23] Noting that it may be referred to as a 'recovery' or 'wellness' plan.

**Resources**

**Respective (provider arm) Clinical Disciplines**

All disciplines were able to present in person, as groups with written submissions. They came across as dedicated and concerned to improve the lot of whaiora. Some of the submissions were extensive and cannot be captured in their entirety here. Many of their concerns overlap with the respective service descriptions. Summaries and excerpts are given:

**SMOs**[24]

Positive aspects of services encompassed ability to attract trainees to the DHB and 'surviving' the media 'onslaught'. They mentioned high retention rates and confidence in their immediate team leaders. However, the following concerns were expressed:

- staff (and bed) shortages in critical areas (CL, MHSOP)
- little growth of services in spite of population increases (e.g., in the burgeoning drug crisis)
- poor staff resources after hours
- inadequate facilities
- lack of respite beds and lack of support for staff managing crises
- frequent restructures
- leadership model with 'ivory tower' approach with little contact with clinicians at the 'coal-face'
- delays in replacing staff
- lack of clear models for services (e.g., Eating DO services)
- Concerns re community mental health services
- Distrust and lack of confidence in the 'funder'

Encouragingly, innovative suggestions were put forward, these include:

- Greater connection with S&F to understanding 'how things work'
- Involve and communicate
- Distributive leadership
- Dedicated local res-rehab facilities
- Address prevention strategies (e.g., in schools)
- Decentralise CMH teams
- Explore the 'outsourcing' of psychology services
- Closer ties and communication with GPs

**Nurses**

The review panel met with groups of nurses within leadership positions. This was inclusive of the inpatient charge nurse managers, the community charge nurse managers, the operations managers, clinical nurse specialists and the clinical nurse director across the provider arm.

[24] This was a sampling only and unclear how representative of the entire cohort

There was a plea for more nursing resource, and specific nursing speciality resource across services especially in the community. This sits alongside a sense of being 'overwhelmed' in the provider arm services by the inability to discharge whaiora with "high and complex" needs. Impacting on this is the lack of suitable community residential care.

It was identified by several nurse leaders that residential providers can struggle with the complexity of the presentations and have limited training/ knowledge in the management of acute situations within the NGO milieu, thus resulting in whaiora being (re)admitted to acute care. Furthermore, as discussed by community mental health nurses, the housing crisis impacts on outcomes for people accessing care, whereby whaiora have limited or minimal support from families. It was noted this cohort can be transient, or challenging to follow-up, can become unwell after a period treatment and go through the process of (re)admission to HRBC (or other DHBs). In addition the nursing teams reported that overall access to the Primary Health Organisations (PHO), the increasing physical health concerns and nursing time, of an aging population also impacted on the 'overwhelmed system'.

Mental health nursing is in a 'hard to recruit to' position nationally and it is noted that the recruitment and retention of registered nurses in the NGO sector proves to be more difficult. Comments were made that some registered nurses employed in mental health and/ or addictions NGO providers (at times) come with limited mental health and addictions experience. It should be noted that NGO nurses are invited to the education workshops facilitated by the Waikato DHB.

There was a desire among nurses for developing a values-based service ensuring the right person, at the right time, with the right service, which would improve outcomes of whaiora. One example of a suggested initiative was the 'short term pathway', i.e., whaiora discharged and followed up for a limited period of six to twelve weeks. It is currently in its infancy regarding the outcomes, but this would meet the ideal in terms of decreased reliance on provider arm services, and increased independence for whaiora and whānau.

MH&AS, in principle, commenced a Dedicated Education Unit (DEU), however due to changes in CNM's it is not functioning as it should. The philosophy is to distribute DEU staff across the inpatient services; however, this is dependent on the educational provider having the academic liaison and MH&AS accepting an increase in students. Initially the DEU, when trialled, was successful; the students became part of the team, in action learning. MH&AS had aligned a Māori nurse educator to support the preceptors. It was a partnership between Te Whare Awanuiarangi, Wintec, professional development unit and provider arm MH&AS.
Regarding the New Entry to Speciality Practice (NESP) nurses within the provider arm, the impression is that they are well supported during their first year of registered work and within their postgraduate studies.

The Māori nursing workforce FTE within the provider arm has been on a slight decline over the past 5 years. There is a sincere determination to increase the numbers of Māori nurses with strategic planning, to retain the nurses who identify as Māori within the provider arm and to identify Māori nurses early in order to support into leadership positions. There is a hope that the work around attracting and recruiting tāngata Māori to mental health nursing will start to show a positive effect on increasing the Māori FTE. The number of Internationally Qualified Nurses (IQN) is 20-30%.

Some nurses raised a few concerns; in 2007 the Māori Director of Nursing was removed and this role has not been replaced. They acknowledged the importance of Māori in significant influential and leadership positions.

In 2018 three Clinical Nurse Specialist (CNS) positions were disestablished to increase the number of Associate Clinical Nurse Managers (ACNM) about which several nurses raised their concerns. However, the adjustment to these roles related to supporting the need for extended nursing leadership outside of business hours. The establishment of the ACNM positions support nurses to work at the top of their scope to ensure that tāngata whaiora, whānau and staff experience positive outcomes of acute inpatient care. It seems to be a difficult balance of keeping within budget, and meeting the needs of provider arm s services. It is important to keep in mind the outcomes and what is beneficial for whaiora.

Nurses working in MH&AS are in position to further develop their skills, both in talk therapy (which is supported by Te Pou) and in postgraduate nursing studies, which can also lead nursing to speciality pathways. It seems that the MH&AS have a culture of supporting nurses to develop their potential.

**Psychologists**

A meeting was held with six of the psychology leaders.[25] Three well-written and comprehensive submissions were received;[26] some of the points are noted below.

It should be acknowledged that psychology as a discipline is a highly valued resource to any multi-disciplinary team. Training is extensive; in measurement (behaviour, brain and mind, adaptation), assessment (all modalities), in psychotherapy (group, individual) and work-place management. Concerns noted are as follows:

- The modality in many of the provider-arm units is predominantly 'bio-medical' (viz., a focus on medication vs trauma)
- Concerns expressed that there is no 'protection' for psychology FTEs
- There is a long wait for some therapies (e.g., DBT, 18-months)
- Logistic frustrations
    - Management is slow, detached and complex (7-layers of approval to recruit)

[25] 25 November 2020.

[26] Dr Gerard Pauley, Leena Brindley-Richards, Kirstin Thomson, Renate Bellve-Wack, Jon Ballantyne, Lily de Bruin. All submissions available on request with requisite permissions.

- Often no access to interview rooms (CMHS)
- A lack of productivity (e.g., Patient DNAs)
- No representation at the 'top table' and a need to be involved in 'governance'
- Opportunity cost in transporting whaiora out of district
- Wasted effort (previous work being discarded for something new).

Several clinical issues were expressed during the meeting, including:

- Increasing whaiora complexity
- Stress and burnout
- Major concern around ICAMHS
- Need for early intervention
- Replacement of four recently retired psychologists
- 'Boundary' protection of other allied services meaning greater workload for ICAMHS
- Struggling rural centres
- Service work overwhelmed by crisis
- Major need for cultural input (e.g., kaitakawaenga)
- Specific issues in specific services (e.g., preponderance of Māori in forensic MH, longer stay allowing for allied health modalities of intervention.

Suggestions were made; many are implicit in the concerns. For example:

- Being valued, involved, responded to.
- The creation of a stand-alone service that deals with complex personality DO e.g., 'borderline', with associated residential services
- The possibility of 'eating DO' beds within the Midland region.

**Recommendations**

45. Convene a meeting with the psychology leaders in order to discuss, clarify and remedy these concerns.

**Social Workers[27]**

The review team were informed that there were sixty-seven (67) Social Worker FTEs across the various Waikato Mental Health services, spread over provider and community arm services. Their professional lead had been recently disestablished in favour of one 'Director of Allied Health'. They alleged there had been little discussion or communication of this move. Other comments were received:

- Homelessness, a major issue
- 'Navigation is the way of the future'
- Need to address trauma
- A promising start to the 'Huntly initiative'

[27] Jinny Grey, Karen Rowan, Lyn Eade.

- Large caseloads

**Occupational Therapists**[28]

It was not made clear during the review process the exact number of Occupational Therapist FTEs in MH&AS. However, concern was raised about the lack of leadership in the discipline, noting that many FTE had recently been lost.
Their suggestions:

- Restore leadership
- Fill FTE positions
- Ensure CME and competency matters are adhered to
- Provide supervision to trainees.

[28] Linda Hardman, Maree Sievwright, Goodhelp Nyashanu.

## Area Specific Issues in Mental Health and Addictions Services

### Community Mental Health Services

Because of the media attention on the acute adult services over the past five years, the community service has lacked the attention that its importance merits. It was described as a 'broken system' by many of the clinicians interviewed. A claim was made that over the past ten-year period demand had increased by 70% without commensurate increase in funding (45%). The review team was unable to substantiate this claim. The result currently is services under pressure with low morale due to a perceived lack of response.

Recent strategies ('Creating Our futures', 'Closer to Home') have inspired a renewed vision; to decentralise from London Street and create a series of integrated 'health and clinical' hubs that will function more effectively and safely. Initial work has begun in Waharoa, Cambridge, and Huntly but planning is at an early stage.

### Recommendations

46. That decentralisation is supported with a move to 'health and clinical' hubs at designated centres.
47. That with the change in configuration and modelling, NGO access to clinician assistance is facilitated

### Mental Health Services of Older Persons (MHSOP)

The MHSOP is a service was developed to provide mental health care for the older person populace of 65yrs and over. Nine percent of the total population of Waikato DHB are 65yrs+. MHSOP comprises both 'inpatient' and 'community' arms, that are integrated (meaning the same service is across both 'inpatient' and 'community' arms). It stands as a model for other services in these respects as this integration makes for efficiency, good communication, a single point of accountability and of governance.

This service includes a fifteen (15)-bed inpatient unit; a facility that covers the entire Waikato DHB region. On Review of the data provided relating to capacity, OPR1 sits at 100%-103%. Due to this level of capacity, OPR1 holds a waitlist for admission, which results at times in a reliance on adult services for help with very acutely unwell people. With limited capacity it is noted that the patient configuration can make for a difficult 'mix' and to make the situation work there is a need to 'manage smarter'. Complicating unit capacity is the issue of three (of the fifteen) having nowhere to be discharged to; essentially being 'stuck'. Further, three of the inpatients are younger than 65yrs.

It is recognised that the projected population growth will be a challenge. The older person populace (65yrs+) under the Waikato DHB as of 2019 represents 68,075 of the overall population. Māori total 6,114 (of the older person population). It is projected by 2025 to have a total older persons population of 83,544, and a total of 8,559 older

people that identify as Māori. The population growth as of 2033 is predicted to be 104,008 and for Māori 11,951.

In addition to the falls risk, OPR1 is one of the higher risk areas for assault (either co-patient or staff). It was stated in review interviews that there is no current permanent access to psychogeriatric beds for people with advanced dementia, and/ or behavioural concerns. It was noted by the MHSOP leads that the demand for services is increasing. Additionally, there are currently two older persons who are difficult to place and one 'high and complex need' older person. At the time of meeting with the teams, there were three people under MHSOP services under the age of 65yrs. It is noted and cited that a business case for a MHSOP acute response team has been submitted, with a desired outcome to reduce, or prevent the need for MHSOP inpatient admissions by providing a more targeted response. The team function with an integrated model of care between inpatient and community services for tangata whaiora having the consistency in psychiatrist input. The team report working in a whānau centred way, encouraging whaiora connectedness to whānau.

Concerns were raised about nursing staff in the inpatient milieu. It was stated that the Registered Nurse FTE was frequently down and that recruitment into OPR1 roles is difficult. Enrolled nurses are heavily utilised in OPR1.

The low number of Māori accessing MHSOP care, was verified anecdotally and also presented on data. As an equity emphasis, the MHSOP team will see people that identity as Māori younger than 65yrs, this being on a case by case basis. The rationale being that Māori can present with earlier onset concerns and the team could provide and offer earlier interventions.
The MHSOP specialty supports the Tairawhiti district with their older person cohort who utilise ECT services from that region. This places additional pressure on the families travelling from out of area to support their whānau.

Recognising the growing population, the MHSOP team reports previously petitioning for twenty-five (25) beds to improve service capacity to meet this growth with a plan to have ten (10) functional beds and fifteen (15) organic beds. Their rationale for the split is that it is a difficult combination to manage the two different presentations.

'Rosendale' (a residential provider under BUPA) are closing some of their beds. Strategy and funding are aware of this and are working through a solution with other possibilities. Strategy and funding anticipate arrangement and formal communication early 2021.

The community mental health for the older person is described as a "robust team" that helps slow the process down into the inpatient setting. There is a multi-disciplinary team mix of specialties in the community consisting of social work, nursing, occupational therapy, psychology and psychiatry. kaitakawaenga were reported to be of 'huge benefit', but have been 'pulled' from the MHSOP service. Within the community setting under the provider arm is the 'memory service', and an older persons services in Thames

within the Manaaki centre. The wait list to obtain an MRI Scan is now of the order of eight months.

Comment: The service is well set up with competent leadership. It does lack capacity for such a large and growing regional population.

**Recommendations:**

48. Seriously reconsider capacity building (beds) in the light of the increasing population
49. Provide kaitakawaenga cover to the service.

**ICAMHS**

Three clusters were formed many years ago. They amalgamated ICAMHS with a number of NGOs and allied agencies relating to childcare. There is no shared governance, and the 'provider arm' is the backup to all problems, after hours. All participants appear unhappy with the arrangements and a review was requested in 2015 (commissioned in 2018) after a rating of 'extreme risk' was recorded on the DHB risk register.[29] ICAMHS continues to be the number one risk for the MHAS of the DHB.[30] The 'unhappiness' appears to relate to the lack of shared risk and the lack of efficiency, meaning that many practitioners are often tied up in meetings in regard to a whaiora they don't know and will not be expected to follow up.

There are two rural areas; The Thames cluster and South Waikato cluster (based in Te Kuiti, Tokoroa, Te Awamutu and Taumaranui) and a Central cluster with two providers (ICAMHS and Hauora Waikato) providing services. The central service provides all assessment and triage in the Hamilton area and requires re-modelling to cope with the number of crisis referrals as well as routinely dealing with managed referrals and therapeutic input.

One interview[31] referred to*" 'golden days' of ICAMHS with marked deterioration in the past two years due to leadership issues, 'toxic' work environment, 'churn' and the stress and disruption of the COVID-19 'lockdowns."*

In addition, problems enunciated included: escalating demand, limited or unavailable advice in times of crisis, unacceptable waiting times, high numbers of suicidal whaiora, limited funding, increasing complaints.

Currently all referrals occur via Hauora Waikato (in partnership with the provider arm operating a 'one service/two provider' model). There is a team of six (6) FTEs (multidisciplinary) with a need to develop a new and more efficient model of care,

[29] Report to Executive Leadership Team/'Investment requirement for Infant Child and Adolescent MH Services Undated

[30] MHAS Review Submission Dr Rees Tapsell.

[31] Interview with A/CD.

dealing with the tension that occurs between consultation with acute presentations and ongoing assessment and triage.

Waiting lists to see a psychologist are unacceptably high (<12-months) and attempts are being made to explore the utility of group therapy of an educative model prior to referral for one-to-one approach. The importance of psychology is emphasised and accepted.

The consensus appears to be that the regular work of ICAMHS is suffering due to the volume of crisis referrals. Many of these are 'kids out of control' presenting with 'gross deregulation'.

**Recommendations**

50. Accelerate the implementation of the proposals enunciated in the 2018 report, which was to reconfigure the ICAMHS services to deal with crisis work more effectively.
51. Rather than only refer to psychology services, initially utilise other therapeutic modalities in the first instance (e.g., training parents, use other trained disciplines, ration the psychology sessions and review)
52. Utilise the 'Psychology Centre' (by contracting from the DHB).
53. In the Central cluster, remodel 'assessment and triage' as distinct from dealing with 'crisis' (I.e., develop two teams with different functions).
54. Provide a 'dedicated crisis clinical pathway' including a Waikato DHB or Midlands Regional solution.

**Pacific Populations**[32]

K'aute Pasifica is an NGO that offers a range of services designed for the Pasifika communities. In many ways it can be considered a functional 'Health, wellbeing and clinical' service providing for physical and mental health, navigation services, employment and housing, school health, immunisation and a raft of social services (crisis counselling, gambling and 'whānau resilience'). They also have established links with other Pasifika NGO/ACP's in Tauranga and Tokoroa.

Approximately thirty-six (36) FTE are seconded to various sub services. The services are built around a general practice and pharmacy. The service knows all the Pasifika families in district and is able to follow the health and welfare of the 127 children they serve. If one area is stressed, the service is able to apportion FTEs temporarily from other areas of service.

In regard to ICAMHS, K'aute Pasifica is in the central cluster. However, because of the high entry criteria to access services and because of the lengthy waiting list, they rarely, if ever, make referrals of children. Their philosophy is to deal with crises and need as they arise.

[32] Services provided under the NGO/ACP 'K'aute Pasifica

When asked about their need and access to secondary MH&A service they responded that, on occasion they do need specialist advice, which is hard to access. They also said that they are unable to access patient files and notes. They requested a 'residential contract' in order to respite parents from problem children.

**Recommendations**

55. Pasifica need to be connected with other community services and be able to access secondary mental health advice more easily.

**Regional Approaches**

Developing regional 'hubs' ('Closer to Home' project) is an important vision.
The regional hubs were based on iwi:

i. Tuwharetoa
ii. Maniapoto
iii. Raukawa
iv. Hauraki
v. Waikato ki Tainui and Ngati Haua.

The Review encompassed many of these groups. (One, when the technology failed, was followed by a regional visit by some members of the review team).

The Review Team was in committed support of the concept of 'Mana Motuhake' (self-determination) and, indeed, a couple of groups are well on the way with well-developed plans and nascent services.

The review Team was equally clear that incremental development following a conjointly developed, time-framed planning was necessary to forestall failure by inadequate support and perhaps a different funding model, based not on inputs but on outputs of a developing system. This would mean accreting the part FTEs and spot funding into a coherent whole.
More discussion will occur in TOR (iv).

**Recommendations**

56. That specific time-framed plans be developed with enunciated goals, respective responsibilities and accountabilities and support with each of the hub developments.

**Addiction Services**

The organisational chart of Waikato DHB and associated services shows that addiction services have a little under 10% of the total MH&AS budget (@ $10.3m/PA); $3m in the 'Provider arm' and $5.2m in the community, which is provided by a mix of beds and FTEs.

While individual addiction services seem to be running efficiently, they are largely unconnected from each other and between the community and the hospital. There is also little in the way of a connected governance framework. According to the Director of Clinical Services MH&AS, there is increasing demand and an 'epidemic' of methamphetamine use and abuse. There are also '*problems related to poor planning and piecemeal contracting for AOD services...with some aspects of the service continuum simply not funded or provided here.*'[33]

[33] Dr R Tapsell.

Services encompass: 'managed withdrawal' ('detox services'), 'methadone management', residential services and community case management.

Detoxification Services: These are 'wholly inadequate' with two notional beds available (but not dedicated). This means that the beds are rarely available, meaning those requiring 'detox' are diverted to medical beds in the general hospital.

In regard to general AOD services, the Clinical Director[34] suggested that the current services provide *'the bones of a very good service'.* However, problems arise as community services do not have multidisciplinary teams and therefore, *'any complex case is referred to CADS'*.

While there are good relations across AOD community services, there is *'no robust model of care across the continuum...'* The standard of care across all services is 'uneven' and there are major issues in rural communities (of access to services).

'Youth Intact' services for Child and Youth is a model that should be emulated.

The 'Drug Court': this will focus on community addiction presentations and be functioning by mid-2021. There will be an anticipated need for addiction expertise and 'kaupapa Māori' advice. Apart from that few details are presently known.

**Recommendations**

57. There needs to be a clinical, governance framework across all related community AOD services
58. Contracts need to operate across the system and be flexible
59. There needs to be more clarity what contracts are held by respective providers in the community
60. Peer support and kaitakawaenga are vital in AOD services and should be contracted
61. 'Navigation FTEs' would be helpful to those who have co-morbid social presentations
62. Support the establishment of the Drug Court and monitor and evaluate its impact
63. As 60-80% of referrals are from Courts and Corrections, greater cooperation and clarity is needed in regard to coordination, and shared responsibility.

[34] Dr A Darby.

## Māori MH&AS clinical services

Each of the following service providers was interviewed:

- Te Runanga o Kirikiriroa
- Raukawa Charitable Trust
- Ngati Maniapoto
- Hauraki
- Waikato Tainui
- Hauora Waikato
- Awhi Mai (Te Awhi Whānau Charitable Trust)

All were impressive in their dedication and commitment to providing the best MH&AS care to their respective whaiora (and their whānau). Each gave a breakdown of service coverage; how many FTEs were employed and how they relate to each other. Some of the comments are recorded here:

- 'No confidence in the current system'
- Current services under-funded
- Procurement processes flawed
- Insufficient dedicated resource to 'Māori kaupapa'
- An authentic Treaty of Waitangi relationship lacking with huge potential for change
- Contracts generally do not cater for inclusion of whānau
- Māori programmes are often not funded
- Clinicians are often not equipped to be therapeutic (for Māori)
- Funding methodology needs changing from FTEs and 'beds' to 'packages of care'
- 'Systemic, sustainable and service-design issues' (e.g., No CPI increases)
- 'Kaupapa services not valued'
- Procurement issues: 'no pattern to service development; fragmentation, service gaps, RFP delays'
- Major rural challenges with ICAMHS (see below)
- Desire for 'connected services', transparent, accountable leadership

**Recommendations**

64. Convene a hui between providers, IMC and S&F to clarify and address the above concerns.

**Important interfaces**[35]

Dr Mills emphasised the importance of Psychiatry Consultation Liaison Services (CL) to general medical (and surgical) patients. Topics ranged over the following illustrating the importance of this service:

**Acute presentations to ED:** Many people present acutely to ED with overdose. This requires 24-48 hrs of assessment and treatment prior to 'clearance'. All need to be seen by the CL team regarding the presence of illness and aftercare follow-up. The issue here is 'responsiveness'[36].

**Eating Disorder services:** these services were described as 'dysfunctional' as, in spite of there being a Community Eating DO Service, it will only see persons domiciled in the community and not those presenting acutely. In these circumstances CL becomes the 'provider'. Whaiora hospitalised with eating DO issues occupy 380-600 bed-day stays per annum[37]

**Pain clinic:** There are two aspects of this service: post-operative pain and chronic pain. This latter service is staffed by part-time anaesthetist and psychiatrist. Resource is lacking[38].

**Gender Dysphoria:** this is serviced by sexual health and endocrinology. From a handful of cases per year this service has burgeoned in the last year with young people presenting for assessment and advice.

**Mother and baby service:** CL staff make the assessments and triage. Ongoing assessment and treatment are the preserve of the perinatal Team.

**Detoxification:** most cases are outliers from the Adult General Psychiatry Service where two beds are notionally for 'withdrawal'. Because of pressure these are rarely utilised[39].

[35] Dr Graham Mills, Medical Director Waikato Hospital.

[36] Note: *Clarification noted that one FTE is supplied by MH&AS to service 'well-being' concerns.*

[37] *In clarification, CL services will initially assess admissions, especially those not known to the community service. Patients admitted under the Act will be managed by the CL team while they are being re-fed. Others will be seen and managed by the dedicated FTE for Eating DO.).*

[38] Note: CL has no involvement here.

[39] Consideration is being given to contracting an NGO for this work.)

**Primary Mental Health Services**[40]

Studies show that mental health constitutes a good percentage of General Practitioners' practice (40-60%). While about 20% of the population will suffer from a mental health issue in a given year, only about 7% will attend their GP for their problem. Many of the mild to moderate mental health complaints are conflated with 'wellbeing' concerns. Many general practitioners see that primary mental health services could drive mental health improvement for the community.

There are several concerning issues that demand the attention of a high-level commission:

- The business model is antithetical to an understanding and resolution of the whaiora presentation
- Access and financial issues mitigate against equity for some, especially Māori
- With the usual short consultation times (typically 15-minutes), the predominant modality is bio-medical. Those requiring counselling are referred on. Counselling services for whaiora are valued by GPs. However, due to budgetary concerns and overwhelming demand, counselling sessions are commonly limited to three to six sessions, sufficient only for mild to moderate cases.
- 'Cherry-picking' of who to see means that many of the whaiora with 'high and complex' needs are referred on to secondary services, who often reject the referrals as 'not meeting the criteria.'

Some practical suggestions are made by primary clinicians:

- Primary MH to be funded differently from the current 'capitation plus fee for service'. There would need to be ease of access and greater subsidy in lieu of the greater time required to listen, assess and treat whaiora.
- There needs to be more support from secondary MH services. The current primary/secondary liaison psychiatrist is the starting point to communicate between the services, provide advice, provide mentoring and advocacy in an important area of service growth.
- One of the pressing needs is to have direct communication with an MHS consultant at the very time of need (when the patient is in front of the GP when issues need clarification or instruction). In some places e.g., Lakes DHB, the 'red phone' hot line exists. This is a dedicated line, manned 24/7 (or in office hours) by consultants on a roster.
- Greater integration would be helpful, viewing the general practitioner as a key member of the multi-disciplinary team. An aspect of this is 'information sharing'. Many general practitioners do not know or are not aware of the many service provision changes in their area and need advice as to where to refer a whaiora with

[40] Thanks to Dr A Darby, Dr Mark Taylor, Drs Maree McCracken, Sheryl-Anne Wilson and Bernadette Doube.

'high and complex' needs. Transparent contract specifications need to be shared knowledge among a group of providers, particularly the rural providers.

- Practical improvements to the primary/secondary MH service interface will include
    - A greater number of 'liaison' specialists attached to GP clusters
    - Provision of a dedicated and 'manned' telephone consultation service
    - Consideration of increasing the 'free' counselling session.

**Terms of Reference (iii)** ***Review the clinical governance structure across all MH&A services within District***

*'Governance is all those processes that underpin governing. It defines the interactions and decision making processes that are directed toward addressing an agreed collective challenge.... Regardless of the definitions, all organisations have rules, policies, procedures and agreed behaviours that drive the organisation towards achieving its goals and moving it from its present position to a position closer to that expressed in its vision statement...Effective governance requires an understanding of authority and its delegation, responsibility, accountability, a sense of stewardship, effective leadership and an agreed mission to move the organisation to that of the boards vision. Activity and outcome must be measured (and measurable), standards set and maintained and opportunities for improvement sought...'*[41]

Cognisant of the above statement, all services, provider arm and/or community, should be able to account in a transparent manner for moneys received by contract for services rendered.
The review team found that governance in the community based services was not uniform and did not function to connect like-service provision. An interesting feature of interviews was that nearly all services expressed a desire for a more uniform governance structures.
The Oversight Group was initially convened to support S&F in a quasi-governance role, albeit without success. This is discussed in this chapter and also in TOR (iv).

The review team interviewed approximately 180 individuals, many set in the contexts of teams and services, both in the 'provider arm' and in the Community (as NGOs/Associate Community Providers). All interviewed were asked about clinical governance and clinical governing structures.

Clinical governance can be defined as a system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, creating an environment in which excellence in clinical care will flourish.[42] Clinical governance groups were examined as part of this review.

The findings were unequivocal; Clinical Governance of MHAS in the Provider arm is well organised and works well. It accounts for clinical, fiscal and cultural concerns. It is stratified in that each service management accounts eventually to senior MH&AS leaders who hold clinical governance meetings every month. There is also excellent data collection and the review team were regaled with how governance data could note and manage trends and respond accordingly. This is important in understanding work output linked to whaiora outcomes, namely 'productivity.'

[41] Taken from 'Quality Assurance Framework (Clinical)' Waikato DHB, draft document.
[42] http://www.hqsc.govt.nz/assets/Capability-Leadership/PR/HQS-ClinicalGovernance.pdf .

Governance appeared to stop at the border between the provider arm and community. We (the review team) surmised that this concerned 'ownership', NGOs maintaining their respective stewardship themselves. We understood that each NGO needed to provide 'governance' as a necessary function to maintain charitable status. However, it was a common finding that community services voiced their support for some common governance across the community, linked with the provider arm . The review team agreed that NGO services receiving government money needed to demonstrate accountability for that funding, delivered and audited by contract. Contract monitoring and auditing is a S&F function and occurs at a 'high level' and seldom gets down to day-to-day clinical issues and has no linking mechanism with like providers or indeed with the Provider arm . The Review Team is aware of the impost on NGOs with further governance compliance via regular reporting but feel that governance regarding common challenges (capacity, flow, risk, assistance) will appreciably help in the current challenges bedevilling the MH&A services.

At a practical level, the review team thought that bringing like services together in a governance framework would assist in feedback (on contracting and clinical need) but also in linking groups working in a similar field of service provision for mutual understanding and support. Governance thus could bring together services such as adult MH, Addictions, ICAMHS, MHSOP and so on with Governance shared between provider arm and community nominees.

**Recommendations**

65. That a framework of governance be instituted across the provider arm /community divide to all contracted services, according to their respective speciality.

**The 'Oversight Group'**

According to the chair of that group,[43] the group was convened in late 2018 (by S&F) to *provide sector governance, leadership, and direction to oversee DHB MH Sector investment toward a vision of improved health and service delivery* for Waikato to 2030. The 'Te Pai Tawhiti' and MH&AS 'Model of Care' documents in concert with 'Creating our Futures' were pieces of work intended to be the blueprint for the Oversight Group. The Iwi Māori Council nominated persons. Others were nominated by Hauora Waikato, Tainui, Kokiri Trust. Senior clinicians (provider arm) and senior members of S&F (as co-chair) were appointed. It was envisaged that 50% of the group would be Māori and that all sectors of health would be represented. This group met regularly but tended to 'fall apart' during the COVID-19 period when the group went into abeyance. Aside from that, the group had problems of focus and was fragmented and directionless. It was clear that any remit the Group had was either misunderstood or lost in the size and composition of the group. Needless to say, the Oversight Group was not able to succeed in its vision to provide limited governance to the sector.

The review team met with the Oversight Group for 90-minutes or so. The review team also met on two further occasions at the invitation of both the chair of the IMC and of the Review Team in order to understand its intended function. It appeared to have a

[43] Tio Sewell, letter to the Review Team, 18 November 2020.

commentary role on development and act in some manner as a governance body. The IMC was insistent that the formation of the 'Oversight Group' was a partial answer to IMC being marginalised from sincere consultation (giving the example of being excluded from the new build). The importance of Wai2575 was raised with its emphasis on 'partnership' and its interpretation.

The review team heard that the Oversight Group is not functioning according to its initial vision. This was reflected in written and oral reports to the review panel, which variously described the Oversight Group as *'fragmented; lacking collaboration between the Waikato DHB and NGOs; highly political; and struggling to convene the NGO providers'*. It appears that the Oversight Group was conceived and birthed by S&F with lofty goals but has lacked the necessary leadership, structure and support in order to achieve its goals.

The review team noted the Oversight Group Terms of reference, which are highly aspirational; if the group is to continue, will need serious consideration regarding what can realistically be achieved by such a group, its composition, its size, and how it is supported and resourced.

**Recommendations**

66. That the S&F together with IMC and provider arm leadership consider the continued viability of the 'Oversight Group', its function, size and composition and support.

Some focus was placed on the optics of Māori governance (structures and leadership) within the DHB. With 23% of the population, Māori, and 40% of the MHAS cohort, Māori, providing Māori with clear a message that the organisational structure of the DHB is capable of understanding Māori and their needs, is important. Some of this is discussed in TOR (iv).

**Terms of Reference (iv)** ***Review the application of Mātauranga Māori and Te Ao Māori practices and approaches across the MH&A services***[44]

*Equity outcome for Māori means "restoration of mauri, maintenance of mana, reciprocation of manaakitanga, establishment of mana motuhake"*

Three factors emphasise the importance of health to Māori: they are Treaty of Waitangi partners; they present to services disproportionately to their numbers in the District; they present with serious equity issues that have a discriminatory impact on their health and wellbeing.

Important cultural services for Māori in MH&AS are provided by Kaitakawaenga, stationed and nurtured within Te Puna Oranga of the DHB. Te Puna Oranga is the Māori Service provider within the DHB to all services. Kaitakawaenga are the 'champions' of 'tikanga Māori' for the Waikato. Another task of Te Puna Oranga is that of Mātauranga Māori.

Equity concerns are prominent in Māori health and relate to 'whole of life issues'. Their entry to MH&AS is invariably another contribution to inequity symbolised by increased use of the Mental Health Act (s 29) and by seclusion incidents, both markers of what has gone before. These 'whole of life' issues also underscore the need for greater use of kaitakawaenga (from their current seven (7) FTEs), and the use of other non-clinical navigators.

Te Tiriti o Waitangi provides the framework for how the Board and iwi Māori meet their obligations for Māori self-determination (Mana Motuhake) in the design, delivery and monitoring of health and disability services. This is related to the application of Mātauranga Māori with the DHB. The vision of iwi Māori is that Te Tiriti o Waitangi will be embedded and enacted in all systems of Waikato DHB, including the framework of the DHB itself. The DHB has committed, through the creation and publication of Te Pae Tawhiti 2018-2030 (The Framework for Change), to the principles of Partnership, Participation and Protection which should underpin engagement with Māori to develop Māori responsiveness. These principles need to be updated to reflect current understanding of these obligations. To embrace a Te Tiriti o Waitangi framework will ensure that Waikato DHB is working in a safe, culturally competent and equitable health and disability service environment.

As identified above, the structure of Waikato DHB needs to be wrapped in a Te Tiriti o Waitangi framework; so too must the MH&AS be grounded in the same framework as expressed in Whakamaua: The Māori Health Action Plan 2020 – 2025. To ensure an effective and successful model of care for Māori, Mental Health need to focus on: Te Tiriti o Waitangi; Equity; Kaitakawaenga; Me Kōrero Tātou; and Mātauranga Māori .

[44] NB Appendix 3 Independent report by Wi Keelan.

Te Puna Oranga is the Waikato DHB's Māori Health Services, and provides a service that reaches across all levels within the Waikato DHB and into the Waikato communities. It is a kaupapa Māori led service that provides strategic, as well as Mātauranga Māori, services. Included in the services provided are the kaitakawaenga (Māori cultural workers), who provide a Māori specific service of cultural care and guidance to whaiora in the Mental Health system.

Kaitakawaenga have acceptability across all domains of the MH&AS providers, both in the provider and community arms. They have two functions: to be the champions of tikanga Māori as determined by the mana whenua of the Waikato; second, to be involved in Mātauranga Māori (in brief, cultural education). Being the champions of tikanga requires expertise. Many Kaitakawaenga will be attached to clinical teams. As with all disciplines they will account to Te Puna Oranga in respect of taha Māori and to the multi-disciplinary teams for their respective clinical involvement. Mātauranga Māori is undefined. It may pertain to whakapapa, local history, narrative therapy (e.g. Mahi Atua), or skills such as kapahaka, mirimiri, or mahi maara (gardening skills). The outsourcing of these contracts may be a possibility.

Other groups are part of the structure, some at a governance level and some at an advisory level. Of interest to the review panel was the Iwi Māori Council (IMC), the Oversight Group and MHAS Clinical Governance Forum.

The review team understood that the IMC is involved in some Waikato DHB operational meetings; they are present or represented at meetings held by Te Puna Oranga, the Provider arm Clinical Governance Forum and the Oversight Group.

As noted under TOR (iii), the role and continued viability of the Oversight Group, created to provide (community) sector governance, leadership and direction, and to oversee Waikato DHB Mental Health Sector investment, needs to be reconsidered (see recommendation 64 above).

Māori, although 23% of the overall Waikato rohe population, represent about 40% of those accessing MH&AS. Māori staff are only approximately 11% of the Waikato DHB population. This needs to increase over time to ensure there are staff who can also be the champions of 'tikanga' and 'Mātauranga Māori '. There is also the issue of equity. Persistent inequity of health outcomes experienced by Māori whaiora and their whānau are a concern. This inequity is symbolised in the over representation of Māori being coercively managed via section 29 community treatment orders,[45] by being subject to disproportionate seclusion events and by the unenviable high death rate by suicide. Furthermore, Māori are more likely to be admitted in the weekend when there is no kaitakawaenga service available.

Throughout the review, the kaitakawaenga team received uniform acceptance and praise for the service they provide. However, with only 7 FTE available, all of whom sit in the provider arm, the kaitakawaenga has insufficient FTE to resource the current

[45] Mental Health (Compulsory Assessment and Treatment) Act 1992.

demand. To give full effect to the cultural importance of the kaitakawaenga, their reach needs to extend past the provider arm and should not be limited to "office hours". The cultural guidance provided by kaitakawaenga is essential to tangata whaiora and whānau well-being and directly aligns with the aspirations outlined in Me Kōrero Tātou.

Me Kōrero Tātou represents the community Māori voice and clearly defines Iwi aspirations for Māori. The iwi voice is to move deliberatively to 'Mana Motuhake'; the enablement of Māori to be Māori and exercise authority over their own lives (inclusive health services) according to their needs, values and traditions. The review team was informed that disappointment has been expressed by iwi that no immediate follow-up response/action by Waikato DHB followed Me Kōrero Tatou's release.

Mātauranga Māori, the knowledge of Māori, needs to be recognised and applied within the Mental Health system. There is immense value in Mātauranga Māori approaches and Te Ao Māori traditional healing practice, including the use of 'Rongoa' as effective interventions for Māori whaiora and their whānau. There is strong evidence that effective Mātauranga Māori cultural intervention programmes can reduce inequity and increase health outcomes for Māori in the MH&AS. The 'medical model' approach to medicine can easily dismiss the cultural importance to well-being. To successfully implement Mātauranga Māori approaches there needs to be recognition and education of different cultural approaches. These approaches must also recognise the importance of staff working collaboratively with tangata whaiora and their whānau in their own treatment. MH&AS must ensure that whaiora and whānau are active partners not only in their own treatment but also within service and organisational processes i.e. the whaiora leave process.

**Recommendations**

67. Establish a co-designed Te Ao Māori Advisory Committee (TAMAC) to strategize, plan, receive and provide monthly reports on the achievements, outcomes of Māori Health gains against a Māori Health Strategy Work Plan.
68. Te Puna Oranga to hold an internal review of its capability and capacity to fulfil its obligations to incorporate Te Ao Māori worldviews into the wide range of DHB clinical and business activities.
69. Reconsider the necessity and function of the 'Oversight Group'; possibly into a newly constituted 'DHB and Associate Service Providers (NGO) Forum' for the clinical-management partnership of the whole MH&AS sector system.
70. Implement Me Kōrero Tātou with specific, conjoint, time-framed planning with respective iwi with the aim leading to Mana Motuhake
71. Ensure training and ongoing education programmes are provided to frontline staff and MHA service operational managers on the Mātauranga Māori Framework and the new Treaty of Waitangi framework and principles as well as good clinical practice
72. That an evaluation is carried out of the MH&A services requirements of the Kaitakawaenga, to determine the level of resource required to provide an effective and culturally competent Mātauranga Māori service to whaiora and whānau of the district, both 'provider' arm and community services

73. Encourage the implementation of a Māori Health Outcomes Framework (such as Hua Oranga) in the MHA service to enable improved measurement of how Māori whaiora and whānau experience the service from their own cultural perspective
74. Co-design across the mental health and addiction sector of implementation plans, with whaiora and whānau at the very outset.

**Terms of Reference (v)** ***Review leave protocols and procedures within the Waikato DHB Provider arm***

It is acknowledged that there are a number of leave protocols and procedures in place in the inpatient services, which were updated in 2020. In addition there is a formal auditing structure in place, auditing against leave guidelines and documentation of leave. It is also acknowledged that the nature of leave has had a change in philosophy, where leave is now part of the therapeutic process and discharge.

The review of the leave protocols and procedures involved three of the panel members (psychiatrist, RN/auditor/management and clinical nurse director/DAMHS[46]) engaging with the operations manager and psychiatrist working in the adult acute services and with the social worker in this area. Further to this, each panel member was involved in a number of interviews, although not directly related to this ToR, which has fed into the overall understanding of the system.

From 2015 – 2019 there were several serious incidents at the inpatient facility, each relating to the leave procedures and protocol. Some incidents sadly resulted in tragedy. Each of these incidents was reported as per the national incident management policy attracting Severity Assessment Codes (SAC[47]) level 1 or 2. It is also noted that WDHB MH&AS have been exposed to negative media attention related to these SAC events.

These events instigated a review of the leave process at that time and AWOL procedures that were in place. Both the past and newly implemented processes of leave and AWOL procedure were investigated as part of these terms of reference.

**Leave and AWOL procedures**

The COVID-19 lockdown allowed for a period where the operations and quality team within acute and forensic inpatient services, an in-house team, could review the leave and AWOL procedures. The leave and AWOL[48] procedures related to Adult Acute Services only, and prior to the in-house review, it was conveyed that the leave procedures were subject to interpretation.

Previous practice (which is no longer acceptable) permitted whaiora to periods of escorted leave to 'smoke, or access the dairy'. This had resulted in several SAC incidents, reporting at varying severity levels, of whaiora 'running away', or legally deemed AWOL.

To be considered AWOL, versus self-discharge, the whaiora had been admitted under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA), noting that a large percentage of whaiora are admitted in this manner. A consequence of

[46] Director of Area Mental Health Services, as defined by the Mental Health (CAT) Act 1992

[47] Severity Assessment Codes are used to categorise incidents reported under the national incident management process for health

[48] Absent without leave.

AWOL often resulted in a substantial amount of work and pressure for staff. The AWOL procedure requires the completion of necessary legal paperwork, as well as notification to the Police, and to the whaiora's whānau. The aforementioned escorted leave practice placed constant pressure on staff to be vigilant on escorted leave due to risk of AWOL. Within the acute adult inpatient environment whaiora placed frequent demands on staff to escort for short 'smoke' leave periods.

It has recently been acknowledged that the practice of leave being taken for smoking and dairy visits was considered non-therapeutic and has since ceased. The revision and improvements for the management of leave and AWOL, principally, is a modification in leave philosophy. Leave is currently recognised for purposes of therapeutic benefits and outcomes, generally with whaiora close to discharge and as part of an assessment of readiness for the preparation of discharge.

The leave is a collaborative approach with whaiora, the service and whānau. It was discussed by the operations team and as part of these terms of reference; the importance of whānau engagement and that whānau are actively engaged in the whaiora's discharge planning. Additionally, it provides an opportunity to discuss with the whānau their sentiments on whaiora taking a period of leave and the involvement in the decision making process. Moreover, this meets the section 7A legal requirements for the service to consult with whānau of whaiora subject to the MHA.

The service has recognised the importance of philosophical principles when addressing leave for a whaiora and is guided by the following:

- Leave is always an aspect of therapy
- Leave is not for smoking or vaping
- Admission to a ward is always for good reason
- Leave is an aspect of discharge planning
- Leave should always be goal-oriented and related to self-accountability.

Of note, the changes of procedures went through a consultation process which was inclusive of cultural and whānau advisors. It is noted that the operations manager (for adult acute services) is already working to make adjustments towards a cultural shift for the new build.

An updated AWOL policy and procedure had been implemented utilising a risk matrix by category. The procedure is clearly set out as a flow chart for staff to follow. An addendum to the AWOL policy included: Risk Management Missing Person AWOL policy and Procedure. A Missing Patient Incidents Report 1 January 2020 to 28 September 2020 was sighted and provided the opportunity for staff to learn from.

As a quality improvement initiative to help mitigate AWOL events, the Senior Medical Officer together with nursing staff, reviews and undertakes a mental health assessment of whaiora, identifies any risks, and goals for leave. This is reviewed in conjunction with daily documented clinical assessment, and is completed prior to whaiora taking leave.

Leave is now a 'risk formulation' and considered process and a planned clinical intervention used to facilitate safe transition into the community. This process is documented on the electronic 'inpatient leave management plan' form. What is missing is the shared understanding and shared decision making with whānau to co-sign a form following discussion for leave (refer to recommendations, below).

Despite initial concerns, specifically from the nursing staff who alerted the unions to shift to a 'blanket' no smoking philosophy, the new protocol has had positive outcomes. There were concerns raised regarding the patient's rights versus a smoke free environment and a fear that a no-smoking policy would distress whaiora. However it has been reported, and noted by the operations and quality and patient care team, that there is a reduction in hostility, aggression and seclusion events. Furthermore, applying this 'across the board' no smoking/ vaping philosophy, has aided in decreasing pressure for staff due to a reduction in whaiora requesting leave. This has meant decreased numbers of whaiora taking non-therapeutic leave, resulting in a reduction of AWOL events.

There are several components that impact on whaiora wellbeing and containment within the ward milieu. As part of engaging whaiora for improved outcomes and to minimise whaiora requesting leave for smoking periods, the team are developing a therapeutic programme within the acute adult ward milieu. This programme will facilitate talk therapy skills and approaches, a range of activities and open-air environmental engagements, led by occupational therapy and psychology. Alongside this programme, and already in practice, is smoking cessation education and Nicotine Replacement (NRT) options for whaiora that smoke. This includes gum, spray and patches. This is fundamentally carried out by the inpatient unit staff.

**Documentation**

To minimise variability in the general practice of nursing documentation, documenting against an approved framework provides a consistent approach of assessment and is helpful in identifying clinical risk from day to day. This helps to provide further information for the formulation, and decision for whaiora to take leave. The nursing team document, in the whaiora clinical file, using the Subjective, Objective, Assessment Plan (SOAP) framework. On-going audit highlights an improving compliancy with almost 100% routine practice week by week. The reviewers sighted audit which demonstrates near 100% consistency in clinical risk being documented over the past few months.

To aid in the identification of whaiora and aggression, the Dynamic Appraisal of Situational Aggression (DASA) tool is applied across wards 34, 35 and 36. Alongside the DASA, a quality improvement initiative is noted regarding a clear escalation process across the adult inpatient units. Education is provided related to different degrees of risk and scenarios, for registered nurses to have an increased understanding of when and how to escalate concerns.

**Other factors impacting on the environment and staff time critical issues**

It is acknowledged that overcrowding and acuity issues can take staff time that impacts on the therapeutic milieu, this in turn impacting on tāngata whaiora, potentially impacting on the risk of AWOL. The review team acknowledges the other factors in the wider picture.

The MH&A services are experiencing high numbers of: complex presentations (dual diagnosis, head injury and mental illness); co-existing disorders (substance misuse and mental illness); anti-social personality traits. These presentations are having a negative impact on the availability of acute beds. At the time of the review, thirty (30) people presenting with high and complex needs were effectively living in the acute wards and were unable to be placed, or find placement, due to their complex needs.

Also, having an impact on the system are whaiora under the influence of methamphetamine. Anecdotally, they are the highest users of seclusion events, however usually with shorter admissions. It raises the issue of where whaiora can be safely managed while under the influence of methamphetamine in a clinically safe environment. These admissions place added pressure on staff due to the potential aggression and higher assault risk. This also results in additional staff being needed for the care and management of these whaiora.

The review team acknowledge there can never be a 'fool proof' procedure or policy in place for zero SAC events. In addition, the review team acknowledges that the unexpected death of a person that occurs during a hospital inpatient admission is a tragic event that causes immense distress to families, carers, and staff. There is currently training on the Ko Awatea learn platform for staff;[49] this needs to be well socialised.

This is especially so where the person has died by suicide. Recognising that these events can impact on health professionals, it is vital that they have a clear understanding of the incident review process.

**Recommendations**

75. Establish and develop a form for whānau to co-sign to hold a level of accountability in regards to whaiora leave
76. Make a therapeutic programme for tangata whaiora (currently in the development stages) a priority
77. Ensure the community and crisis teams advise tangata whaiora of the smoke free and leave procedures. Smoking cessation can start in the community
78. Ensure a clear algorithm is set and socialised to all staff regarding the process of the incident review. Recognising that Serious and Sentinel events impact on health professionals, an on-line tool has been developed to support health practitioners through those difficult times. This is accessible via Ko Awatea LEARN platform.

[49] Ko Awatea LEARN is a health sector focused eLearning and education community with a wide range of programmes, courses, and community forums.

**Reference Material**

- Leave-Adult Mental health inpatient Wards Doc 2184 v06, 21 May 2020
    - Monitoring record
    - Leave management guide
- Leave-Puawai Inpatient wards, Doc 6266 v01, 21 May 2020
    - Approved leave form
    - Patient profile form + photograph
    - Approved leaves special and non-special patients
- Informal tangata Whaiora-Client information
- AWOL Procedure, Doc 3555 v06, date 12 Dec 2019
    - Flow charts
    - Risk Management-Missing Persons AWOL
- Missing Patient Incidents reported in DATIX for MH&A services 1/01/20-28/09/20
- 2015 Section 99 review (Dr John Crawshaw; Ministry of Health)
- Leave management plan

**Terms of Reference (vi)** ***Review communication protocols and procedures in respect of 'tangata whaiora', family and whānau on admission, during assessment and treatment, at discharge and in any adverse incident within the Waikato DHB Provider arm .***

It is acknowledged that there are a number of communication protocols and policies that guide engagement between tangata whaiora, whanau and staff. These provide high level guiding principles. However, there was little evidence that these principles had been adapted into ward procedures. Further, although audit mechanisms have been built into MH&A services protocols and policies, it is not clear whether these audit tools had been utilised effectively. This review relied on anecdotal evidence to establish whether the communication protocols and procedures where being implemented and, if so, whether they were successful.

Whaiora, whānau and staff services and the mental health & addiction sector recognise that currently the best possible care and support for whaiora, whanau and family is not yet provided.

The documents to support effective communication and engagement with whaiora and whānau are in place. However, according to the people and services who contributed feedback, there are still major gaps between the vision and the reality.

**Background**

Whaiora and whānau, being active partners in people's journey with mental health and/or addictions, are widely acknowledged as essential to providing person-centred care in MHA&A services. Whānau inclusion in educational and therapeutic interventions can improve outcomes for whaiora, with aspects of medication compliance and throughout the duration of inpatient stays (Wonders, Honey & Hancock, 2019). Working alongside whaiora and their whānau towards recovery requires shared decision-making, collaborative communication and information sharing (Fukui, Mathias & Salyers, 2015). To ensure the quality of shared decision-making, there needs to be needs to be equitable attention paid not only to scientific evidence but also consumer preferences and values (Fukui, Mathias & Salyers, 2015).

**What are the communication protocols and procedures for 'whaiora', family and whānau on admission, assessment and treatment and discharge?**

Whaiora engagement is linked to providing people-centred care (Waikato DHB, 2015). Waikato DHB Mental Health and Addiction Services (MH&AS) recognises this with specific protocols for Tāngata Whaiora and Whānau participation. Underpinning the protocols and guidelines around communication with whaiora and whānau in the Waikato DHB is the strategic focus in particular of:

- Oranga
- Manaaki and

- Whanaketanga (Waikato DHB, 2016).

Oranga concerns a focus on health equity for high needs populations, whaiora and particularly Māori whaiora, who do not have equitable health outcomes when compared to the general population.
Manaaki, is about people-centred services and ensuring that care provided across all health services are respectful to individuals and whānau needs and values.

Whanaketanga is about productive partnerships in health, Waikato DHB incorporating Te Tiriti o Waitangi in everything they do, and authentic collaboration with all services and communities. Having this strategic document supports the need to ensure that whaiora and whānau are active partners in care.

In Waikato DHB, a framework for providing people-centred care has been established through a number of reports developed by, and for, Waikato DHB. These include *Me Kōrero Tātou: Let's Talk* and *Te Pae Tawhiti*. They are helpful in that they express the general principles that should be adhered to when engaging whaiora, and family and whānau during admission, assessment and treatment, and discharge, however there are specific policies developed to guide staff. These policies, developed by Waikato DHB, include:

- *Whānau Participation. Doc ID: 0896.06*;
- *Service user/Tangata Whaiora Participation. Doc ID: 1855.06;*
- *Family/Whānau Inclusive Practice. Doc ID: 5795.01;*
- *Use of seclusion in Mental Health and Addiction Inpatient Services. Doc ID: 1860;*
- *Visiting Adult Inpatient Mental Health wards. Doc ID 6267;*
- *Mental Health & Addictions Services, Integrated Care Pathway. Doc ID: 1703.*

These protocols outline the need for employees to "work inclusively" with whaiora and their whānau, ensuring that whaiora and whānau are active partners not only in their own treatment but also within service and organisational processes (Doc IDs: 0896, 1855, and 1703, 2019).

Waikato DHB MH&AS has a guideline for whānau inclusive practice which outlines how staff can ensure that whānau are included throughout their loved one's recovery journey (Doc ID: 5795, 2017). The policies also acknowledge that when working with whānau, through the incorporation of the Te Whare Tapa Wha framework enunciated by Dr Mason Durie, it is important to acknowledge the potential impact of mental illness on whānau (Doc ID: 5795, 2017).

Specific guidelines have been developed regarding the communication required throughout the seclusion process for both whaiora and whānau. It is stated that every effort should be made to provide the whaiora with information on what to expect within the seclusion room and how their basic needs can be met (Doc ID: 1860). Further, the decision to use seclusion must be discussed with the whaiora whānau as soon as practicable.

Contact with whānau/family can have significant positive impact on a whaiora's recovery. Therefore it is important to a service user's recovery that they continue to maintain contact with family / whānau and significant others (visitors) as their main support systems throughout their care, including during admission to an acute inpatient unit, and that users have reasonable access to a family / whānau / carer and visitors whilst in the inpatient unit (Doc ID: 6267).

As well as setting a clear expectation for staff regarding their behaviour towards tangata whaiora, it is stated that all staff working in the MH&AS are responsible for ensuring their practice is up to date with appropriate learning about working in partnership with service users / tangata whaiora; this includes, but is not limited to, attendance at regular education forums.(1855)

Waikato also has a DHB wide framework for consumer engagement which provides further backing to the MH&AS protocols. The framework was intended to ensure that consumer engagement was embedded in practice in way that was more systematic and effective, with the goal of improving consumer experience (Waikato DHB, 2015).

**Working? Why/why not?**

The documents are in place to support effective communication and engagement with whaiora and whānau. However, according to the people and services who contributed feedback, there are still major gaps between the vision and the reality.

Whaiora and whānau often feel unheard and excluded from decisions about their care and the treatment plan. There were 49 complaints made to MH&AS from October 2019 to September 2020; of those, 63% were related to communication in some way. Lack of clear and courteous communication were the most common reasons for the complaints, indicating a lack shared decision-making and working in active partnership with whaiora and whānau.

While the value of whaiora and whānau engagement and participation is recognised in protocols and strategic documents, staff and services need to be supported with working in active partnership. There have been mixed reviews through Real Time Feedback survey, which provides an overview of whaiora and whānau feedback for MHAS, as to whether this is occurring. Some respondents felt that people in adult inpatient services communicated with each other; (from October 2019 to September 2020) the average score out of five was 3.4 for whaiora and 4.3 for whānau. Twenty-seven people chose to comment; 41% of those comments were positive about MH&AS and 33% offered suggestions for improvement.

The differences in experience suggest that the protocols are not always being adhered to. It is not enough to have something written down without having adequate resourcing, education, training, peer and cultural workforce and self-care for all parties to back up what is written.

It has been widely accepted that advocacy and peer roles are recognised as being key to supporting whaiora and their whānau in the recovery journey (Stomski et.al., 2018). Despite this, consumer and whānau support/advocacy roles and services often continue to be excluded from the decision-making process and the value of these roles are not fully recognised. For the funding for adult mental health and addiction services within the provider arm there are 202.2 FTE, with 2 FTE (1%) of that directed to consumer and whānau leadership roles. In the funding for NGO adult mental health and addiction services there are 234.2 FTE with 13.6 FTE (6%) specifically directed to consumer services.

**Consumer services**

Within Waikato DHB rohe there are a few well established and experienced consumer services which provide support and advocacy for whaiora. Many of these services embrace the principles that Waikato DHB and its Mental Health service have expressed throughout their communication documentation, however are yet to be implemented. It is the application of these principles that is at the centre of peer-led services success; success that Waikato DHB could learn from.

Centre 401 located in the centre of Kirikiriroa/Hamilton, is a completely tangata whaiora owned and operated service. The ethos of Centre 401 is self-determination, self-help and recovery promotion; the staff at Centre 401 apply wisdom from their own learned experience to walk alongside whaiora in their recovery journey. Centre 401 have established 'He Roopu Manaakitanga', with the approval and support of the local iwi, Ngāti Māhanga. They recognise they are not a kaupapa service but do have responsibility to Te Tiriti o Waitangi and support their people in their push for 'mana motuhake' (self-determination).

'Stepping Out Hauraki' is another peer led service located in Thames that works across the Hauraki area. 'Stepping Out Hauraki's' aim is to support people to maintain mental wellbeing through peer support, resources, advocacy, referrals and education.

'Progress to Health' is based in Kirikiriroa and provides community-based support for people with long-term mental health conditions. There is a team dedicated to consumer resource and information services and 44% of staff identify as having lived experience of mental health and/or addictions.

'Te Runanga o Kirikiriroa Charitable Trust', a peer support services for adults, is an urban authority, acknowledges mana whenua and tangata whenua of the Kirikiriroa city area.

'Ngā Ringa Awhina o Hauora Trust', a kaupapa Māori organisation specialising in needs assessment and service coordination at a secondary mental health services level, resides in greater Hamilton area, and has 1.3 FTE specifically funded for consumer roles. There are 13.6 FTE funded by Strategy and Funding for consumer/peer support roles in community services.

**Recommendations: solutions suggested by those with lived experience**

79. Compassionate care starts at the start of the whaiora and whānau journey with mental health and addiction services. The way people are greeted and treated matters. All staff in the sector (including administration roles) must have education and training on effective communication skills, trauma informed care, and the recovery approach.
80. The Mental Health and Addiction sector needs to have, as a genuine foundation, the premise that tangata whaiora and whānau deserve to be active partners in care. Information and decisions should all be shared, and people should be supported to understand the information and decisions need to be made.
81. Effective communication is essential to the journey of tangata whaiora and whānau with mental health and addiction services, so the responsibilities outlined in protocols and strategic documents need to be aligned with accountability.
82. Align funding streams so that support can be tailored to tangata whaiora and whānau needs. Build connections rather than services working in silos and isolating people.
83. Mana motuhake for tangata whaiora and their whānau requires a multi-level focus on effective communication and active partnership, with:
    i. Appropriate and adequate resourcing of peer and cultural workforce
    ii. Tangata whaiora and whānau active in decision-making process about their care
    iii. Peer and whānau roles and services active in decision-making process about sector
    iv. Genuine co-design across the mental health and addiction sector, with whaiora and whānau at the very first step
    v. Tangata whaiora and whānau roles to coach and support staff on whaiora and whānau perspectives
    vi. Adequate resourcing for staff self-care.

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Wonders, L., Honey, A. & Hancock, N. (2019). Family inclusion in mental health service planning and delivery: consumers' perspectives. *Community Mental Health Journal,* 55: 318-330.


**Lived Experience/Whānau individuals & services represented (ie face to face meeting)**

Henry Rongomau Bennett Centre – met with tāngata whaiora

London St Community Mental Health – sat in reception area talked to tāngata whaiora and whānau
Centre 401 – peer led support provider
Evolve Peer Trust – peer led programme funded through MSD
Stepping Out Hauraki – peer led consumer resource & information provider
Progress to Health -consumer resource & information, activity & vocational support provider
MHAS Recovery Advisor Quality and Whānau Community Development Advisor

# Appendices

## Appendix 1 – Terms of Reference

### Waikato Mental Health and Addiction System Review 2020

The Waikato DHB MH&AS has been subject to media scrutiny in recent times and have been under increasing pressure from increasing demand and internal and external pressures. The 2018 Mental Health Inquiry of NZ also found that across the mental health system, the outcomes for Māori are worse than for the overall population. Health system deficiencies for the Māori population were further highlighted in the Stage One Wai 2575 report of findings in 2019.

Recent transformative changes (of MH&AS) locally, include progress on the development of a new model of care for service delivery to support the new acute adult MH facility and placing ownership of the MH&AS provider arm with the Executive Director Hospital and Community Services.

Given the expectations of the Waikato DHB under the NZ PH&D Act (2000), its commitment to 'Te Tiriti o Waitangi' and obligation to all stakeholders within the District, the Chief Executive and Executive of the DHB need to know that the population of Waikato can have confidence that the MH&A services that service our community are safe, effective, integrated in a seamless manner and are adequately resourced.

These services must be aligned to the Waikato DHB Strategic Priorities and Opportunities for improving in planning, structuring and delivering MHAS. This review provides us the opportunity to build on the previous valuable work undertaken in this area.

**TERMS OF REFERENCE**

**MENTAL HEALTH AND ADDICTIONS SYSTEMS REVIEW**

**Scope:**

A review of the current configuration of MH&A services in the Waikato District is required. An independent Review Team has been established to do this.

They will:

i) Review the configuration of MH&A services, what is purchased and whether that meets the District population needs, especially its Māori population;
ii) Review the approach to ensure that services are safe, effective, integrated in a seamless manner across the continuum of care and are adequately resourced, cognisant of both Māori and non-Māori communities and ongoing and persistent inequities that exist for Māori;
iii) Review the clinical governance structure across all MH&A services within District;
iv) Review the application of Mātauranga Māori & Te Ao Māori practices and approaches across the MH&A services;
v) Review leave protocols and procedures within the Waikato DHB Provider arm;
vi) Review communication protocols and procedures in respect of tangata whaiora, family and whānau on admission, during assessment and treatment.

**Methodology**

i) The review will be conducted in a culturally appropriate manner and in a way that is consistent with the principles of Te Tiriti o Waitangi as outlined in the Ministry of Health's, Māori Health Action Plan entitled, Whakamaua (2020-25).
ii) The review team will account and report to the Waikato DHB, Executive team via an appointed person.
iii) The review team will capture the range of perspectives across the system and consider available documentation necessary to meet the objectives of the review.
iv) In reviewing the system the panel should also consider the insights, intelligence and guidance provided within Te Pae Tawhiti, the Lets Talk Me Kōrero Tātou report and 2019, He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction and Tumu Whakarae Mental Health Inquiry Submission, 2018.

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| **Timeframe**<br><br>An independent draft report will be presented to the Chief Executive and Executive of the DHB, and key persons by mid-December, 2020. |
| **Name of Chairperson:**<br><br>Dr David Chaplow<br><br>**Advisor:**<br><br>Prof. Ron Paterson |
| **Independent Review Panel Members**<br><br>1. Dr. David Chaplow – Chair<br>2. Charles Joe, JP<br>3. Gail Goodfellow<br>4. Joanna Price<br>5. Sherida Davy<br>6. Sheryl Matenga, Mana Whenua Mana Rangatahi. Mana Whaanau<br>7. Wi Keelan<br>8. Dr Maria Baker |

Date: 20 November 2020

**Appendix 2 List of Interviewees**

The Review Team met with:

**Waikato DHB Senior Leadership:**

Te Pora Thompson-Evans, Chair, Iwi Maori Council
Riki Nia Nia, Executive Director Maori, Equity & Population Health
Tanya Maloney, Executive Director Strategy, Investment & Transformation
Leena Singh, Executive Director Hospital & Community Services
**Clinical Leadership**
Dr Graham Mills, Clinical Unit Lead, General Medicine
Dr David Graham, Clinical Unit Lead, Waikids/Paediatric Medicine

**Suicide Pre/Post-Vention Coordinator**

Clare Simcock

**Te Puna Oranga**

Kaitakawaenga
Janice Eketone, Director

**Waikato DHB, Mental Health and Addictions Services:**

Vicki Aitken, Services Director Mental Health and Addictions Services
Dr Rees Tapsell, Director of Clinical Services Mental Health and Addictions Services
Sue Critchley, Director
Rachael Aitchison, Director
Kylie Balzer, Operations Manager
Nicki Barlow, Operations Manager
Nicola Livingston, Operations Manager
Grant O'Brien, Project Manager
Carole Kennedy, Nurse Director
Virginia Endres, Team Leader Intelligence
Brendon Dolman, Recovery Advisor
Wheeti Maipi, Community Whanau Advisor

**Professional Groups:**

Senior Medical Officers
Psychologists,
Social Workers
Occupational Therapists
Community Team Leaders/Charge Nurse Managers
Inpatient Team Leaders/Charge Nurse Managers
Rehabilitation Team

**Specialist Services:**
Mental Health Services for Older People
Infant Child and Adolescent Mental Health Services
Forensic Mental Health Services
Community Alcohol and Drug Services
Adult Community Mental Health Services
Crisis Assessment and Homebased Treatment Services
Perinatal Mental Health Services
Primary Care Psychiatry

**Strategy, Investment & Transformation**

Tanya Maloney, Executive Director
Phil Grady, Director
Regan Webb, Director
Rachel Poaneki, Director
Gareth Fanning, Manager
Jolene Profitt, Manager
Alana Ewe-Snow, Manager
Francie Dibley Mason

**Enterprise Portfolio Office**
Chris Fisher, Director
Michelle Jones, Project Director

**Primary Care Liaison Team**

Mark Taylor
Bernadette Doube
Maree Munroe
Sheryl-Ann Wilson

**Iwi Maori Council**

Te Runanga o Kirikiriroa
Raukawa
Ngati Maniapoto
Pare Hauraki
Waikato Tainui

**Consumer Organisations**
Stepping Out
Evolve
Centre 401
Progress to Health
Individual tangata whaiora discussions.
Te Runanga o Kirikiriroa

**Associate Providers**
Hauora Waikato
Wise Group
Emerge Aotearoa
Te Kokiri Trust
Te Runanga o Kirikiriroa
Awhi Atua, Awhi Mai
K'aute Pasifica
Care NZ
Community Support House (Manning Street)
Youth Intact

**Other Groups/Meetings**

Te Roopu Tautoko Ki Waikato
MHAS Joint Leadership Group
Clinical Equity Leaders Group
Ara Poutama – Project Director, Waikeria Mental Health Services
Local Advisory Group (LAG)
Managed Isolation Facilities
Wai2575 Claimants/Maipi whanau
Primary Health Organisations (Pinnacle, Hauraki)

# Waikato DHB MHAS System Review 2020 - Mana Tangata: Achieving Equity in Health

# Recommendations for Te Ao Maori & Maatauranga Maori – Manuka Takatohia: Kawea

## Whakautu Roopu Maori

**December 12 2020** **wikepa keelan**

## Contents

## Purpose

The purpose of this document is to provide recommendations from the Te Ao Maori, and Matauranga Maori perspective as set out in the Terms of Reference (TOR) for this project (Terms of Reference WDHB 2020). Our task as Maori representatives of the review team was set after discussion with our colleagues and the chair. In so doing we agreed to provide an appropriate response to two areas:

- TOR ii: review the strategy to ensure services are safe, effective, integrated in a seamless manner across the "provider arm" and across the "community" and are adequately resourced, cognisant of both Maori and non-Maori communities and ongoing persistent inequities that exist, and

- TOR iv: Review the application of Matauranga Maori and Te Ao Maori practices and approaches across the Mental Health and Addiction services (MH&As).

## Introduction

The Waikato Mental Health and Addiction service (MH&As) has been the subject of media frenzy and scrutiny over recent years relative to perceived poor quality of care and treatment dispensed to whaiora and their whanau. Added to this has been increases in demand for services and back pressure emanating from issues involving capacity and flow and community confidence in the system. Further-more the persistent inequity of health outcome experienced by Maori whaiora and their whanau. All these problems have led to the appointment of the review panel which over the next two months have been set the task of fulfilling the Terms of Reference given it by the leadership of the District Health Board (DHB).

## Te Tiriti o Waitangi and Equity

The DHB itself in one of its documents, Te Pae Tawhiti The framework for Change (WDHB 2018 - 2030) identifies the principles of Partnership, Participation and Protection will underpin engagement with Maori to develop Maori responsiveness. The writer notes that the DHB version of Te Tiriti o Waitangi is outdated and a recommendation will be made to update to the Ministry of Health's new Treaty Framework as set out in Whakamaua: Maori Health Action Plan 2020 – 2025 (MOH 2020) that sets the Government's directions to improving health outcome and inequity for Maori over the next five years. We have comprehensively outlined the new Treaty Framework below to clearly outline the changes for the purpose of the review. Also contained in the Maori Health Action Plan are the advances by the Waitangi Tribunal in 2019 to the Treaty principles (Wai 2575 2019). All this information is contained in this section of the document.

The vision of iwi Maori is that the Treaty of Waitangi will be embedded and enacted in all systems of the DHB. In so doing it will guide everyone's way to working together in a safe, culturally competent and equitable health and disability service environment. This means stronger partnership and sharing with iwi Maori upholding the Articles of Te Tiriti o Waitangi as identified in the new Treaty Framework of MOH:

- Article one Governance: Mana Whakahaere: How the DHB (government) exercises effective and appropriate stewardship over the health and disability system for all
- Article two: Mana motuhake: enabling Maori to be Maori and exercise authority over their own lives (inclusive health services) according to their needs, values, and traditions
- Article three Mana tangata: Achieving equity in health and disability system outcomes for Maori contributing to Maori wellness
- Article four: Mana Maori: Enabling Maori access (to health services) which are framed by Te Ao Maori, enacted through tikanga and encapsulated with Matauranga Maori (IBID 2020)

The principles of Te Tiriti o Waitangi as articulated by the courts and the Waitangi Tribunal provide a framework for how the Crown through the DHBs meet their obligations under the Treaty in our day to day work. From the Waitangi Tribunal Inquiry into the primary health care system, the 2019 Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry held in Wellington recommended changes to the principles now applicable to the wider Health and Disability system:

- Tino Rangatiratanga (provides for Maori self-determination and Mana Motuhake in design, delivery and monitoring of their H&D services)
- Equity (requires the DHB to commit to achieving equitable health outcomes for Maori)
- Active protection (fully requires the DHB to act to achieve equitable health outcomes for Maori. That it's Treaty partner the Iwi Maori Council are well informed to the extent, the nature and efforts to achieve Maori health equity)

- Options ( requires the DHB to properly resource Kaupapa Maori H&D service delivery. Furthermore, the DHB is obliged to ensure that all H&D services are provided in a culturally appropriate way that recognises and supports the expression of hauora Maori models of care)
- Partnership (requires the DHB and Maori to work in partnership in the governance, design, delivery and monitoring of the H&D services. Maori must co-design with the DHB, of the health system for Maori (Wai 2575 2019)

## Background

This review is taking place against a background of research that shows Waikato District Health Board (WDHB) has one of the largest proportional Maori populations at 23% (89,861) of the total population and that over the next 15 years the Maori population will rise to 30% (117,210) of the total population. This means that WDHB will need to take a more than piece meal approach to future service development with respect to Maori whaiora and their whanau who are disproportionately high users of the MH&A system. This has been highlighted in the Needs Assessment of Mental Health and Addiction Service Utilisation carried out in 2017 by WDHB which showed significant health inequities for Maori across the MH&A system some related to co-morbid physical conditions which lead to shorter lives. (WDHB 2017)

The quality of MH&A services at WDHB is impaired by pressures on inpatient and community services and other factors. The available occupancy rate data clearly shows occupancy rates beyond their capacity, add to this the apparently limited availability of community services, such as suitable community crisis and community treatment teams and rehabilitation programmes or accommodation to discharge people and you begin to appreciate the size of the problem. There is also the issue of what to do for people whose needs are so complex that none of the range of existing programmes can care for them outside the hospital, mainly young Maori men aged 18 to 35 years. And now, factor in the Maori complexities brought by the lack of culturally competent MH&A services in an area where the Maori population who are high users is of MH&A services is increasing. These are some of the difficulties for this DHB going forward. One thing is certain! The same old will not do! Reliance on clinical services approaches alone will not heal the system for Maori. This view is supported by Whanau ora Commissioning Agencies that the new direction is toward local solutions – that empowering whanau to find solutions for themselves is the right approach (Whanau Ora Commission 2019).

There are two developments on the horizon that may alleviate pressure. The first is a new build adult acute inpatient area at Waikato hospital, the second is the establishment of 100 new mental health beds at Waikeria prison (Waikeria Prison Development 2020) . However, people interviewed by the review criticised the lack of connectedness and coherence of these developments, that although they welcome the new investment in MH&A in the region they believe its success will be short-lived because part of the sector really requiring investment, the community, has been largely neglected. Others commented the planned treatment of mental health patients in prison flies in the face of past reviews, the Gallen Inquiry (1983) and the Mason Report (1988). Both strongly opposed building prison hospitals for psychiatric patients. There are no plans to imminently invest in the community mental health services of the DHB. People who work in those services told about resources being taken as were recently kaitakawaenga from ICAMHs, or positions much needed placed on hold by the administration negatively affecting capacity and flow of whaiora through the whole MH&A system.

A new commissioning approach is needed similar to that employed by the Whanau ora Commissioning agencies aimed at community development, strengthening whanau and incorporating Matauranga Maori service approaches. We heard that the conventional funding model used by the DHB in the MH&A area is preventing maximising health outcome for whaiora and their whanau. Furthermore, the model cannot address the impact of social determinants that create pressure within whanau thereby increasing their susceptibility to ill health. The need for a new commissioning approach based on shared outcome has been discussed widely by Maori nationally however main-stream health services, it seems, prefer the status quo. The need for change was made clear to WDHB during Me Korero Tatou consultations.

To give credit where it is due WDHB has over the past two years, embarked on a community development approach involving Iwi Maori (Me Korero Tatou 2018) and those consultations have been the initiative for commissioning - small at this stage, but exciting possibilities and partnerships with Iwi Maori primary health providers. Six small contracts commissioned to provide Matauranga Maori modelled services in their communities, close to their homes thereby enabling them access to a wider range of primary and community cultural interventions to enhance the work of clinicians. Maori believe this holistic approach to be the way forward.

The Report of the Mental Health Inquiry (He Ara Oranga 2018) found a striking degree of consensus on the need for a new direction in mental health and addiction services: one that gave greater emphasis to community development, including a larger focus on prevention and involving people and communities in designing and transforming the system, providing expanded access and increased choice of services, strengthening whanau and community based responses. These are similar to directional changes asked for by Maori of the MH&A service both nationally and locally as reflected in the views

and ideas given by the Waikato community to the DHB during recent consultation to guide new directions and improve their MHSs. These themes included:

- More support, education and involvement of whanau and more rapid response to their needs
- Whanau ora as a model of care for the Mental Health Service
- Access to alternative treatments to medication and alongside medication .e.g. ( Rongoa Maori, Talk therapies)
- People who listen, show respect and treat whaiora and whanau with care
- Improved access to crisis care, local solutions for people in crisis while waiting for the community assessment team
- More local solutions including local respite, local points of entry, to services and local follow up
- Better integrated care
- Addressing transport issues in rural communities
- Provide support for rural GPs ( Me Korero Tatou DHB Report on Community Consultation including Iwi Maori 2019)

**The Journey so Far**

The review team has agreed to a Treaty approach to the model we are applying in compiling the recommendations for the review. This has enabled the development of the following recommendations for TOR ii and TOR iv that are contained in a framework and divided into two rows: Whaikupu (Recommendation) and Putanga Matua (Key Finding). The explanation of the recommendation column is self-explanatory as is the Key Finding where we considered the need to reasonably explain the why of what was required for each recommendation. This would be important when the information from this document is transferred to the larger overall review document(s) Maori and non-Maori.

The process undertaken to identify these recommendations follows the casting of the Maori equity lens over the organisational structure beginning at Corporate Governance and Leadership cascading into necessary recommendations for Te Puna Oranga that supplies kaitakawaenga and kaitaiaki cultural workers into parts of the organisation and on into the MH&A provider services and the Planning Funding service, to look at commissioning arrangements for achieving Treaty benefits including equity. In each of these arenas care processes and practice have been examined incorporating the use of the equity lens and relevant recommendations have been made.

## Corporate

| Whaikupu: Recommendation | Putanga Matua: Key Finding |
|---|---|
| ***Governance and Leadership*** | |
| 1.<br>That overall accountability for implementing the governance and leadership section recommendations will be the Executive Director Maori Health Equity and Public Health. | That Maori leadership and genuine Iwi Maori partnership for developing Matauranga Maori and Te Ao Maori approaches across the DHB is required to reduce inequity and increase Maori health outcome<br><br>That conscious and unconscious bias and confusion and ambiguity are creating barriers to agreement and implementation of a MH&A wide Matauranga Maori service model |

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| ***Te Tiriti o Waitangi*** | |
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| 2.<br>That a review and update Te Tiriti o Waitangi (TOW) in the DHB be carried out to reflect the Ministry of Health's new Treaty of Waitangi framework | The DHB requires to upgrade to the new Treaty of Waitangi Framework recently published by the Ministry of Health in Whakamaua, the Maori Health Action Plan 2020-2025 (MOH 2020) |

| ***Memorandum of Understanding (MOU) between the Iwi Maori Council and DHB*** | |
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| 3.<br>That the MOU agreed between the DHB and Iwi Maori Council 2017 is reviewed and updated to the new Treaty of Waitangi Framework | The DHB and IMC MOU requires upgrading to reflect the new Treaty of Waitangi Framework, including the Waitangi Tribunal's recent review of the Treaty principles. |
| 4.<br>That the training education programme for governance and leadership groups is informed with respect to the new Treaty of Waitangi framework | Commitment of the DHB is required embedding and enacting the new MOH principles and articles of the Treaty of Waitangi in the new MOU |
| 5.<br>That the DHB commit to the development of visible and genuine partnership arrangements for achieving health equity for Iwi and whanau in the governance programme of the DHB | |
| 6.<br>That the DHB provide secretariat and other resources as necessary to IMC that they may operate effectively and carry out their responsibilities as the Iwi partner to the DHB as set out by Te Tiriti o Waitangi | |

## Te Puna Oranga Maori Service

| *Whaikupu: Recommendation* | *Putanga Matua: Key Finding* |
|---|---|
| ***Te Puna Oranga/Kaitakawaenga*** | |
| 7.<br>That an evaluation is conducted with respect to the deployment of all kaitiaki and kaitakawaenga staff from Te Puna Oranga into frontline health and disability services of the DHB and determine if the current modus operandi is the most effective and efficient use of this valuable resource | Currently there are seven kaitakawaenga providing cultural services to whaiora and their whanau. They are not able to meet the cultural requirements of all of the M&A service. They are employed Monday – Friday 9 am – 5pm . According to MH&A data the majority of Maori are admitted to the MH&A service after hours and those people cannot access cultural care on entry to the MH&A service<br><br>Equity gaps exist in the MH&A service relative to the cultural competence of staff. In order to assess what is required to improve health outcome for Maori an evaluation of the resources is needed |
| 8.<br>That an evaluation is carried out of the MH&A services requirements of the Kaitakawaenga and determine the level of resource required to provide an effective and culturally competent Matauranga Maori service to whaiora and whanau of the district | There is a need to quantify the number of Kaitakawaenga required to deliver an effective and competent service for Maori consumers and their whanau across the MH&A service. |
| ***Maori Health Outcome Framework*** | |
| 9.<br>That resource is made available for designing and implementing a Maori Health Outcomes Framework such as Hua Oranga (HO) in the MHA service to enable improved measurement of how Maori whaiora and whanau experience the service from their own cultural perspective | There is no health outcome measurement tool available in the MH&A service to adequately evaluate how Maori whaiora and their whanau experience care from their own cultural perspective. Hua Oranga A Maori measure of mental health outcome – Kingi and Durie Massey University School of Maori Studies – Te Pu Manawa Hauora Palmerston North.<br><br>The measurement of Matauranga Maori based aspects of the MH&A service for improving equity and Maori health outcome are inaccessible using existing conventional outcome measurement data sources<br><br>Data collected from the Maori Health Outcome Framework can better inform the development of more effective and equitable MHA service and imp[rove the quality of care for whaiora and their whanau. (file:///:/Users/Kahu/Download/ORA DATA BASE MANUAL 20.03-2014%20(3).pdf. |

## The Mental Health and Addiction Provider Services

| Whaikupu: Recommendation | Putanga Matua: Key Findings |
|---|---|
| ***Te Ao Maori approach and Matauranga Maori service model*** | |
| 10.<br>That a Matauranga Maori service model based on Te Ao Maori healing practices and approaches is agreed and implemented across the MH&A service at WDHB<br><br>11<br>That accountability for implementing the Te Ao Maori approach and Matauranga service model will be the Directors Maori Health and Mental Health and Addiction<br><br>12.<br>That whanau participation in the care of their loved one is one of the basic tenets of care and treatment for Maori whaiora in the MH&A service | There is no agreed Matauranga Maori model or agreed Te Ao Maori healing practice and approach consistently employed across the MH&A service<br><br>Matauranga Maori approaches and Te Ao Maori traditional healing practice, including the use of rongoa as effective interventions for Maori whaiora and their whanau are effective in reducing inequity and improving health outcome (Bpac.org.nz, Practical Solutions for Improving Maori Health, 2008) ( Me Korero Tatou DHB Report on Community Consultation including Iwi Maori 2019)<br><br>Effective Matauranga Maori cultural intervention programmes can reduce inequity and increase health outcome for Maori in the MHA services (Inquiry into Maori health inequities-Whanau ora Commissioning Agency 28 August 2019 https//www.whanauora.nz/) |
| 13.<br>That a training and education programme is provided to frontline staff and MH&A service operational managers on the Matauranga Maori Framework and the new Treaty of Waitangi framework and principles | MH&A workforce requires to improve cultural safety and competency for meeting the needs and aspirations of Maori whaiora and their whanau<br><br>MH&A service needs to reflect on how being a good Treaty partner impacts on the roles of people who work in MH&A services and improves health outcome for Maori people who use the MH&A services |
| ***Clinical Governance*** | |
| 14.<br>That the governance group is expanded to overview the MH&A system, including primary mental health and NGO services to provide an environment where the system for treatment and care is monitored, safe, effective and delivered by a competent workforce.<br><br>15.<br>That as well as clinical skills the governance group will contain the necessary expertise to enable access to Matauranga Maori approaches and | No one group has a joined-up view of capacity and flow throughout MH&A service from community providers to primary providers and secondary providers or the opportunity to identify areas for improvement particularly for Maori who are disproportional users of the system<br><br>The governance group lacks the focus to bring together future strategies for primary care and inpatient care as requested by Iwi/ Maori of the region where the aim is prevention and education and strengthening whanau to care for their own in primary and community settings closer to their homes<br><br>Matauranga Maori and community experts interviewed about the governance group were unsure as to their (the governance group's) capacity or capability to design, plan and future proof the MH&A service for Maori |

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| broaden treatment options for Maori whaiora and their whanau. | The governance group does not have a whole of system view with up to date data and knowledge of service capacity and whaiora flow within the system. |
| ***Improving Service Transition*** | |
| 16.<br>That a review of MH&A service transitions be carried out for whaiora and their whanau who along with iwi Maori will be engaged as part of the review<br><br>17.<br>That a review be conducted on the effectiveness of discharge planning processes for whaiora and whanau and necessary improvements made to keep them safe | Service transitions are multiple and recognised as a risk to whaiora and their whanau and service providers. A significant number of whaiora are lost to follow up and are a failed transition<br><br>From 2017/18 DHBs have been monitored and required to report on discharge planning, 95% of people are required to have a discharge plan<br><br>International evidence shows when done well discharge planning brings together a persons health and broader social needs and enables those needs to be met (Report Office of Auditor General 2016) |
| ***Maximising Physical Health*** | |
| 18.<br>That key stakeholders including Maori and consumer representatives explore the need for initiating a review to assess the physical condition of whaiora Maori in the MHA service with chronic mental illness | WDHB's MHA Health Needs Assessment MHA Utilisation, 2017 identified significant health inequalities for people with mental illness. Additionally, the document highlighted mental illness and other morbidities disproportionately impacting Maori facing greater socioeconomic deprivation than non-Maori.<br><br>Many people who suffer with serious mental illness also suffer chronic physical health conditions and many live shorter lives The Office of the Auditor General IBID<br><br>The impact of mental illness or/ and physical health disproportionally impacts Maori people who face greater socio-economic deprivation |
| ***Improving Medication Management*** | |
| 19.<br>That a review of Maori whaiora prescribed clozapine, that has significant adverse reactions and increased risk of cardiac death, is carried out | That Guidelines concerning practice and administering of Clozapine are available in the policies and procedures manual of the MH&A service<br><br>Literature concerning increased health risk and adverse reaction when prescribing clozapine are well known (BPac Clozapine: Safe Prescribing 2014),(Clozapine – Safe Prescribing – we are counting on you, Waitemata DHB 2017)<br><br>Researchers at Otago University tracked ethnic use of Clozapine and found that Increasing numbers of Maori and Pacific people are being prescribed clozapine. They found Maori are more likely to be prescribed clozapine than other people and the rate of prescribing is increasing (Otago University 2018)<br><br>When a group of MH&A physicians were questioned by members of the review about the use of atypical antipsychotics especially clozapine in relation to the need for regular |

| | |
|---|---|
| | monitoring, they responded…. "We do not think patients here (at the DHB) are being prescribed this medication." They did not sound certain therefore a recommendation has been made to review its use at the DHB in the MH&A service |
| ***Minimising Restraint and seclusion*** | |
| 20.<br>That approaches employed to prevent and reduce seclusion use are reviewed including: the use of equity lens approaches, recovery, trauma informed care, the human rights approach, the public health prevention model and the use of Maori cultural interventions | Maori consumer inequity and experience of seclusion features very strongly in the data from both the HRBC and Puawai.<br><br>The reasons for high Maori frequency and duration in this service requires in depth exploration and analysis and questions asked as to whether we have tested all approaches and tools available to us to avoid admission to seclusion in the first place. |
| 21.<br>That regular training is provided to all frontline staff with respect to the latest evidence-based approaches for forensic care. | Frontline staff in MH and the forensic service need to be armed with the most up to date forms of evidence-based practice. |
| 22.<br>That the training programme should also include conscious/ structural bias and unconscious/ implicit bias. Lastly, the training to include korero about health equity and Te Tiriti o Waitangi and how these frames impact the roles of health workers and the well-being of Maori | The evidence is clear, to reduce Maori inequity and improve health outcome, cultural interventions are required to enhance clinical practice ( A window on the quality of Aotearoa New Zealand's health care 2019. He matapihi ki te kounga o nga manaakitanga a hauora – Health Quality & Safety Commission) |
| ***Use of the Mental Health Act on whaiora Maori*** | |
| 23.<br>Review the use of the Mental Health Act 1992 with respect to Maori consumers receiving treatment at MHA services. | MHA service data shows that Maori are treated at a higher rate than non-Maori either under inpatient or community compulsory treatment orders. There is significant inequity between Maori and non-Maori |
| 24.<br>Staff are trained in the appropriate application of the Act, the use of equity instruments and can identify and deal effectively with issues that emanate from that perspective | Ensure the Act is applied appropriately and in a way that maintains the person's dignity, mana and safety<br><br>The workforce involved during the application of the Act are appropriately trained and supported acknowledging it can be traumatic for them, and for the person and their whanau |

## Planning and Funding Service

| *Whaikupu: Recommendation* | *Putanga Matua: Key Finding* |
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| ***Commit to Te Ao Maori service development and commissioning approaches*** | |
| 25.<br><br>That the accountability for planning and implementing these recommendations is shared between the Directors Maori and Planning Funding<br><br>26.<br>That the Planning and Funding (PF) service commit to service development that builds on Te Ao Maori approaches for Maori as outlined in the Report Me Korero Tatau – Let's Talk undertaken with the Waikato Tainui community including Iwi Maori | The Planning and Funding service needs to recognise the value of Matauranga Maori approaches and Te Ao Maori traditional healing practice, including the use of rongoa as effective interventions for Maori whaiora and their whanau |
| ***Strengthen Te Ao Maori approach and commissioning in the Planning and Funding Workforce*** | |
| 27.<br>That the PF team is strengthened with a person who has experience and knowledge of commissioning services that incorporate Te Ao Maori and Matauranga models and approaches | The evidence shows effective Matauranga Maori cultural interventions can reduce inequity for Maori in the MHA services |
| ***Improve Planning and Funding Clinical Governance*** | |
| 28.<br>That formal engagement is completed between the MHAS, Planning and Funding Service and clinical governance group for overall MHA system improvement | There is no formal relationship across the MH&A system to enable an over-view of capacity and flow and mitigate potential problems before they occur<br><br>There does not appear to be a clear understanding or over view of the MH&A system |

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| ***Resource and evaluate current and developing DHB/ Maori/ Iwi provider initiatives*** | |
| 29.<br>That resource is provided to evaluate current and developing DHB/ Maori/ Iwi provider partnership initiatives | Consultation with Iwi and Maori communities has resulted in whanau being very clear about the services they want close to home. These services are to be built on the following principles. They will:<br>• Strengthen whanau<br>• Build resilience<br>• Stop Suicide<br>• Access wellness influencers<br>• Recognise Maori Mana Motuhake<br>• Provide crisis resolution and<br>• build a well-being workforce |
| ***Invest in successful initiatives that contribute to Maori health equity*** | |
| 30.<br>That investment be provided to expand access and choice for whaiora and whanau to proven successful initiatives | There are currently six Iwi Maori innovations either completed or in development in partnership with the DHB.<br><br>Monitoring and rewarding successful innovation between the DHB and Iwi Maori providers and communities are an effective way of healing the Maori population of the Waikato Tainui district<br><br>Maori are over-represented at 44% of the people who use these services, particularly Alcohol, Drugs and Other Substances (WDHB's MHA Health Needs Assessment MHA Utilisation, 2017)<br><br>Health equity is a strategic Imperative for the DHB stated in its documents as: "a radical improvement in Maori Health outcomes by eliminating inequity for Maori" |

## Conclusion

Our brief for this document was to provide recommendations from the Te Ao Maori, and Matauranga Maori perspective for the review. In so doing we agreed to provide an appropriate response to two areas:

- TOR ii: review the strategy to ensure services are safe, effective, integrated in a seamless manner across the "provider arm" and across the "community" and are adequately resourced, cognisant of both Maori and non-Maori communities and ongoing persistent inequities that exist, and

- TOR iv: Review the application of Matauranga Maori and Te Ao Maori practices and approaches across the Mental Health and Addiction services (MH&As).

### *TOR ii Review of the Strategy*

From the TOR we focused particularly on two questions:

- Are services provided in a safe, effective and integrated manner across the "provider arm" and across the "community" and are they adequately resourced cognisant of the Maori community and persistent inequities that exist? And
- How are Matauranga Maori and Te Ao Maori practices applied across the MH&A system?

The information below captures the salient response to our questions which aimed at the provider and funding arm of the DHB which were subjected to health equity tool analysis. The following are

*Provider Arm*

In response to the first question the review found a number of areas of inequity particularly in the provider and funding arms of the DHB. In the provider arm these occurred in the following:

- The compulsory use of the Mental Health Act where Maori whaiora were two times more likely than Europeans to be placed under both Community Treatment Orders and one point 9 times more likely to be placed under Inpatient Treatment Orders
- The area of Medication Management was also given a recommendation particularly with respect to the prescribing and monitoring of the high risk adverse reactions atypical antipsychotic, clozapine and deaths internationally and nationally associated with this medication
- The area of whaiora Physical Health as identified by the DHB Needs Assessment of Mental Health services conducted during 2017 with respect to the ageing Maori mental health population affected by co-morbidities and shortened lives
- In the area of service transitions where a high number of whaiora Maori are lost to follow up and therefor a failed transition
- The High Needs and Complex group where Maori men aged 18 – 35 years were disproportionately represented. There is no specialist service to meet their needs
- Maori whaiora were disproportionally represented in the forensic and inpatient adult mental health services with limited access to kaitakawaenga cultural services
- Maori whaiora were disproportionally represented in the CAMHs with no identified Maori service to meet their cultural needs. This was similar for Maori whaiora in the ICAMHs.
- There is no agreed Matauranga Maori or Te Ao Maori model and approach across the MH&A service
- The existing Kaitakawaenga practioners number only seven and cannot extend their reach to all services of the MH&A service. Neither can the provide after-hours support, the time when most Maori enter the adult inpatient service
- There is no Maori Health Outcomes Framework to measure their experience of the MH&A service from their own cultural perspective. Existing conventional measurement tools are incapable of capturing culturally practices, rituals and relevant data.

*Funding Arm*

In the funding arm although recent consultation had occurred (Me Korero Tatou 2018) exploring the opinions and views of the Waikato community, including Maori, of their preference for MH&A services, very little investment or action had been taken with respect to changing commissioning practices aligned to those Maori views and preferences. In the funding arm inequity occurred in the following areas:

- Governance and management across the MH&A system where investment is required to establishing a single point or group to govern and monitor: fiscal, clinical, cultural and flow and capacity issues in real time thereby enabling better overview and use of the system
- The equity lens to be used over the funder commissioning system. Purchasing needs to reflect the realities of Maori health and what is required to shift whaiora and whanau from illness to wellness
- The PF team is strengthened with a person who has experience and knowledge of commissioning services that incorporate Te Ao Maori and Matauranga models and approaches
- Connection between provider, funder and associate providers (NGOs) to be improved and purchased as a single system (many providers; one system)
- That greater investment be provided to expand access and choice for whaiora and whanau to proven successful and culturally competent initiatives in the provider arm and the community including primary mental health

### *TOR iv Matauranga Maori and Te Ao Maori practice*

Question two related to the application of Matauranga Maori and Te Ao Maori practices. The review found that because access to kaitakawaenga cultural services are limited, it follows that the application of Matauranga Maori approaches are inconsistently performed across the MH&A system. Some parts of the service had no access at all thereby providing a poor quality of service to whaiora and their whanau. Furthermore, there is not a system wide and agreed Matauranga Maori service model. Recommendations have been made to improve this situation.

In view of our findings we concluded the MH&A services are not provided in an effective and integrated manner across the provider arm or across the community for Maori whaiora and their whanau. We also agreed that funding is required cognisant of their needs to reduce inequity and improve health outcome.

Our findings were similar for the funding arm of the DHB where small steps in terms of recently commissioned partnerships with Iwi Maori health providers have been made in the right direction, but more investment is needed if positive impact is to be made on the persistent poor quality of MH&A service currently experienced by Maori in the Tainui Waikato area.

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## Appendix 4 MH&A Systems Review Recommendations

| Terms of Reference (i): Review the configuration of Mental Health and Addictions Services (MH&AS), what is purchased and whether that meets the District population needs, especially its Māori population | | |
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| 1. | Operational planning needs completion and planned actions need to be implemented. It is important for whaiora, whānau, mainstream and iwi to have time-framed, incremental pathways to realise the issues expressed as important to them in documents such as 'Me Kōrero Tātou'. | |
| 2. | S&F consider utilising the expertise of provider arm clinicians to explore ways or working and supporting the transition of high and complex whaiora out of the inpatient services into a community service "home for life". | |
| 3. | Whaiora transition plans be developed with both Provider Arm and ACP's/NGOs that is agreed and implemented incrementally (over many months) to allow the whaiora to adapt to the new environment successfully. This will require a package of care funding envelope. | |
| 4. | Clinicians support ACP's staff to implement behavioural management plans for whaiora, provide oversight, mentoring and supervision to enable staff expertise working with this cohort to grow and develop positively. | |
| 5. | Strategy and Funding consider funding a provider that has expertise delivering high and complex services. | |
| 6. | That regular, open and transparent, quarterly meetings occur between the Provider Arm manager and S&F for the purpose of reporting against the PVS. The process would also be an opportunity for the provider arm management to highlight key achievements e.g. therapeutic "leave" management recently instigated in the inpatient services (reduction in absence without leave- AWOL) and the numerous quality initiatives of merit that were being achieved. | |
| 7. | Any reconfiguration of FTE be agreed with S&F with a relevant rationale to share and mitigate risk. | |

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| 8. | New service development must include S&F and not be undertaken in a "vacuum". | |
| 9. | The DHB involve clinicians to a greater degree in service planning | |
| 10. | Strategy and Funding assist Provider Arm Clinical Leads by supporting co-location opportunities with MH&AS NGO/ACPs (supportive letter to all providers identifying what the Clinical Leads were attempting to achieve) particularly in the smaller urban areas and rural communities for closer to home responsive services. | |
| 11. | ACPs be provided with a template to input their mission, vision and model of care for service delivery along with service expectations and relevant monitoring in the Provider Specifics Terms of Conditions section of the funded agreement and this be included in the new agreements. | |
| 12. | Utilise the use of flexibility clauses to support whaiora costs e.g. clothing to attend an interview for a job; respite placement. A schedule of the rationale and flexibility spend would need to be sent to S&F by ACPs as agreed, for monitoring within a flexibility (variable) funding envelope for each provider. | |
| 13. | Review all pricing across the MH&AS sector and agree pricing standards (price by unit) e.g. clinical FTE rates; non-clinical rates; bed rates etc. | |
| 14. | Agreed pricing rates are transparently shared by S&F with providers to minimise competition and enable trust to grow in the sector | |
| 15. | All MH&AS provider service specification by FTE, Bed Day, Programmes are listed on a template and all providers have access to the information. This approach allows staff to identify who provides what service across the system. | |
| 16. | Longer term funded agreements be renewed every three years to ease payment processes and improve budget efficiencies. This will also reduce demand on staff at the WDHB and MOH managing ad-hoc payments and follow up payments on behalf of providers. | |
| 17. | Move to PRIMHD reporting for all providers across the sector moving away from Performance Monitoring Reports | |

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| 18. | Consider a similar accountability reporting framework that is aligned to monthly provider arm reporting to identify value for money and emerging risk analysis. | |
| 19. | Reconsider Wash Up management as an exception not a rule. However Relationship Managers will need to have regular (four times a years) face to face meetings with NGO/ACPs staff to ensure transparent open communication is ongoing to mitigate relevant risks and implement wash up as required. | |
| 20. | Audit schedules are provided annually and communicated to all providers. This will reduce the miscommunication across the sector regarding audit activity. | |
| 21. | Issues Based Audits (IBA) are utilised more often by S&F. | |
| 22. | S&F seek solutions of support for providers who face challenges e.g. utilising other provider support of staff. | |
| 23. | Consider including mandatory the Governance Social Sector Accreditation Standard (SSAS) in routine audits and IBA's as a more comprehensive criterion for audit. | |
| 24. | That feedback is provided to all providers at the conclusion of an RFP process to clarify learnings. | |
| 25. | EPO activities are profiled and relevant outcome updates are posted on the WDHB Facebook page and communicated by the Relationship Manager to the MH&AS sector | |
| 26. | RFP processes and outcomes are managed transparently and lawfully. | |
| 27. | Specify provider MH&AS models of care and whaiora outcomes on WDHB Facebook pages on a monthly basis where health outcomes/gains have been identified (provider arm and ACPs). | |
| 28. | Profile all evaluation of service activity on Facebook too to enable providers to learn from each other to facilitate replication of cost effective treatments and wellbeing outcomes | |
| 29. | Each month profile a service (Provider Arm and ACP) the team, what they do and how they work. With consent, ask whaiora who are willing to share their stories of hope on Facebook/social media. | |

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| 30. | As a public funded sector, set up a portal for all MH&AS providers or alternatively utilise the WDHB Facebook page to include all related planning, funding and service development being undertaken. | |
| 31. | Provide a schedule of services by PUC and provider to all funded services including provider arm staff via email or hardcopy and update this annually. | |
| **Terms of Reference (ii) Review the approach to ensure that services are safe, effective, integrated in a seamless manner across the continuum of care and are adequately resourced, cognisant of both Māori and non-Māori communities and ongoing and persistent inequities that exist for Māori** | | |
| 32. | Operational/commissioning planning needs completion. This will be important for Whaiora and iwi to have a time framed, incremental pathway to realise the issues expressed important to them in documents such as 'Me Kōrero Tātou'. | |
| 33. | To explore common criteria of service governance across the entire MHAS spectrum | |
| 34. | To explore a framework of 'management' over the entire spectrum of services | |
| 35. | S&F and the MH&SA explore ways whereby S&F can retain independence while funding for service integration. Likewise, S&F portfolio managers to avail themselves of the opportunity to be part of sector governance. | |
| 36. | MH&AS leadership explore ways with the community service providers to mutually support services and whaiora when needed | |
| 37. | Concerted effort to build on the two PT liaison specialists with GPs with improved integration and perhaps mentoring with common governance explored for those dealing with whaiora. | |
| 38. | With urgency, subacute beds to be contracted in the community connected (by planning, contracting and by governance) to the inpatient and forensic units) | |
| 39. | Capacity must be created by creating flexibility in the acute adult MH inpatient services. This may occur in two ways | |

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| | i. Ability to decant to a supported community service with clinical capability<br><br>ii. Dealing with the 'high and complex' whaiora. | |
| 40. | Creation of a small specialist unit dealing with the H&C Whaiora. This would necessitate the involvement of specialist care experienced in dealing with risk, rehabilitation and interagency involvement. | |
| 41. | Immediate enlargement of the 'active transition team' dedicated to this small but significant group of whaiora with 'high and complex' needs | |
| 42. | Early interagency involvement in the assessment and triage of whaiora in crisis; a 'Whānau Ora' type model (noting that the majority of whaiora who present in crisis with social needs need assistance other than inpatient admission) | |
| 43. | There needs to be an insistence on 'diagnostic formulation' and a one transferable 'management plan'. Note aka recovery or wellness plan | |
| 44. | Careful discharge planning, involving the triangulation of Whaiora, Whanau and clinician needs to occur with commensurate managed followup | |
| 45. | Convene a meeting with the psychology leader in order to discuss, clarify and remedy these concerns | |
| 46. | That decentralisation occurs with a move to 'health and clinical' hubs at designated centres. | |
| 47. | That with the change in configuration and modelling, clinician access to NGOs is considered | |
| 48. | Seriously reconsider capacity building (beds) in the light of the increasing population | |
| 49. | Provide kaitakawaenga cover to the MHSOP | |
| 50. | Accelerate the implementation of the proposals enunciated in the 2018 report, which was to reconfigure the ICAMHS services to deal with crisis work more effectively. | |

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| 51. | Rather than only refer to psychology services, initially utilise other therapeutic modalities in the first instance (e.g., training parents, use other trained disciplines, ration the psychology sessions and review) | |
| 52. | Utilise the 'Psychology Centre' (by contracting from the DHB). | |
| 53. | In the Central cluster, remodel 'assessment and triage' as distinct from dealing with 'crisis' (I.e., develop two teams with different functions). | |
| 54. | Provide a 'dedicated crisis clinical pathway' including a Waikato DHB or Midlands Regional solution | |
| 55. | Pasifica need to be connected with other community services and be able to access secondary mental health advice more easily. | |
| 56. | That specific time-framed plans be developed with enunciated goals, respective responsibilities and accountabilities and support with each of the hub developments | |
| 57. | There needs to be a clinical, governance framework across all related community AOD services. | |
| 58. | Contracts need to be more systemic and flexible | |
| 59. | There needs to be more clarity what contracts are held by respective providers in the community | |
| 60. | Peer Support and kaitakawaenga are vital in AOD services and should be contracted | |
| 61. | 'Navigation FTEs' would be helpful to those who have co-morbid social presentations | |
| 62. | Support the establishment of the Drug Court and monitor and evaluate its impact | |
| 63. | As 60-80% of referrals are from Courts and Corrections, greater cooperation and clarity is needed in regard to coordination, and shared responsibility | |
| 64. | Convene a hui between providers, IMC and S&F to clarify and address the above concerns. | |

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| **Terms of Reference (iii) Review the clinical governance structure across all MH&A services within District** | | |
| 65. | That a framework of governance be instituted across the provider arm/community divide to all contracted services, according to their respective speciality | |
| 66. | That the S&F together with IMC and provider arm leadership consider the continued viability of the 'Oversight Group', its function, size and composition and support. | |
| **Terms of Reference (iv) Review the application of Mātauranga Māori and Te Ao Māori practices and approaches across the MH&A services** | | |
| 67. | Establish a co-designed Te Ao Māori Advisory Committee (TAMAC) to strategize, plan, receive and provide monthly reports on the achievements, outcomes of Māori Health gains against a Māori Health Strategy Work Plan. | |
| 68. | Te Puna Oranga to hold an internal review of its capability and capacity to fulfil its obligations to incorporate Te Ao Māori worldviews into the wide range of DHB clinical and business activities. | |
| 69. | Reconsider the necessity and function of the 'Oversight Group'; possibly into a newly constituted 'DHB and Associate Service Providers Forum' for the clinical-management partnership of the whole MHAS sector system. | |
| 70. | Implement Me Korero Tatou with specific, conjoint, time-framed planning with respective Iwi with the aim leading to Mana Motuhake; | |
| 71. | To ensure a training and ongoing education programmes are provided to frontline staff and MHA service operational managers on the Matauranga Māori Framework and the new Treaty of Waitangi framework and principles as well as good clinical practice; | |
| 72. | That an evaluation is carried out of the MH&A services requirements of the kaitakawaenga and determine the level of resource required to provide an effective and culturally competent Matauranga Māori service to whaiora and whānau of the district, both 'provider' arm and community services; | |

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| 73. | Encourage the implementation of a Māori Health Outcomes Framework (such as Hua Oranga) in the MHA service to enable improved measurement of how Māori whaiora and whānau experience the service from their own cultural perspective; | |
| 74. | Co-design across the mental health and addiction sector of implementation plans, with whaiora and whānau at the very outset. | |
| **Terms of Reference (v) Review leave protocols and procedures within the Waikato DHB Provider arm** | | |
| 75. | To establish and develop a form for whānau to co-sign to hold a level of accountability in regards to whai ora leave | |
| 76. | Make a therapeutic programme (noted that it is in the development stages) for tangata whaiora a priority | |
| 77. | Ensure the community and crisis teams advise tangata whaiora of the smoke free and leave procedures. Smoking cessation can start in the community | |
| 78. | Ensure a clear algorithm is set and socialised to all staff regarding the process of the incident review. Recognising that Serious and Sentinel events impact on health professionals, an on-line tool has been developed to support health practitioners through those difficult times. This is accessible via Ko Awatea learn platform. | |
| **Terms of Reference (vi) Review communication protocols and procedures in respect of 'tangata whaiora', family and whānau on admission, during assessment and treatment, at discharge and in any adverse incident within the Waikato DHB Provider arm.** | | |
| 79. | Compassionate care starts at the start of whaiora and whānau journey with mental health and addiction services. The way people are greeted and treated matters. All staff in the sector (including administration roles) must have education and training on effective communication skills, trauma informed care, and the recovery approach. | |
| 80. | Mental health and addiction sector needs to have, as a genuine foundation, the premise that tangata whaiora and whānau deserve to be active partners in care. Information and decisions should all be shared, and people should be supported to understand the information and decisions need to be made. | |

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| 81. | Effective communication is essential to tangata whaiora and whānau journey with mental health and addiction services, so the responsibilities outlined in protocols and strategic documents needs to be aligned with accountability. | |
| 82. | Aligned funding streams so that support can be tailored to tangata whaiora and whānau needs. Building connections rather than services working in silos and isolating people. | |
| 83. | Mana motuhake for tangata whaiora and their whānau requires a multi-level focus on effective communication and active partnership. | |