SYNERGIA

TIME FOR CHANGE

Te Hurihanga

A review of the mental health and addiction system

Commissioned by Southern District Health Board

June 2021

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Contents

ACKNOWLEDGEMENTS

Synergia would like to thank the people of the Southern region and key sector stakeholders for sharing their stories, expertise and insights to support this review. A broad range of stakeholders have generously given their time to support this work, and their willingness to be involved illustrates the importance of the issues being explored. It is clear there is a genuine desire to continue to improve outcomes for people with mental health and addiction needs.

We would particularly like to acknowledge the insights we gained from our partnership with Māori throughout the review and the input of people with lived experience and those families and whānau impacted by mental illness and addiction. Without this, we would not have had the grounded reality needed to focus our attention.

Synergia would also like to specifically recognise the leadership and guidance provided by the steering group throughout this review. Your insights into how to undertake the review as well as your support to make connections and link us to key stakeholders across the system was invaluable.

This has been a challenging review to undertake. The sheer volume of people who wanted to engage is testament to the desire for people to have their voices heard but has also been overwhelming at times. We know we haven't been able to engage with everyone but we genuinely hope this review will make a difference. While we want you to read it, interrogate it, discuss it and challenge it, above all, we hope you use this review to make change happen.

1. Te Tiriti o Waitangi

As the founding document of New Zealand, Te Tiriti o Waitangi must be acknowledged and its principles incorporated in all aspects of health services provision for all New Zealanders, and in particular for tangata whenua. The review team acknowledges the significance of Te Tiriti as the original statement for interactions between the Crown and tangata whenua.

1.1 Article one

Article one places an obligation on the Crown to consult and collaborate with iwi, hapu and Māori, as tangata whenua, in order to determine their attitudes and expectations with regard to the functions and operation of 'good government'.

With regard to the public funding and provision of mental health and addiction services, this requires meaningful consultation with Māori, and Māori involvement in the planning of those services.

1.2 Article two

Article two guarantees Māori rights of ownership, including non-material assets such as te reo Māori, Māori health and tikanga Māori, and confirms the authority of iwi, hapu and Māori, as tangata whenua, over their own property, assets, and resources. Article Two establishes the principle of tino rangatiratanga – self-determination and jurisdiction for Māori communities and organisations – such that they can manage their own property, assets and resources. This article directs agents of the Crown to negotiate directly with iwi, hapu and whānau with regard to policy which impacts on them.

Tino rangatiratanga can be acknowledged through specification of Kaupapa Māori services and providing Māori with increased opportunities to create and implement strategies and services which will improve mental health and addiction services, and mental health and wellbeing outcomes for Māori.

1.3 Article three

Article three guarantees Māori the same rights of citizenship and privileges as British subjects, including the rights of equal access to mental health and addiction services, to equal health and wellbeing outcomes and to access mainstream mental health and addiction services which meet the needs of Māori.

This review report provides a strong call for equity of participation, access, funding and outcomes, and points to the need for significant and sustained change if these goals are to be achieved.

2. MIHI

E tū ake nei tō tātou whare whakahirahira

Ko Ranginui e tū ake nei hei tuanui

Ko Papatūānuku e takoto nei hei whāriki

Ko te reo me ngā tikanga hei tāhuhu

Ko te iwi hei poutokomanawa

E tū e te whare e!

Hei whakairi i ō tātou wawata, ō tātou tūmanako, ō tātou moemoeā!

There stands our house in all its grandeur

The sky is its roof

The earth is its carpet

Our language and culture is its ridge pole

And the people stand at its centre

Stand erect!

So that you may house our hope and dreams within!

3. A SHARED FOREWORD

To support this review, a steering group, independently chaired by Dr Clive Bensemann, was established. The steering group welcomes this report provided by Synergia, summarising the review of the Southern district's mental health and addiction system.

We would like to thank all those who contributed to the review across the district. The level of input into the review has been enormous; over 500 people directly engaged with via interviews, meetings and workshops; over 325 survey responses from people with lived experience; and over 450 from the workforce and providers delivering services across the district.

It is clear that the findings of the review summarised in this report present challenges for us all. Not just for the Southern District Health Board (SDHB), but for our Māori partners, non-government organisations (NGOs), other government agencies, local communities and people, and families and whānau. The review findings also present opportunities and provide us with the critical 'start here' points that we need to focus on now. Throughout the review, the steering group has provided the Synergia team with guidance and direction. It is fair to say that the steering group has not always agreed with everything. We had a number of robust, but constructive and respectful debates during the review, a true sign that we all care deeply about the future of our mental health and addiction system and want it to reflect the best knowledge, experience and evidence possible.

The people across the Southern district are proud, resilient, and resourceful. We are the ones that are here, on the ground, doing the mahi and making a difference every day. We are the ones who need to own the findings of this review and lead the changes required.

It would be remiss not to mention the recent health system review announcements which are significant. Whilst the changes could be viewed as presenting challenges, the steering group feel they offer a unique opportunity to implement the changes needed to improve our mental health and addiction system now and into the future.

Starting from where we are and looking forward, it is clear that only together will we make a difference. To realise change will require strong leadership and commitment across us all. The feedback via the review has been loud and clear: there is no time like the present to start taking action.

SIGNED BY THE STEERING GROUP

Dr Clive Bensemann (Independent chair), Thomas Cardy (Pact), Heather Casey (SDHB), Chris Fleming (SDHB), Dr Pat Hastilow (GP), Toni Huls (Lived experience representative), John MacDonald (chair, NLG), Donna Matahaere-Atariki, Te Rūnanga o Ōtākou (Co-Chair), Dr Ursula O'Sullivan (SDHB), Gilbert Taurua (SDHB).

EXECUTIVE SUMMARY

4. EXECUTIVE SUMMARY

4.1 This report and its structure

This report summarises the outputs of the review undertaken from late January 2021 to June 2021. The terms of reference for the review (included in the appendices) stated that the review will take a whole-of-district, whole-of-system view and will consider:

1. the conditions that support current pockets of innovative and/or excellent practice
2. the pressure points in the mental health and addiction (MH&A) system and their underlying root causes, identifying barriers, connectivity, gaps and opportunities for service development, configuration which is equitable across the Southern area
3. the changes and/or improvements that need to be made to the model of care in order to better meet the needs of the population in each locality
4. the best structure and mix/configuration of resources and services and the preferred model of service delivery in each locality
5. what governance and leadership should look like in order to ensure that modern, contemporary clinical practice can be delivered effectively.

These five areas provided the high-level objectives for the review team.

The ultimate aim for this review is for it to make a difference for the people across the Southern district. We have purposely structured the review process and this report to act as a catalyst for change. From Synergia's perspective, even before we began this review, there was already a level of awareness, interest and a genuine desire to improve the system, which has only been reignited by this review. It is important that this report is not seen as an end, but as the start of the next phase of the journey. A focused and transparent journey towards a better mental health and addiction system that helps people stay well and supports their recovery when they become unwell.

We do not want this report to become a paperweight or door stop, to sit on a shelf gathering dust. We want it to be used, to be read, to get dog-eared and to get added to, to be improved. It also represents a point in time that should be built on, completed and put to one side when done.

The review in numbers

- **500+ people engaged with directly (face to face and virtually)**
- **475 workforce / provider survey responses**
- **325 lived experience survey responses**
- **20 direct written submissions**
- **Eight service development workshops across four districts**
- **Three dedicated Māori Hui**

During the review stakeholders asked us to help provide a focus on what a great mental health and addiction system could look like and also needs improving in short, medium and longer term. To highlight the 'fix now' actions and the 'creating the future' recommendations.

The structure of this report reflects this desire. The report is split into five sections:

1. Executive summary
2. Section A: A vision for the future
3. Section B: 'Fix now' priorities
4. Section C: Creating the future
5. Section D: Appendices.

Following the executive summary, **Section A** outlines a vision for the future of the mental health and addiction system that is based on what people told us throughout the review. Stakeholders want change. They do not want a few tweaks here and a few tweaks there. They want there to be a significant reframing of the mental health and addiction system that is person, whānau and community centred, with a clear focus on localities and integration across services. They want the MH&A system to embrace a modern, primary and community-oriented system that not only harnesses the resources of people, their families and whānau, but the skills of the entire workforce, whether they be peer workers, support workers or clinical staff. A MH&A system that supports people to work together horizontally and vertically as one system, as opposed to the current system which people described to us as being like a fragmented, disconnected set of disparate pieces that operate in siloes.

The vision described in Section A cannot be achieved without a strong foundation. **Section B** highlights the 'fix now' priorities. During the review, the team uncovered many areas for improvement. The review team believes that listing all these areas risks diluting the need to take action on a small but significant set of recommendations and adding to the already overwhelming sense of the change burden that people spoke of during the review. Hence, we have selected some areas of change over others and focused our recommendations on those areas. That is not to say that the other areas are not important. They are, but they are less of a priority right now.

The review team used a prioritisation process to select the areas for change, in part because we believe the ones selected are critical to address now and are most likely to create the space for a set of positive reinforcing dynamics that will help the system improve over time.

The structured prioritisation process is described in the appendices of the report. We recommend this process is used to continue to clearly prioritise action going forward. Once the recommendations in this report are complete, it will be time to move onto the next set. Having a structured approach which is understood, transparent and applies a clear discipline to the process of prioritisation is critical. People need to know how actions/projects/initiatives are selected and how decisions are made.

Section C talks about where the whole system needs to go. Work can start on this now, but not at the expense of the 'fix now' priority areas. Given the recent announcements regarding the proposed changes to the health system it would be easy to get distracted; however, we cannot ignore the impact that the creation of the Māori Health Authority, Health New Zealand and regional/local commissioning networks will have on the MH&A

system. They have the potential to be profound so we should look to the future, but not forget about today. In this section we have attempted to outline where the broader MH&A system needs to go – to be more local, more integrated, more people-centred and for local communities to have a much greater control over how decisions are made and resources are allocated.

Section D, the appendices, provides summaries of the wide range of supporting evidence we have collected from people, organisations, groups we talked to, the data analysis, and survey responses during the review.

4.2 What people told us

During this review, we spoke directly to over 500 people and received written feedback from over 750 consumers, carers and the MH&A workforce. For those working across the mental health and addiction system, a clear message we heard and felt was the passion people had for their jobs, a genuine desire to make a difference and support people and whānau wellbeing. However, these people also told us that they are frustrated. Many spoke of the sense that they were fighting the system and that the right thing to do was often made much harder by the existing systems and structures. Many spoke of other reviews that have been done over the years, of good ideas going nowhere, of business cases that seemed to disappear and of change being promised and nothing happening.

An extremely concerning message we heard was the view that Māori continue to be significantly disadvantaged. The lack of Kaupapa Māori MH&A services and the lack of focus on actively reducing inequalities and inequities are impacting on the lives of people and their whānau.

There is a strongly held view that the equity issues are systemic. This can be seen in the lack of transparent reporting of data on equity, lack of cultural awareness in services, lack of representation of the Māori voice in senior leadership positions and the defunding and active decommissioning of services for these priority populations.

Stakeholders also highlighted the failure to support children and young people and provide early intervention and support for this high-priority sub-group. The imbalance in funding across the system away from children and young people towards adults is a real example of that, irrespective of all the recent rhetoric in support of children and young people's mental health and wellbeing, it is still not receiving the funding and attention it needs.

Many stakeholders in professional roles, such as general practitioners and NGO providers, spoke of difficulties accessing timely advice and support from senior clinical professionals when they needed it. When access to advice and support was not available, it often meant making a formal referral for support, despite the fact that a formal referral was not specifically what was needed.

Consumers and carers talked of a fragmented, complicated system that was hard to understand, navigate or access. People said it felt like each service was designed around the needs of that service, rather than meeting the needs of people, their whānau and their communities. They talked about the excellent experience and support they

received when they did get to the right person or team – but that it felt more like luck than the result of a good and reliable process.

Stakeholders across the board talked of the need for local solutions for local people, whānau and communities. Many people talked about the need for support to be integrated and connected locally, where people live, work, learn and play. There was significant concern about the lack of crisis response options and community resources to match the changing demographics, particularly for more rural communities.

People spoke of a specialist DHB workforce that is under pressure. The workforce spoke of the increasing complexity of the people they support and that many more people are now presenting with multi-faceted issues covering many areas of their lives, not just mental illness and addiction. The workforce spoke about the limited visibility of important patient information, duplicated effort and an overall sense of not being able to resolve a person's issues before having to move onto the next person. The poor physical environment was raised by many stakeholders, which combined with inadequate information technology solutions meant it was very difficult to work to top-of-scope and deliver the care that the workforce is trained and able to deliver.

"I often have to drive around in the middle of the night, get the key to the office to access the paper records in another building, on a person that is waiting downstairs, adding time, stress and waste to an already difficult situation." Source: senior clinician

Primary care and NGOs expressed frustration at the number of lost opportunities to strengthen the wider system of care. They suggested that the lack of an integrated system between primary care, NGOs and DHBs was one of the main reasons the DHB mental health and addiction specialist services were struggling. In addition, active disinvestment in some NGOs has further reinforced the message that community services are not needed, nor are they valued. Respondents talked about the need for a change in mindset and culture by all staff that puts consumers' needs at the centre of the conversation and not our organisational or professional silos.

Throughout the review the level of emotion and the sense of despair was very strong. Consumers and carers are worried about the system in its current form. Equally, the workforce and providers often felt that they needed to convince other professionals that a person presenting required support, rather than being trusted, listened to and respected for their knowledge and experience – whether they were a GP, nurse, community worker or psychiatrist.

The system feels like it's focused on working out where to put people who seek help, referrals, triage, eligibility, rather than just asking 'how can I help' and supporting that person with what they need there and then or helping them access the care they need. – NGO provider

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That said, there were many examples of innovative approaches already operating or about to be realised. They are mentioned throughout this report, but they are in pockets and are not widespread. 'How can we support and spread these innovations' was a question asked by many throughout the review.

To support improvement, people called for increased investment in change. The review found that stakeholders want change and want to be involved – but it is difficult to do so on top of an already busy workload. There were calls for the need to invest in change, and for resources to support a dedicated mental health and addiction programme office that is tasked with taking the outputs of this review and implementing change.

4.3 Summary of recommendations

4.3.1 Hauora Māori – take equity seriously

1	**Increase funding** for Kaupapa Māori providers from its current level of 2% (circa $2 million) of the mental health and addiction budget to at least 6% (circa $6 million) over the next three years.
2	**Create** a dedicated and/or ring-fenced 'by Māori for Māori' investment pool that is used to design and commission local responses for Māori. This is much broader than Kaupapa services.
3	**Strengthen** the function and accountabilities of the Iwi Governance Board to oversee commissioning and funding decisions related to Māori.
4	**Improve** the collection and use of reliable Māori-specific performance data to help identify inequities in service provision, utilisation and outcomes of care, and routinely track progress over time in addressing them.

4.3.2 Fix gaps in the continuum of care

5	**Develop** the full range of crisis response options with an immediate focus on Queenstown, Central Lakes and Waitaki.
6	**Transform** current day services into community wellbeing hubs with an immediate focus on Invercargill and Dunedin.
7	**Develop** options for an acute home-based mental health specialist service.
8	**Improve** access to senior medical officer advice for primary care, community mental health teams and community providers.
9	**Review** contractual structures and explore the reconfiguration and/or decommissioning of non-value-adding services.
10	**Review** the full range of alcohol and other drug services with a view to identifying the high-priority areas for development.

4.3.3 Adopt a life course approach and design services accordingly

11	**Ensure** that the dedicated and/or ring-fenced 'by Māori for Māori' investment pool (recommendation 2) specifically targets maternal mental health, pēpe, tamariki and rangatahi mental health and addiction services.
12	**Create** an investment plan to utilise growth funding for services for infants, children, young people and their families/whānau – with particular attention to the Pacific and Asian populations, as the number of young people in the 0-19 age group in these ethnic groups are projected to increase over the next ten years.
13	**Support the investment plan** with a workforce development plan that specifies the actions that will be taken to increase, strengthen and support the infant, child & youth workforce.
14	**Improve** the collection and use of reliable ethnicity-related performance data to help identify inequities in service provision, utilisation and outcomes of care, and routinely track progress over time in addressing them. Related to recommendation 4.

4.3.4 Improve the physical environments

15	**Signal** the intent to close the adult mental health and intellectual disability inpatient facilities located on the Wakari site.
16	**Develop** a concise plan and timeline to develop the capacity of community and alternative responses to support the closure of Wakari (options should include packages of care, step-down and alternatives to admission). This should also include links to crisis responses options as per recommendations 5, 6, 7 and 8.
17	**Work** in partnership with the Ministry of Health to develop an investment business case for the development of new adult inpatient facilities to replace the services currently provided on the Wakari site. These new inpatient facilities should be aligned in design and as much as possible in close physical proximity to the new Dunedin general hospital. *Note: This does not include the forensic inpatient services, as they require a different configuration.*
18	**Explore** new premises for services currently located in the Fraser building that offer easier access and improved experience of care for consumers, families and whānau.
19	**Support** the development of a plan to better utilise the rural hospital network as community wellbeing hubs, including the co-location of community and crisis mental health and addiction services.

4.3.5 Reconfigure supporting functions and structures

20	**Create** a full-time mental health and addiction strategic commissioning role at the Executive Leadership Team level.
21	**Create** a 'by Māori for Māori' commissioning function, with a lead role in implementing the investment pool outlined in recommendation 2 and 11.
22	**Support the** strategic commissioning role/function with robust data and intelligence that informs local and regional commissioning decisions.
23	**Disestablish** the current Network Leadership Group and establish a new cross-sector intelligence and stewardship group.
24	**Support** the creation of strong local consumer advisory networks that are linked across the district and have representation via the cross-sector intelligence and stewardship group noted in recommendation 23.
25	**Strengthen** existing family/whānau networks as a way to meaningfully engage with and learn from them.
26	**Develop** a clear prioritisation and decision-making framework which supports the clear delegation of roles, responsibilities and accountabilities.

4.3.6 Support and develop the workforce

27	**Develop** a comprehensive mental health and addiction workforce development plan that specifies high-priority areas for development and offers clear direction in terms of actions, particularly with regard to the peer workforce.
28	**Develop** a separate Māori mental health and addiction workforce development plan that specifies actions to increase the Māori mental health and addiction workforce based on known critical success factors.
29	**Urgently** implement health and safety measures to create healthy and safe workplaces for District Health Board mental health and addiction staff.

4.3.7 Organisational development and the role of culture

30	**Invest** in organisational development across the system.
31	**Develop** a deeper understanding of the culture as part of the system change process to make informed decisions about where and how to intervene.
32	**Invest** in the development of a learning system.

4.3.8 Invest in change

33	**Create** the structures required to implement the recommendations in this report. This is likely to include local and regional structures.

34	**Engage** consumers as active agents and equal partners in the change process – as per the principles of co-production.
35	**Engage** with other stakeholders throughout the change process in a genuine way via active and reciprocal partnerships.

5. A ROAD MAP FOR CHANGE

Taking action and creating momentum will be important next steps in the change process. Below are the reviewers' suggestions for the recommendations that are the priorities for the next 12 months – to offer a starting point for creating momentum.

5.1.1 Short term – first three months

- Develop a plan to increase crisis response options to support the Queenstown and Central Lakes and Waitaki regions.
- Signal closure/change to the adult MH&A and ID inpatient facilities which currently operate from the Wakari site, and develop a high-level plan to support the changes required with a focus on closing ward 11 as a priority.
- Signal that the current Network Leadership Group (NLG) will be disestablished and a new cross-sector intelligence and stewardship group created with clear purpose, function, membership and roles. Develop new terms of reference and membership and hold first meeting.
- Commission external support to deliver organisational development programme (leadership lab is an option).
- Scope initial by Māori for Māori investment and plan to execute – agree the investment and process in partnership.
- Finalise the plan to support Ward 11 patients to transition to alternative and appropriate community-based options (packages of care).

5.1.2 Medium term – three to six months

- Execute a process to invest in targeted crisis response options in the Queenstown and Central Lakes and Waitaki regions.
- Develop a peer led crisis/wellbeing café model to be implemented in a range of sites (potentially Invercargill, Dunedin, Oamaru and Queenstown as starting points).
- Develop a high-level plan to grow, develop and support the peer workforce.
- Begin the supported transition of Ward 11 clients into alternative options.
- Begin an organisational development programme with external support.
- Begin implementation of first by Māori for Māori investment.

5.1.3 Longer term – six to 12 months

- Implement peer led crisis/wellbeing café plan in at least one location.
- Establish dedicated primary/community access and advice telephone help line.

SECTION A: A VISION FOR THE FUTURE

6. A VISION FOR THE FUTURE

6.1 Introduction

The current mental health and addictions system has evolved out of the first and second waves of deinstitutionalisation, with a focus on specialist responses for people with the most severe mental health and addiction issues. He Ara Oranga (New Zealand Government, 2018) acknowledged that this focus has led to significant pressures on the intensive end of the MH&A system and that overall, the system is not sustainable in its current form. It outlined a vision for the future which included an explicit focus on supporting people to develop their own capability to live well (i.e., resiliency, recovery and whānau ora) and the development of layered responses, starting in primary and community settings through to more specialised and intensive MH&A services (i.e., integrated stepped care).

During the review we identified a number of features that represent the current system. Table 1 provides a summary of these. The table also describes the characteristics of what a future system could look like. These characteristics are drawn from a number of different information sources, including what people have told us during this review.

Table 1: Transitioning from the 'current system' to the 'future system'

Current system >	Future system
Offers people a service-shaped response	Offers a person-centred response
Medical model	Holistic mental health & wellbeing model
Hospital-orientated MH&A system	Community-orientated health and social system
Siloed and disjointed service delivery	Integrated primary, community and specialist mental health and addiction services
Opaque decision-making processes	Highly transparent decision-making processes
Weak locality networks	Strong locality networks
Sporadic consultation and co-design	Co-production is an integral part of the system
Inequitable access and inequitable outcomes	Equity is a high priority
Structural racism	Te Tiriti o Waitangi principles & obligations are reinforced
A reactive system	A learning system
Managed gateways to services	We can help you find the right door for you
Do you meet our service criteria?	How can we help you?
Long waiting lists	A no-wait system

The locality population health and wellbeing approach

The Southern district must move towards this future with purpose and intent, and the timing is ideal.

The proposed health reforms present Southern District Health Board (SDHB) with an amazing opportunity to re-design the MH&A system in ways that continue to build on the actions outlined in the Southern Primary and Community Care Action Plan (Southern DHB & WellSouth Primary Health Network, 2018) and potentially transform the MH&A system – in keeping with the aspirations of He Ara Oranga (New Zealand Government, 2018) and the national health reforms (Health & Disability System Review, 2020).

Primary and community MH&A care in the future system will be reorganised to serve the communities through 'localities' with a focus on population health and wellbeing (see Figure 1). According to the proposed health reforms, these localities will have a geographical dimension and cover a population of between 20,000 and 100,000 people. The boundaries of each locality will be set in ways that make sense to the communities being served according to a combination of factors including natural borders, local territorial authority boundaries and iwi rohe.

While every locality will have a consistent range of core services, the intention is that local MH&A services will be delivered in ways that meet the needs and priorities of local communities. The clear intention is that all health service providers will be incentivised to work collectively towards shared outcomes and objectives for the local population via a common network contract and new funding arrangements (The Health and Disability System Review: Proposals for Reform: CAB-21-SUB-0092).

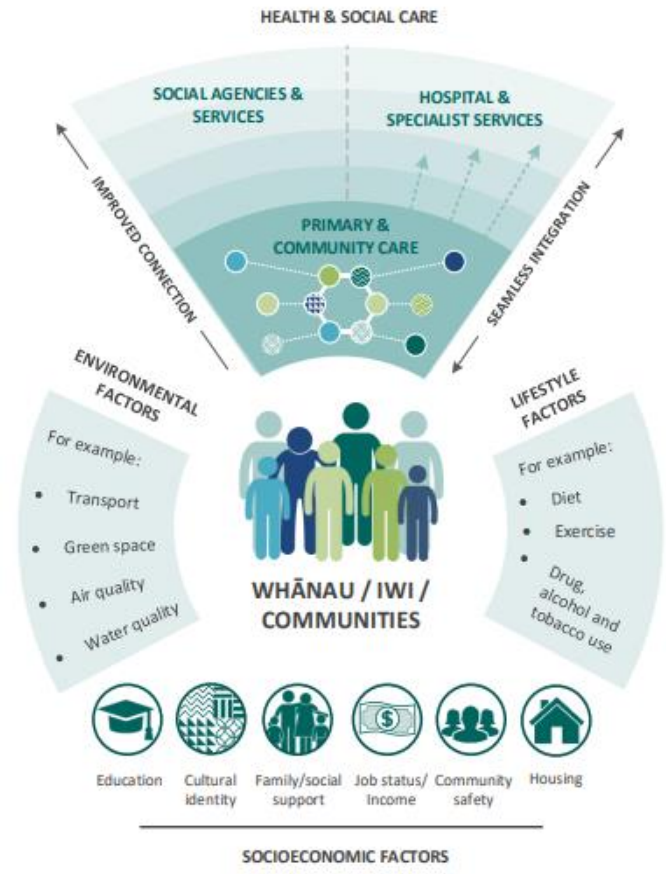


Figure 1: Population health approach (Health Transition Unit, 2021)

There is evidence from the United Kingdom (NCCMH, 2017) to suggest that organising services around smaller populations of interest in localities makes it easier to identify the issues that really matter to people, to build relationships across professions and organisations, and to work with other sectors to address the wider determinants of health.

Ham & Alderich (2015) have set out some design principles to help guide the development of place-based (localities) systems of care in the NHS. In developing these principles they have drawn on the works of Elinor Ostrom (2010) on managing common pool resources, and Kania & Kramer (2011) on how partners can achieve collective impact, as well as on their own work on integrated care and population health (Alderwick et al., 2015; Curry & Ham, 2010). The ten principles are:

1. Define the population and the boundaries of the system.
2. Identify the right partners and services that need to be involved.
3. Develop a shared vision and objectives reflecting the local context and the needs and wants of the public.
4. Develop an appropriate governance structure for the system of care, which must meaningfully involve consumers, families/whānau and the public in decision-making.

5. Identify the right leaders to be involved in managing the system and develop a new form of system leadership.
6. Agree how conflicts will be resolved and what will happen when people fail to play by the agreed rules of the system.
7. Develop a sustainable financing model for the system across three different levels.
8. Create a dedicated team to manage the work of the system (i.e., backbone functions).
9. Develop 'systems within systems' to focus on different parts of the group's objectives.
10. Develop a single set of measures to understand process and use for improvement.

The list of design principles has been replicated here because the development of place-based systems of care is new to New Zealand. The details around how Locality Networks will be established and how they will operate in practice have not yet been made clear. For these reasons it is important that all key stakeholders start to become familiar with the concept of place-based care and look to identify examples in other parts of the world where the approach has worked well (and where it has not) and why, so that they can participate in a discussion about how the future MH&A system will function – both within and across each of the localities.

Case study: East London Foundation Trust (ELFT)

East London NHS Foundation Trust (formerly known as East London and The City University Mental Health NHS Trust) was formed in April 2000. The new ELFT brought together mental health services from three community trusts in Tower Hamlets, Newham, The City and Hackney, pooling resources and much of London's major mental health expertise to become one of the UK's largest specialist NHS providers. The ELFT population has the highest mental health need of any in the UK.

The Trust is aiming to co-produce improvements to mental health care based in and around local primary care networks (PCNs). The PCNs are groups of GP practices that specifically focus on the needs of local populations. Their transformation work aims for NHS, social care and third sector services to work together to make a greater positive impact on the health and lives of groups and communities of people living with mental ill-health. Through providing more integrated care across mental and physical health services, and across health, social care, the voluntary sector and wider services in inner London, they have been able to test new ways of working within the PCNs in the context of a new national framework for community mental health services.
The scale of the 30–50,000 population focus means that the number of GPs, community mental health team (CMHT) staff, community agency staff, and psychiatrists is such that everyone is known to each other, and this has enabled a sense of 'team' to evolve across multiple organisational boundaries. Everything that they speak of that has been key to their success comes down to relationships. A significant number of CMHT nurses now have a primary relationship with one of these 'virtual' teams and one or more general practices, and that has been very successful. The nurses see

consumers in the GP clinic, write notes in the GP PMS, and are known to the team and to the local community agencies and services. Every morning there is an MDT case review meeting where the GP and community agency staff can join in if they have concerns about someone. This process has got past the issue of 'referrals' as the commitment is to develop a joint plan, regardless of who undertakes it.

6.2 Strengthen local community responses

The World Health Organisation (WHO) has recently published some guidance for the development of person-centred and human rights-based approaches in community mental health services. The guidance provides summary examples of good practice MH&A services from around the world, including the linkages needed with housing, education, employment and social protection sectors. These examples demonstrate that the scaling-up of local networks of mental health services that interface with the social sector services is critical to the provision of a holistic approach that covers the full range of mental health services and functions.

The WHO guidance incudes specific recommendations and action steps for the development of community mental health services that respect human rights and focus on recovery. With these action steps in mind, SDHB could strengthen the primary/community MH&A response in a number of different ways – as follows:

1. Plan and design core MH&A service responses around a number of 'localities' with clear linkages to specialist MH&A services.
2. Each local network to also include a suite of health and social service responses that are tailored to meet the unique needs of the local population.
3. The local community network will maintain a focus on the person in the centre. People will receive wrap-around support if they need it, firstly through their primary care/community team, and in many cases a Health Care Home, a Youth One-Stop Shop, a Wellbeing Hub and/or a Kaupapa Māori service.
4. Invest in the growth and development of MH&A NGOs to deliver a broader range of MH&A services (e.g., peer support, rapid crisis response options, acute alternative options, individual employment placement and support services, etc.), starting in those localities where there are obvious gaps in the continuum of care.
5. Situate the local specialist community mental health teams (CMHTs) alongside a range of other health and social service agencies in community settings, potentially in Wellbeing Hubs or integrated Health Care Homes that are close to public transport.
6. Enable all clinical specialist staff to work to 'top-of-scope' in relation to their community partners.
7. Build on and expand the relationships with the rural hospital network as a key part of the locality response.
8. Incentivise collaborative partnerships amongst service providers within each locality so that they deliver a more integrated, holistic response to consumers and their families/whānau.

9. Base the commissioning of MH&A services on sustainably-funded partnerships with primary and community service providers.
10. Provide more options for consumers and their families/whānau to increase their health literacy, build their resilience (e.g., recovery colleges, etc) and meaningfully participate in the co-production of the MH&A system.

6.3 How will people experience the new system?

The new system should have people's mental health and wellbeing at its heart – where a good level of mental wellbeing is attainable for everyone, outcomes are equitable across the whole of society, and people who experience mental illness and distress have the resilience tools and support that they need to regain their wellbeing. (He Ara Oranga, 2018, p11).

In the process of redesigning the system, it is important to invest in those things that matter the most and will deliver the greatest value to consumers and their families/whānau. With this value proposition in mind, there are a few things that people have told us that would tell them that the Southern district MH&A system is changing in a positive direction. In no particular order, they are:

- People are able to manage their own recovery, on their own terms.
- People feel respected and are involved as active participants in their care.
- People have the skills, tools and resources to keep themselves well.
- People are able to access a wider range of evidence-based MH&A interventions and supports when and where they need it – either physically located in their community and/or available online.
- People who are in crisis are able to access an appropriate, rapid-crisis response.
- People have more choice of services that are provided closer to home (e.g., culturally appropriate MH&A services, peer support services, etc).
- People's physical health receives the same amount of attention as their mental health.
- The health and social services in each locality are able to work together to help people solve their problems – at the point of first contact.
- People are able to access and maintain good housing, educational opportunities and employment.
- People feel connected to their local community.

It is noted that the consumer experience of the MH&A services forms part of the Triple Aim (Berwick et al., 2008) and will be an important indicator of the performance of the MH&A system, especially as the change process and the health reforms start to take effect. Please note that while the *Marama Real Time Feedback* tool is utilised by SDHB, it does not provide enough information to enable the DHB to tell if the consumer

experience of the wider MH&A system is improving. Additional sources of information will be required (see Figure 2), potentially via the proposed MH&A Consumer Advisory Network and existing family/whānau networks (see section 11.2.5).

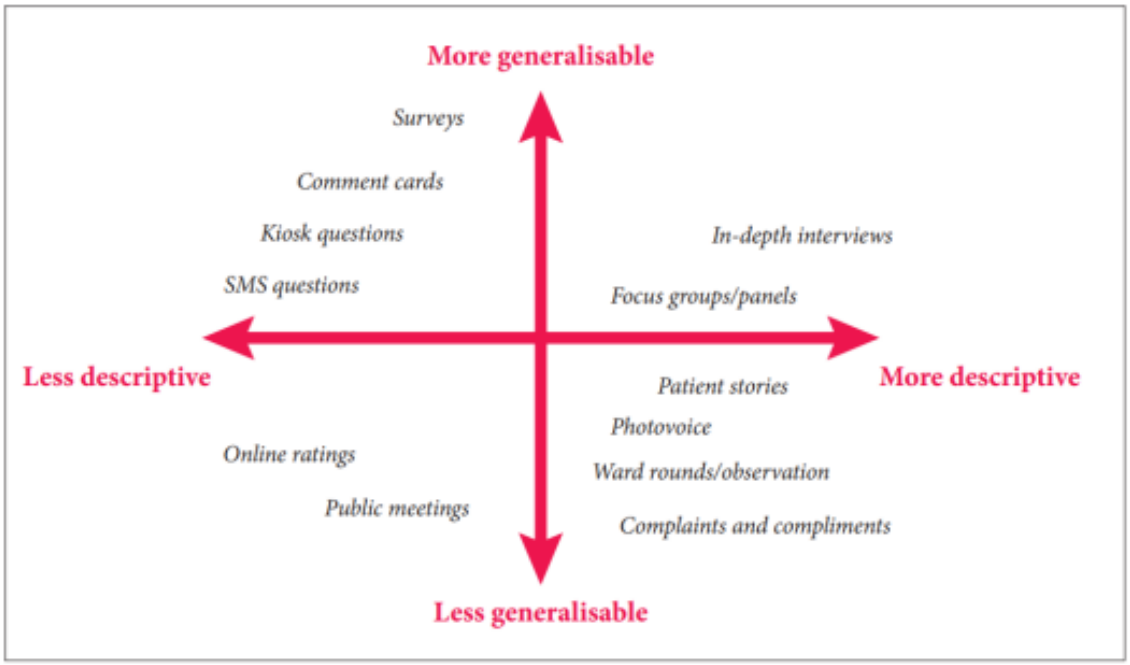


Figure 2: Methods used to measure health service experiences (de Silva, 2013, p7)

6.4 What is working well?

Some may read this vision for the future and feel it is too far away – another nice description of a MH&A system that is unattainable. The reviewers would like to challenge this notion. During the review we came across a number of examples of innovative practice and effective community networks in the Southern district that could potentially inform the establishment of more formalised service provider partnerships in each locality including:

- Safer Waitaki Community Coalition, which includes 160 community groups and organisations. See section 14 of this report for a description of the critical success factors of this initiative.
- Te Kāika is a partnership between Ngāi Tahu (Te Rūnanga o Ōtākou), Ārai Te Uru Whare Hauora and the University of Otago. Te Kāika in partnership with Oranga Tamariki and The Ministry of Social Development are developing an integrated wellbeing hub to provide holistic, whole-of-life, wellbeing support which will include community-based mental health and addiction support.
- The Central Lakes Mental Wellbeing Psychosocial Recovery Action Group, which was set up in response to COVID-19. The group includes representatives from SDHB, Well South PHO, Queenstown Lakes District Council and Central Lakes Family Service.
- The Ministry of Social Development is administering the Community Wellbeing Package, which consists of three initiatives that enable NGOs and local

communities to continue to provide a range of social services during the response and recovery phases of COVID-19.

- The network of rural hospitals offers a unique foundation with the potential to act as hubs or homes for the locality networks in the communities they service. Acting as part of the 'place' around which integrated physical, mental and wellbeing services could be organised.
- The Integrated Mental Health and Addiction Services (IPMHAS), as part of the Ministry of Health funded access and choice programme, is becoming more widespread and seen as a great opportunity to continue to improve access to integrated care within primary care settings. The programme also offers opportunities for increased integration between primary care, NGOs and specialist DHB provided services.

6.5 What does this mean for Māori?

A Kaupapa Māori approach would include multiple entry points and multiple pathways that enabled whānau to flourish. Kaupapa Māori services would be designed and implemented by the local community, rohe and iwi. The responses would also include mainstream services with the capacity to provide culturally safe services for Māori. Central to the process of strengthening the MH&A system to better respond to Māori aspirations is the need for Te Tiriti to underpin services, structures and resourcing.

"The evidence about what works is pretty clear … we know what a good system looks like.

However, more and more, I feel like I'm ***fighting the system*** *to do the right thing for people."*

– *Senior specialist clinician*

SECTION B: ‘FIX NOW’ PRIORITIES

7. 'FIX NOW' PRIORITIES

7.1 Introduction

Section A outlines a vision for the mental health and addiction sector that, whilst realistic, appears to be far away from where the current system is at. Throughout the review, stakeholders made it very clear that whilst they wanted to see a future vision, they also wanted to see urgent action to fix a number of areas in the current system.

The areas covered in the following section are considered to be high priority and in need of immediate attention. There are a large number of additional 'fixes' that follow hard on the heels of this initial list, but we need to prioritise our efforts towards the initial fixes first.

Some of these fixes will require investment. Without this investment, however, the current dynamic of pressure on acute services and the sense of 'running to stay still' will prevail. The system needs investment to provide the circuit breakers that will enable all stakeholders across the continuum of care to lift their heads for long enough to take a breath and explore opportunities for new ways of working and innovation.

Whilst many fixes are focused on what could be called the primary and community setting, they offer the best opportunities to reduce the pressure on more acute service areas – in particular inpatient, crisis services, community mental health teams and specialist alcohol and other drugs (AOD).

Without this investment to fix the glaring gaps, the system will remain in a reactive, high-pressure state, lurching from crisis to crisis, struggling to stay afloat.

The reviewers acknowledge that it will not be easy to invest in areas at a time when resources (financial, workforce etc.) are constrained. However, without some targeted investment no change will happen.

The areas that have been selected for the first tranche of change are:

1. Hauora Māori – take equity seriously.
2. Fix gaps in the continuum of care.
3. Adopt a life course approach and design service responses accordingly.
4. Improve the physical environments.
5. Reconfigure supporting functions and structures.
6. Support and develop the workforce.
7. Organisational development and the role of culture.
8. Invest in change.

8. HAUORA MĀORI – TAKE EQUITY SERIOUSLY

8.1 Rationale for prioritisation

Equity can be defined as provision of care that achieves the highest attainable health outcome for all people, no matter where they live, or their socioeconomic status, gender, ethnicity, age or other patient-related characteristics. The evidence from the review would indicate that the triage and urgent response components of SDHB do not currently support equity.

The Health Quality & Safety Commission (2019) report titled *A Window on the Quality of New Zealand's Health Care* discussed a range of equity measures for different patient groups (ethnicity, age and socioeconomic status) across the healthcare pathway – from access to services, quality of treatment, patient experience and outcomes. The profile of the inequities that exist across SDHB may be captured in management reports, but it is not visible enough, and by not being visible, it is too easy to sweep them under the carpet and not address them. As part of moving forward, equity needs to be made a strategic priority for SDHB.

This section of the report focuses specifically on achieving equity for Māori – as per the DHB's obligations under Te Tiriti o Waitangi.

8.2 Fast facts

- Māori represent 10.9% of the total population in the Southern district.
- The New Zealand Index of Multiple Deprivation (University of Auckland, 2017) found that the proportion of Māori living in data zones within SDHB in 2013 ranged from 2.2% to 45.2%. The proportion of Māori per data zone was the greatest in two data zones in Bluff (45.2% and 43.3%), followed by one in Invercargill (31.1%) and one in Mataura (30.6%).
- Kaupapa Māori MH&A services attract 2% of the DHB's total expenditure on MH&A services.
- Only 79% of Māori are enrolled with a general practice (Ministry of Health, 2021). This is the lowest rate of enrolment in the country.

8.3 What needs to happen

The Health and Disability System Review (2019) has stressed that Māori as Tiriti/Treaty partners have not been well served by the health and disability system in New Zealand. SDHB is no exception, with several service providers and service users reporting that SDHB services are less accessible for Māori, and that even when someone can get access to a DHB service, the person and/or their whānau may not receive the same level of treatment as others, or culturally-safe care.

There needs to be immediate improvements to the way the DHB funds and delivers MH&A services for Māori. At the moment there is only one Kaupapa Māori community

service provider in the entire district that receives funding from the DHB to deliver MH&A services to Māori. Given that Māori represent approximately 10.6% of the total population in the Southern district, and the high mental health and addiction needs they experience, there are clear imbalances that need to be rectified via an investment plan that grows the range and distribution of Kaupapa Māori services over the next five years.

The reform of the New Zealand health system is placing a greater emphasis on primary health care based on the premise that universal coverage will reduce exclusion and social disparities in health. However, the dominant approach to primary health care (i.e., general practice) does not adequately respond to the needs of Māori, especially the most disadvantaged who tend to have lower trust, lower rapport and lower organisational access to traditional primary health care. The good news is that there are many examples from around the country of non-traditional primary MH&A services for Māori that the Southern district could learn from (e.g., Marae-based services and wellbeing hubs). The current development of a wellbeing hub in Dunedin is a step in the right direction, but it is not a systemic solution to the problems of low engagement, low access and poor outcomes.

In addition, there is an expectation that partnership with Māori and the integration of Māori voice into every part of the MH&A commissioning cycle should become a central feature of how the DHB performs its role. The lack of investment in Kaupapa Māori MH&A services would indicate that the current partnership with Māori is not working as well as it should be. The DHB needs to develop a stronger role for iwi-Māori governance and leadership to identify local priorities, make investment-related decisions, develop local solutions that best meet the needs and aspirations of Māori communities and drive improvement in hauora Māori in accordance with the DHB's obligations under Te Tiriti o Waitangi. This approach aligns with the strategic remit of the impending Māori Health Authority, which will commence operations on 1 July 2022 as part of the current reform of the health system in New Zealand.

As an example of the possibilities that might emerge with the development of the new health system in New Zealand, the review team wondered if there might be the opportunity, at some time in the future, for a local Māori entity to have a direct funding relationship with the Māori Health Authority. This entity would be responsible for commissioning and funding all Kaupapa Māori community MH&A services in the Southern district.

Quotes from stakeholders:

- "A kaupapa Māori service would be whānau centred, and located in the community rather than the fragmented, siloe'd care that whānau currently have to navigate their way through."
- "We don't just want equity. We want flourishing. To do this we need rangatiratanga that is a shift in power. Māori leadership across the board, from decision making, funding, workforce development and whānau empowerment."

- "Whānau know the what and the how – what the solutions are and how to make these work. But the money, the resources and the valuing of their knowledge needs to follow."

The report completed by Mauriora Associates Limited on behalf of the Māori Expert Advisory Group for the Health and Disability System Review (2019) outlined the characteristics of a future-focused system for Māori. The list is replicated here because it not only reflects the korero captured across the Hui and interviews, but it also offers a clear picture of what an equitable system for Māori could look like in the Southern district:

- The system would be designed and managed in ways that are consistent with Te Tiriti o Waitangi.
- Services would be integrated, strengths based and centred on the needs and aspirations of whānau.
- Health services would be accessible, affordable and accountable to ensure equity for Māori.
- There would be a strong, competent, and supported the Māori health workforce, and non-Māori health workers would be responsive and culturally competent to deliver services to Māori.
- Whānau would be empowered, health literate, and have access to the skills and resources they need to achieve health and wellbeing.
- Kaupapa Māori and mātauranga Māori including te reo, karakia and rongoā would be incorporated into health services and approaches.
- Māori would achieve equitable health outcomes, and there would be consequences for services where this was not happening.
- There would be pay parity and equitable funding for sustainable, Māori-led health services and providers.

8.4 What is working well in other parts of the country?

Examples of good practice include *Mahi a Atua* (tracing ancestral footsteps), which is a Māori therapeutic intervention that involves the retelling and sharing of stories (pūrākau) as a way of engaging with, assessing and treating whaiora (distressed people) who present with mental health problems. It is being delivered in a number of DHBs.

8.5 Recommended actions

1	**Increase funding** for Kaupapa Māori providers from its current level of 2% (circa $2 million) of the MH&A budget to at least 6% (circa $6 million) over the next three years.

2	**Create** a dedicated and/or ring-fenced 'by Māori for Māori' funding pool that is used to design and commission local responses for Māori. This is much broader than Kaupapa services.
3	**Strengthen** the function and accountabilities of the Iwi Governance Board to oversee commissioning and funding decisions related to Māori.
4	**Improve** the collection and use of reliable Māori-related performance data to help identify inequities in service provision, utilisation and outcomes of care, and routinely track progress over time in addressing them.

9. FIX GAPS IN THE CONTINUUM OF CARE

9.1 Rationale for prioritisation

Contemporary mental health and addiction systems of care include a range of components from supporting people to stay well through to crisis and acute options. Frameworks such as stepped care are an often-cited way of structuring connected layers of services across the continuum of care. The evidence clearly shows that providing the full suite of support options across the continuum of care offers the highest likelihood that people will have access to the most appropriate care to support their needs.

The reviewers found that in many locations across the Southern district there are either gaps in the continuum of care, or the available resources at points along the continuum are not adequate to meet the needs of the population being supported.

These gaps often result in the escalation of service response to people's individual needs over and above what may have been appropriate to support that person.

Source: Adapted from the World Health Organization.[31]

Figure 3: Example of stepped care (Blueprint II, 2012)

For example, stakeholders described many examples of people presenting in crisis, and due to there being limited crisis response options available, the person had to be admitted to an inpatient facility. In many cases stakeholders felt very strongly that if local options were available to support the person in crisis (i.e., respite, supported housing, acute home-based treatment and peer support) the person could most likely have been supported in their home without the need to access an acute inpatient facility.

This area has been prioritised due to the impact that these gaps have on other parts of the care system and the consumer, their families and whānau.

9.2 Issues

Pressure on inpatient facilities: It is clear that one of the reasons the Invercargill inpatient unit often runs close to, or over 100% capacity, is the lack of crisis response options across the region that the inpatient unit covers (i.e., Southland, Gore, Queenstown etc.). The lack of appropriate crisis response options in these communities means there are limited local options to provide safe support to people when in crisis. This means that in many situations the only option available to community mental health teams is to transport

people, sometimes inappropriately, to Invercargill to access care. This causes huge disruption to people's lives and disconnects them from their family/whānau and communities. It is also very disruptive to the staff involved and their wider teams. Having to travel with a patient to Invercargill or Dunedin inpatient facilities can result in needed to cancel all community appointments the following day or handing over of additional work to other members of the team.

Challenges with discharging people from inpatient care: Due to the lack of local step-down and crisis response options, inpatient services sometimes find it difficult to discharge people home as they know that local support is not available if the person relapses or their situation escalates.

Limited peer support resources available: The need for increased peer support capacity is discussed in other parts of the report. It is important to note this gap also means that local options to support people can become limited. Even if a facility is available, the workforce to support and care for the patient often is not.

Limited access to SMO advice and support: Primary and community care providers in particular felt that with access to the right advice and support from senior medical staff that people in crisis or acute need could in some cases be managed locally. Delays in accessing this advice cause primary and community care providers to make decisions to manage their own risk, which sometimes could have been avoided.

Uneven distribution of resources: It is clear there are disparities in the distribution of resources across the district. Some of these disparities have developed over time as population and demographics have shifted across the district. To further investigate this issue the review team has analysed the current distribution of resources (including FTEs, inpatient beds, community beds, treatment slots and care packages) and assessed these against the resource guidelines provided in Blueprint I (The Blueprint for Mental Health Services in New Zealand – How things need to be 1998). This analysis is summarised in the appendices and provides evidence to support the uneven distribution of resources across the district as highlighted by numerous stakeholders. For example, the analysis indicated that the Queenstown, Central Lakes region community mental health teams are between 20% and 30% under resourced, based on the current population demographics. It also highlights significant resourcing gaps in AOD provision across the district.

9.3 What needs to happen

9.3.1 Develop full range of crisis response options

The reviewers have found that there are gaps in crisis response options across the district (including respite options, home-based treatment and peer-led alternatives to acute admission). The most significant gaps being in Queenstown, Central Lakes and Waitaki. The lack of crisis response options and the smaller size of the local community mental health team in these areas has the combined impact of people needing to be admitted to an acute inpatient unit in Dunedin or Invercargill – often several hours' drive away. This is not to diminish the need for crisis response options in every other part of the district (particularly in Invercargill and Dunedin), but we recommend prioritising initial efforts

where the largest gaps exist. Whilst we recommend that local stakeholders ultimately design what services should be in place, we recommend that a facility-based option that is supported by an appropriate peer workforce be considered. This facility could be modelled on similar examples in other parts of New Zealand, such as the Wairarapa. Options to further utilise the resources available across the rural hospitals should be explored.

See the workforce section which further explores the investment needed in peer support.

9.3.2 Transform current day services into community wellbeing hubs

There are a range of community day services available across the district. For the most part they are well regarded and deemed to be effective. The day service model of delivery is somewhat dated and could be refreshed with a more contemporary model of care that incorporates a wider range of planning and crisis support options.

Rata House in Invercargill is one example of a community-based resource that could be further enhanced if it was expanded to provide a wider range of supports. Stakeholders suggested that Rata House could be expanded to include crisis café-style supports. Similar community day service options could be considered in Dunedin and the rural centres of Wanaka, Dunstan, Oamaru, Gore and Balclutha. However, it is recommended that a focus be placed in Invercargill, due to the reviewers' sense of the nature of the demand being experienced across the city – as evidenced by the feedback from the lived experience workshop held as part of this review.

In addition, ideally a community day service and crisis centre, operating under a more appropriate name such as a Community Wellbeing Hub, should be delivered by a community-led and/or Kaupapa Māori provider, rather than by the DHB, as it is currently. Serious consideration should be given to transitioning this service out to a community provider as opposed to it sitting within the specialist DHB provider arm. There was also strong support for such a service to be delivered via a robust, evidence-based peer support, peer-led approach.

9.3.3 Develop options for an acute home-based mental health specialist service

It is mentioned above, but stakeholders highlighted the need to improve options to support acute and urgent needs of people in their own homes and/or community settings. It is recommended that options for an acute home-based mental health service be explored with a particular focus on Dunedin and Invercargill. Many other DHBs across New Zealand have well-established acute home-based treatment services. Rather than designing a service from the ground up, it is recommended that Southern explore what is already working in other parts of the country and design a service in response to the unique characteristics of each locality.

9.3.4 Improve access to SMO advice to primary care, community mental health teams and community providers

Access to specialist advice and support has been highlighted as critical to enabling the support of people in primary and community settings. During the review, general practitioners spoke of their frustration at not being able to access advice and support from SMOs. They indicated that the result of not being able to get advice in a timely way was to refer the patient – often to multiple places at once in the hope that someone would pick them up.

Why is it that I can call a cardiologist or other specialist medical practitioner colleague and get advice about a patient but I just cannot do the same for mental health. – Invercargill GP

It is well known that the SMO workforce is constrained, with ongoing vacancies and shortages. For the reviewers this only increases the need to explore innovation options to enhance the access to this valuable support. In particular, the use of technology should be greatly enhanced as an option for providing real-time advice and support to primary care, community providers and community mental teams (amongst others). The SMO group should explore offering enhanced advice and support via an agreed roster. This would involve SMOs being available at set times for advice and support to other professionals i.e., GPs, NGOs or community mental health teams. There are many examples of this working effectively throughout New Zealand. It has been shown that over time the capability of those seeking advice develops over time leading to less and less demand for advice.

The SMO group in Invercargill described an excellent initiative to have an online support forum where other health professionals across the district could post mental health and addiction questions with the community being able to respond with advice/support. This service utilised a free Google service and was well regarded as being extremely useful. Unfortunately, Google discontinued this service, and as such, the forum ceased. Some systems around the country operate at set times, some have SMOs available within office hours at any time, others use secure DHB platforms to supplement specialist advice. The various options should be explored by MH&A teams across the district in order to identify one or more solutions that would give general practitioners better access to specialist MH&A advice in each locality.

9.3.5 Address service gaps for people whose primary diagnosis is alcohol and/or substance abuse

Addiction is a multi-faceted and complex area that encompasses the entire range of harmful, hazardous and dependent patterns of alcohol and other drug use, and problem gambling. Nationally, there are no guidelines about the resources that are required to deliver essential MH&A services in a contemporary MH&A system. To help fill this gap the review team chose to apply the resource guidelines that were developed for Blueprint 1 (Mental Health Commission, 1998). Whilst those guidelines were developed in relation to

old service models and strategies, they still offer a useful yardstick for assessing whether or not specific service types have enough resource to deliver what is expected of them. With this question in mind, the following table outlines the estimated level of resources that are required to deliver a range of AOD services to the population of the Southern district – based on Blueprint 1 guidelines.

Table 2: Blueprint AOD resource guidelines applied to the population of the Southern district

Service component	Unit	0-14	15-19	20-64	65+	TOTALS
Alcohol and drug detoxification services	Beds or care packages	0.0	0.0	5.9	0.0	6
Alcohol and drug residential treatment services	Beds or care packages	0.0	0.2	19.0	0.0	19
Alcohol and drug community-based teams	FTEs	0.0	0.2	29.2	0.8	30
Methadone treatment	Places	0.0	2.3	292.6	0.0	295

The information in this table appears to support what specialist AOD staff have told the review team – i.e., that there is not enough capacity and capability in the right places to meet the demand for AOD services, especially in the Queenstown/Central Lakes area and in the smaller rural CMHT teams where there is often a sole AOD practitioner who is covering the whole locality.

"There is a lack of AOD service providers in the community."

"We end up managing people's MH&A issues and not treating people. We offer them what we can provide, not what they need."

"People who have co-existing mental health and AOD needs fall between both services. It would be good to be able to access peer support services in the community."

Providing access to a range of treatment options in response to differing levels of complexity will be a vital component of the SDHB mental health and addiction system going forward. A few of the issues are noted below, which should be covered as part of a deeper dive into AOD service provision across the district.

Opioid Substitution Therapy (OST) services

One of the biggest issues that was mentioned be specialist AOD staff in Dunedin was the significant amount of time that was being spent on the Opioid Substitution Therapy (OST) programme compared to the amount of time that was going into offering other specialist AOD interventions. The SAS team estimated that the OST programme absorbs about 70% of the team's total capacity to deliver AOD services. This is due to the high number of

people on the OST programme coupled with the fact that the majority of this group are presenting with complex health and social problems that need intensive input.

In the period 2015 to 2019 SDHB had one of the highest rates of methadone dispensing in the country (Figure 4). The Specialist Addiction Service (SAS) in Dunedin told the review team that they were funded to deliver Opioid Substitution Therapy (OST) to 320 people, but that they saw 420 people, with a further 18 people on the waiting list. It has become their main focus to the detriment of other work that they could be doing to support community-based AOD services.

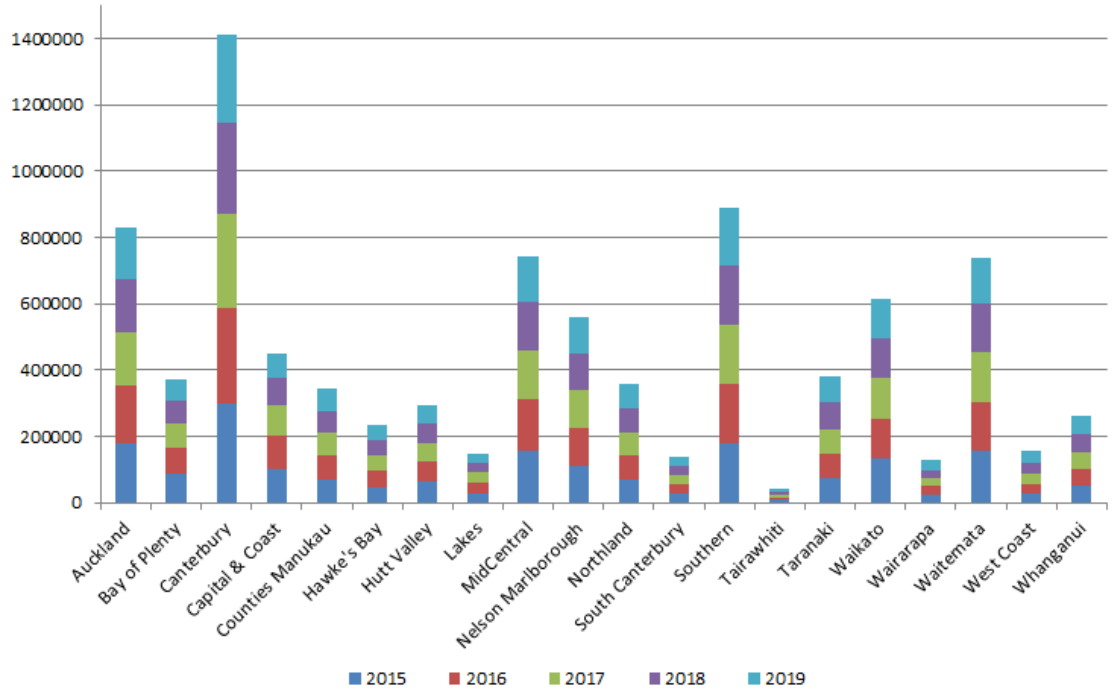


Figure 4: Methadone dispensing rates by DHB – for the period 2015–2019 (Ministry of Health, 2020. Pharmaceutical data web tool (data extracted from the Pharmaceutical Collection on 5 March 2020), Wellington: Ministry of Health)

Lack of capacity and capability in community-based AOD services: Screening and brief interventions can be provided by a wide range of staff, including general practitioners and others in primary care, staff in accident and emergency departments, staff in MH&A NGO services and community workers who are working in other parts of the health and social sector. However, there is a sense that screening and brief interventions do not form part of everyone's skill set and that the development of some core competencies in this area is not a high priority across the system. This means that some consumers who would benefit from receiving this service at a very early stage in their journey are not getting it. It also increases the likelihood that consumers with mild-to-moderate problems will be referred onto a specialist service, when in fact they do not need it.

People with more severe problems do need access to intensive addiction treatment options, including withdrawal management (detox), counselling, group programmes, intensive day programmes and residential programmes. Initial indications are that there are gaps in this area, but it is too hard to identify services gaps without developing a

deeper understanding about how the current AOD system is (or isn't) working, starting with the delivery of low-level interventions to the delivery of more intensive treatment at the specialist end of the continuum.

We run a great group programme (we see about 300 people per year). This service could be run by an NGO rather than a specialist AOD service. – AOD clinician

AOD services for young people: It is important to note that the initial analysis points to a significant gap in service provision for people in the 0–18-year age group who have either alcohol and other drug problems or co-existing MH&A problems – with only 10% receiving either an AOD or a co-existing MH&A service, compared to 27% nationally. This issue needs to be explored in more depth as part of the deeper dive into AOD service provision for this age group.

AOD services for the prison population: There are clear impacts on AOD services that have arisen in relation to the closure of the old prison, which had about 49 beds, and the opening a new 400-bed prison near Milton in South Otago. Many of the prisoners have AOD problems and choose to remain in Otago when they are released from prison. This has resource implications for the local AOD services.

AOD services for Māori: There is a higher prevalence of alcohol and other drug problems amongst Māori. Those Māori who have both mental health and AOD problems are particularly disadvantaged. There is a need for more Kaupapa Māori alcohol and drug services in the district as well as a culturally appropriate response from mainstream mental health and AOD services.

9.3.6 Review contractual structures and explore the reconfiguration and/or decommissioning of non-value-adding services

Whilst there are key gaps in the continuum of care and there is a need to invest to fill these gaps. The reviewers are cognisant of the current financial situation of the DHB. However, resources must be found to invest in filling the gaps – or it will be impossible to begin to resolve the reinforcing dynamics which DHB provider arm services, in particular, find themselves in. Part of the answer to investment is to identify areas for reconfiguration and/or disinvestment.

The Southern district has so many service providers and some are poor quality. The NGO sector must be accountable as well, and some of the services should not be funded. There are some cases where disinvestment is appropriate. – Community stakeholder

During the review a selection of primary and community service providers highlighted the fact their current contracts supported inflexible and, at times, inefficient delivery of services. If contracts could be altered to incorporate more contemporary contracting approaches (i.e., high-trust, longer-term, outcome-based), then more value could be realised from the investment.

Further in this report we recommend the establishment of a strategic commissioning role. An important initial task for the new role will be to review current service provision and make decisions on what services require reconfiguration and/or decommissioning. This includes services provided by the DHB, by NGOs and by other primary/community organisations. The decommissioning of services is often difficult, but it is necessary to ensure that the MH&A system is modern, agile and using best practice and the latest evidence.

9.4 Recommended actions

5	**Develop** the full range of crisis response options with an immediate focus on Queenstown, Central Lakes and Waitaki.
6	**Transform** current day services into community wellbeing hubs with an immediate focus on Invercargill and Dunedin.
7	**Develop** options for an acute home-based mental health specialist service.
8	**Improve** access to senior medical officer advice for primary care, community mental health teams and community providers.
9	**Review** contractual structures and explore the reconfiguration and/or decommissioning on non-value-adding services.
10	**Review** the full range of alcohol and other drug services with a view to identifying the high-priority areas for development.

10. ADOPT A LIFE COURSE APPROACH AND DESIGN SERVICE RESPONSES ACCORDINGLY

Hazel was 11 years old when she started to become unwell and she was 26 years old when she died, having made several attempts on her life over the years. She was a beautiful and intelligent human being who never got the time (and space) to recover. It would seem that cancer is better served than mental health… We are not treated equitably. – Hazel's mother

Blueprint II (Mental Health Commission, 2012) introduced a 'life course' approach (Figure 5), which looked at the critical points in the development of mental health and addiction issues across the life span. The benefit of adopting a life-course perspective is that it makes explicit the influence of family/whānau, community, environment and the wider societal issues on people's lives. Such an approach implies that the development of health (and other outcomes) over a lifetime is an ongoing, interactive process and that pathways are changeable (Fine & Kotelchuck, 2010). It also suggests that it is possible for health and social services to work together to make a real difference in people's lives by intervening earlier and more effectively in the life course, thereby improving people's health, wellbeing and long-term outcomes, thereby reducing the downstream costs to society.

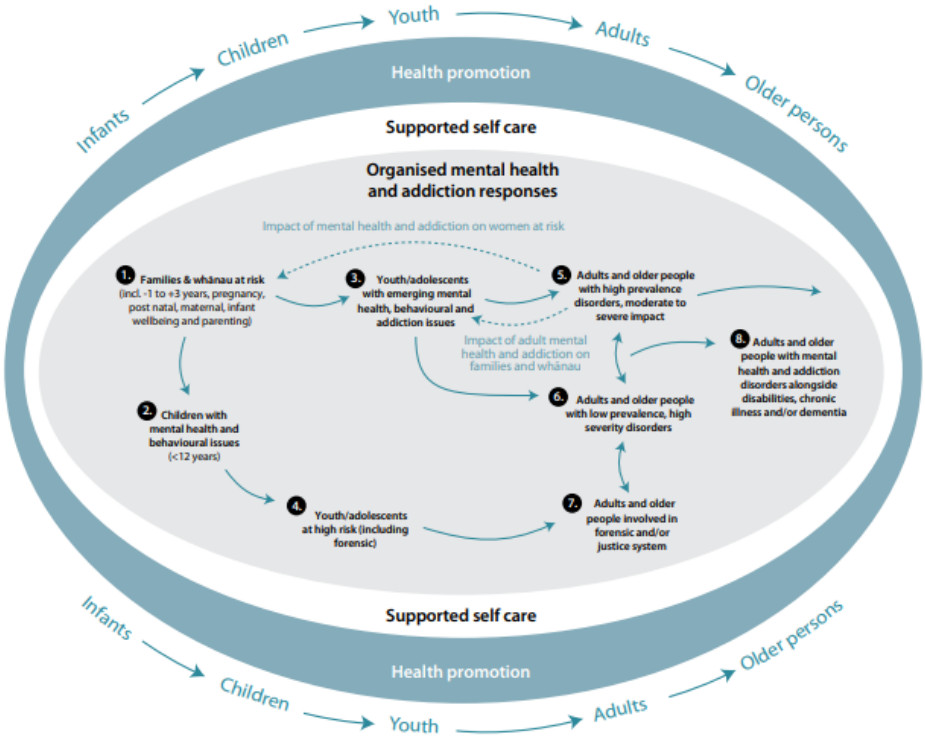


Figure 5: Life-course approach (Mental Health Commission, 2012, p9)

Table 3 provides an overview of the current state with regard to the level of investment in infant, child and youth MH&A services in the Southern district in 2020/21. The data has been selected based on the account codes as per the Ministry of Health Purchase Unit Descriptions. In some instances, some contracts with service providers are 0–24 years, while others may be 0–19 years. There are also some adult services that can be accessed by youth.

Table 3: 2020/21 budget for child & youth MH&A services – excluding funding for mental health for older persons

	Adult		Youth		Total
	NGO	Provider	NGO	Provider	
Sum of 20/21 budget	$19,215,548	$63,528,586	$6,084,053	$7,588,281	$96,416,468
% of budget	19.94%	65.89%	6.31%	7.87%	100.00%
		85.82%		14.18%	

Table 4 provides the same information, but includes funding for mental health for older persons.

Table 4: 2020/21 budget for child & youth MH&A services – including funding for mental health for older persons

	Adult		Youth		Total
	NGO	Provider	NGO	Provider	
Sum of 20/21 budget	$19,215,548	$69,093,232	$6,084,053	$7,588,281	$101,981,114
% of budget	18.84%	67.75%	5.97%	7.44%	100.00%
		86.59%		13.41%	

Note: Infants, children and youth in the 0–24-years age bracket comprise **31%** (108,450) of the total population of the Southern district (349,750), but attracted less than **15%** of the total budget (approximately $102 million) on MH&A services in the 2020/21 financial year.

The Māori population has a younger age structure compared with the non-Māori population, with over **50%** in the 0–24-year age bracket. This age group also has a higher rate of mental health and addiction issues, as well as a higher rate of suicide, particularly amongst young Māori men.

10.1 Infant, child, youth & families/whānau – rationale for prioritisation

Mental illness and addictions are the leading cause of disability and poor life outcomes for young people in New Zealand. The onset of mental illness peaks in adolescence and

early adulthood, with 50% of all mental disorders developing before the age of 15, and 75% by the age of 25. New Zealand also holds the shameful record of having the highest youth suicide rate for children and youth aged 10–19 years amongst 19 developed countries (Shah, Hagell & Cheung, 2019).

The 0–24-year age group is a priority because the experience and impact of trauma and mental distress during this life stage is very significant and can have lasting, negative effects as an adult. Targeted prevention measures, early intervention services and effective treatment options for this group present the best opportunity to reduce the personal, social and economic costs of mental distress and addiction problems that are experienced by infants, children, young people and their families/whānau – both now and in the future.

In every locality across the Southern district people told the review team that the DHB should be doing more to help improve the mental health and wellbeing of infants, children, youth and their families/whānau. We heard from young people, from families/whānau and from staff who all considered that existing infant, child and youth MH&A services are not able to respond to the increase in demand for services in their district.

A few quotes from youth:

- "Funding is set aside for youth mental health, but we don't see where it's going, it just seems to disappear."
- "Young people are forced to be very self-directed in their journeys, which when you're experiencing mental distress and illness can be very challenging or impossible."
- "Youth access to mental health services is very poor."
- "Waitlists of months to be seen by someone, and the six-session limit on some services (e.g., student health, but also brief interventions, etc.) is a problem."
- "The only option offered is medication rather than counselling or access to other resources." **Note:** This issue was mentioned multiple times.
- "Not enough exposure to what mental health or wellbeing services are available, or information about the steps to access these services."

A few quotes from whānau, family members and family-focused organisations:

- "Adolescent services need to be overhauled in Dunedin to ensure they are able to respond to the needs of the young people presenting. Funding suitably skilled supported accommodation for young people with no whānau connections is the most challenging gap in this age group. And respite care is non-existent to support those who are living at home."
- "From an education point of view, we are finding a worrying trend where much younger children (under 12) are experiencing trauma that affects their learning and behaviour long term. These young people and their families in urban and

rural areas are finding it increasingly difficult to access support that is coordinated and relevant for their needs."

- "Enhance engagement with family and whānau, provide more planned and crisis respite options, and provide more education and practical support for families/whānau."
- There were a number comments about the poor interaction with the general emergency department (ED): "It was difficult to find an appropriate health professional to take our situation seriously and/or guide us in the right direction for access, recognising this was a mental health problem and not addiction and/or criminal behaviour, accessing help in an emergency. When we called EPS to ask for help to have our son assessed we were told that as he may be violent they couldn't come to him rather we needed to bring him in, managing to bring him in to (ED initially) took quite some time and risk on our part, once in ED the wait was so long and in difficult conditions that his already distressed state escalated out of control."
- "My son also had to spend 13 hours in a police cell to await assessment and wait for a bed at Wakari."
- "I didn't know there were support services, I never was advised of this."
- A family with a child who had an eating disorder noted issues getting things moving at the GP level- i.e., "do not expect GPs to know where to go."

10.2 Fast facts

- People aged 0–24 years comprise 31% of the total population in the Southern district.
- People aged 0–19 years comprise 24% of the total population in the Southern district.
- SDHB apportions approximately 15% of its total expenditure on MH&A services (including youth forensic services) to people aged 0–19 years.
- Growth in the 0–19 segment of the population over the 2018–2028 time period is projected to be 17% (Māori), 31% (Pacific) and 24% (Asian).
- The 2012 Adolescent Health Research Group findings, via the National Health School Survey of 8,5000 secondary school students aged 12–18 (Clark et al., 2013) found that 16% of females and 6% of males reported symptoms of depression that were likely to be clinically significant. A further 38% of females and 23% of males reported feeling down or depressed most of the day for at least two weeks in a row.
- The 2012 Adolescent Health Research Group (Clark et al., 2013) found that approximately 11% of high school students met the criteria for very high substance use. This included students right through the high school years (4% of those aged 13 or under, and 15% of those aged 17 or over). The very high level of use is likely to cause students significant harm and may cause long term problems.
- In 2019, Youthline experienced a 50% increase in contacts from young people reaching out for support, a 90% increase in care and protection matters and a

23% increase in suicide risk nationally. In the Southern district Youthline reported a dramatic increase in young people under the age of 12 in the Waitaki district who were needing access to a counselling service.

- Pregnancy and childbirth are particularly vulnerable times for women. An estimated 14% of New Zealand women will develop depression, anxiety or other mental health issues during this time.

10.3 Issues

Service demand (numbers and complexity) outweighing workforce capacity and capability: Several respondents made comments about the increased demand for both specialist MH&A interventions and community support services for expectant mothers, children, youth and their families/whānau. They were concerned about the inability of the current MH&A system to respond to the increased level of demand, particularly with regards to maternal mental health and children/youth with complex needs.

Long waiting lists: People talked about having to wait a long time to access a Child & Youth MH&A service (e.g., ten weeks to access a youth NGO service) and expressed concern about the strain on community providers that were expected to support distressed teenagers and their families/whānau until such time as a specialist MH&A service was able to offer assistance.

Problems with the general emergency department (ED) and the emergency MH&A service (EPS): People talked about the difficulties that they experienced accessing support from ED/EPS in Dunedin. They described waiting for long periods of time to be assessed, sitting in a depressing physical environment, and the lack of support that was available for consumers and families who found themselves in this situation.

Lack of mental health & addiction education and support for college-age students: A group of college students who met with the review team talked about how mental health problems were common amongst their peer group and how much it was still such a stigmatised issue. This stigma meant that students were reluctant to talk about their problems with their peers and/or seek help. They thought that it was important that students learn more about mental health as a core part of the school's health curriculum and suggested that it was a topic that should be talked about right throughout the school year instead of being treated as a 'one-off' event or a lone learning module.

The result of the Adolescent Health survey (Clark et al., 2013) indicates that efforts to support students with very high substance use will need to be able to reach at least 11% of the high school population. Any interventions will also need to consider the student's family and school contexts and will need to address multiple social, health, mental health and behavioural issues.

It is noted that some specialist ICAMHs staff expressed a desire to work more closely with local schools to help teachers address mental health issues as part of a targeted early intervention strategy, but said that they were unable to do this at the moment because of the lack of ICAMHs staff and the lack of resources.

Youth inpatient beds: Ward 9C has two South Island regional youth inpatient beds within a dedicated youth area, but the area is situated within the acute adult inpatient unit. This is not an ideal situation, but there are few alternatives, apart from redirecting a young person to the specialist child, adolescent and family inpatient service in Christchurch. Figure 6 shows the number of child and youth admissions for the period 2013 to September 2017, based on the figures generated as part of a SDHB project on bed management.

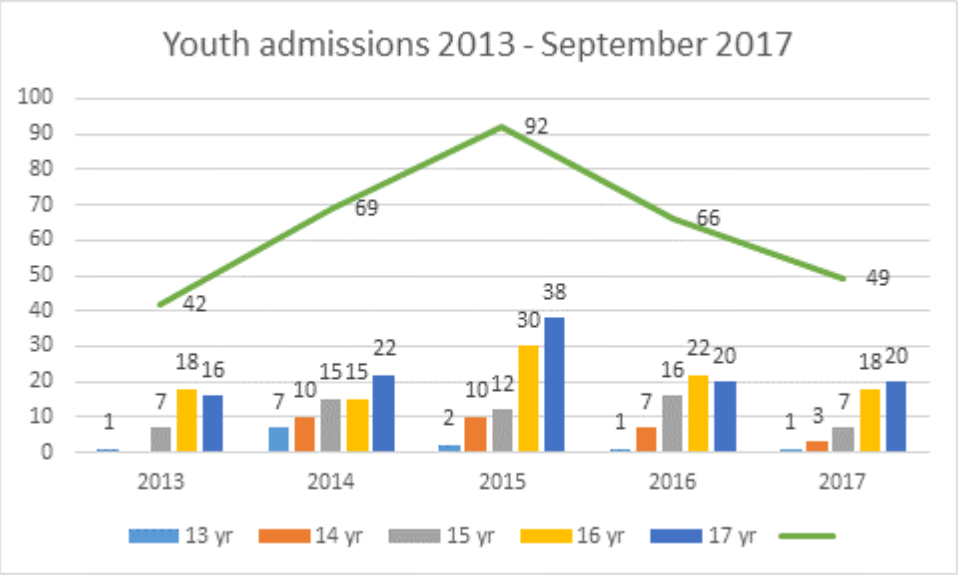


Figure 6: Number of child and youth admissions 2013–Sept 2017

Student health services are not well integrated into DHB MH&A services: There are over 21,000 students at Otago University (77% come from other DHB districts), 7,000 students at Otago Polytech in Dunedin and Cromwell and 13,000 students with SIT in Invercargill and Queenstown. Feedback from young people and other community stakeholders would indicate that the student health service is not well integrated with the wider MH&A system, including primary care.

FASD: Lack of MH&A services for people with foetal alcohol spectrum disorder.

Transgender healthcare: Mental health access is tied to transgender healthcare in the SDHB due to the requirements for psychiatric assessment as part of the medical transition process. As such, it is highly likely that a trans person will have contact with the SDHB mental health system. Two respondents reported significant variation in practice with regard to trans people and said that the Auckland service, which is run through the sexual health clinic, is considered by trans advocacy groups as being a best-practice service.

Rainbow mental health and addiction: A youth representative reported that it's common for MH&A clinicians to focus on a casual mention of a person's queer identity as being an issue, regardless of whether or not that's the reason why the service user was in distress or seeking counselling. On the other hand, clinicians are often not well equipped to handle

instances where queer identity does factor into a service user's distress. Given that queer youth have higher rates of depression, suicide, substance use, homelessness and school drop-out rates than heterosexual youth, the level of cultural competence in this space is a MH&A workforce development issue.

Neurodivergence (e.g., ADHD, autism, and other neurological/developmental conditions): A peer youth worker reported unclear and costly diagnostic processes, poor clinical competence and referrals to inappropriate services for young people with neurological/developmental conditions.

Greater focus on youth appropriate services: The long transition from adolescence to adulthood means that some young people in the 18–24-year age group are best served by a dedicated youth MH&A service (particularly if they are already known to that service) rather than being transferred to an adult MH&A service. However, the retention of some young people who have hit the upper age limit for access to a child and youth MH&A service does have resource implications.

Ethnic diversity: The Southern district has had a significant increase in refugees and migrants over the years, many of whom are living in rural areas where services are not well equipped to deal with language and cultural differences. In the Southern region, the numbers of young people identifying as being of Māori, Pacific or Asian ethnicity are predicted to increase over the next two decades, with the Asian 0–19-year age group growing at the fastest rate (24%).

Mothers with substance use problems: The review team was informed that access to AOD services for young mothers who had substance abuse problems had become problematic, particularly in Dunedin.

Family violence/family harm: The effects of trauma and maltreatment experienced in childhood can result in long-term physical and mental health consequences, including depression, anxiety disorders, drug abuse and suicidal behaviour. The Family Harm approach aims to drive down the significant harm experienced by families through an integrated cross-agency response.

10.4 Where are people aged 0–18 being seen?

Figure 7 indicates that a higher percentage of people under the age of 18 are being seen by NGOs (36%) compared to the national average (18%), with the majority of presentations being for mental health related issues (91%) compared to the national average (78%).

Conversely, a much lower percentage are being seen by DHB specialist services only (50%) compared to the national average (68%). Shared-care arrangements are about the same.

It is important to note that the initial analysis points to a significant gap in service provision for people in the 0–18-year age group who have alcohol and other drug problems, or co-existing MH&A problems – with only 10% receiving either AOD or co-existing mental health and AOD services, compared to 27% nationally. This issue needs to be explored in more depth as part of the deeper dive into AOD service provision.

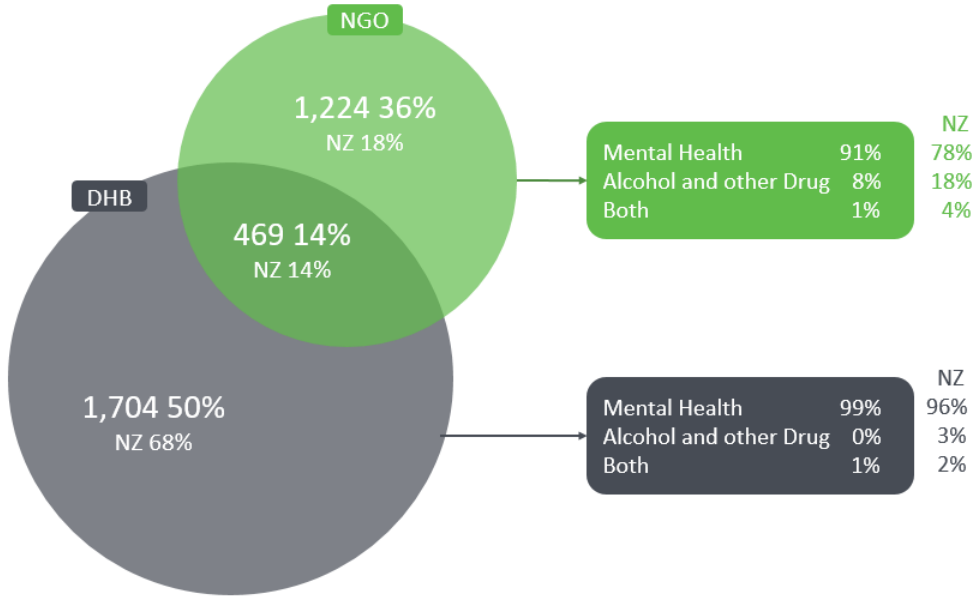


Figure 7: Southern DHB area (under 18 years) for the period January 2020–December 2020

10.5 What needs to happen?

The following recommendations reflect the areas of focus in the Werry Centre's (2019) national stocktake of child and youth MH&A services:

- Increase and allocate appropriate levels of funding that is targeted at specific segments of the infant, child and youth population (and their families/whānau).
- Increase, strengthen and support the specialist ICAMH/AOD services and workforce, starting with those localities where there is high demand (volume), high acuity and low staffing levels.
- Increase, strengthen and support the development of primary and community MH&A services and the workforce (including the youth peer workforce).
- Develop and provide early intervention programmes and services in settings such as schools and community hubs/youth centres.
- Support the development of new initiatives to meet local needs, e.g., through the development of youth-specific services and the co-location of specialist youth mental health services in primary/community settings.

What we are also doing well in Invercargill is 'Family Connection', which we have just started, and this involves a 12-week free programme aimed to support for families/whānau of people with mental health distress. It is an evidenced-based programme and provides an opportunity for the family to gain skills for better communication, to understand the distress of their loved one and to share experiences. It is run weekly, in the evenings, for 12 weeks. Source: Lived Experience representatives

10.5.1 Mobile youth team

One submission suggested that the age range for access to Youth Specialist Services (YSS) in Dunedin be extended to 25 years so that it was a true youth service, similar to that of Orygyn in Melbourne, the Headspace centres across Australia, and Youthspace in Birmingham. The idea is that young people would receive a fairly intensive level of input, and that anyone who then transitioned from a youth service into the adult CMHT would do so because they had more enduring MH&A needs that required a different treatment approach. Given the relatively high numbers of youth aged 18–25 years who are seen by the North and South CMHTs in Dunedin (approximately 221 people), it would be feasible to create a youth team by reconfiguring current resources without too much financial outlay, other than making sure the team was mobile and undertook outreach work. Setting the boundaries to correspond with those in the NGO sector (and the impending localities) would better reflect a stepped-care model. The team could also provide consultation-liaison support and/or guidance to entities such as the school counsellors and primary care practitioners.

10.5.2 Youth one-stop shops and community youth wellbeing hubs

The challenge for the MH&A sector is to configure services that address youth concerns about privacy and confidentiality, to provide youth-specific healthcare, and to promote healthy choices. A number of community youth health organisations have been established in New Zealand over the past 20 years to respond to this challenge, including Youth One Stop Shops (YOSS).

The Youth One Stop Shops provide access to a range of services in youth-friendly settings, including health, social, education and/or employment services with the ability to refer to secondary or tertiary services as required. In 2009 the Ministry of Health evaluated fourteen YOSS services provided throughout the country and found that they provide a range of accessible, effective, youth-friendly health and social services at little or no cost to young people. In 2008, 'Number 10' Southland Youth One Stop Shop was established to respond to the needs of young people aged 10–24 in Southland. It is noted that this is the only YOSS that is operating in the Southern District.

Figure 8 is a diagram of an ideal 'clinic' for young people that has been drawn by the SDHB's youth advisory group, specifically for this review. It offers a useful starting point for the DHB should it be interested in commissioning other youth-friendly MH&A services in the Southern district.

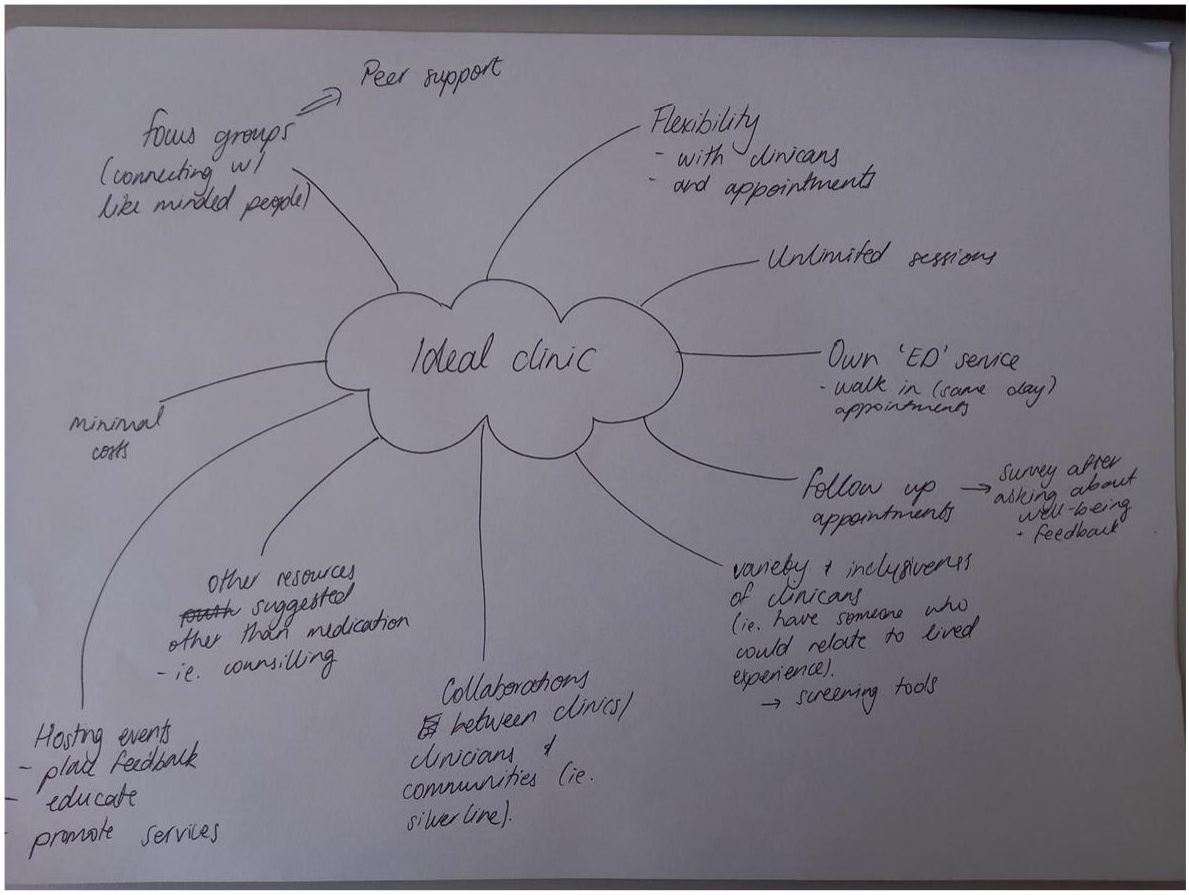


Figure 8: The ideal youth MH&A clinic/service (SDHB youth advisory group, May 2021)

10.6 What does this mean for Māori?

A Kaupapa Māori approach would include multiple entry points and multiple pathways that would enable rangatahi to flourish. Kaupapa Māori services would be designed and implemented by the local community, rohe and iwi, in conjunction with rangatahi. The response would also include mainstream services with the capacity to provide culturally safe services for rangatahi. Central to the process of strengthening the MH&A system to better respond to Māori aspirations is the need for Te Tiriti to underpin services, structures and resourcing.

A list of MH&A service responses for tamariki, rangatahi and their whānau could include the following (HQSC, 2020, p41):

- Ensure Māori mental health and addiction services provide 'trauma-informed' approaches to care that take account of, and accommodate, Māori worldviews.
- Expand service responses to recognise psychological distress and safety concerns.
- Prioritising Māori specific concepts of suicide and wellbeing in care and prevention, and expand options to include Kaupapa Māori providers.
- Support improvements in hospital and community Māori maternal mental health services.
- Train DHB staff to deliver culturally responsive care.

- Ensure access to culturally safe services for those in remote and/or rural locations.

Figure 9 was developed by a group of young wahine Māori in Invercargill, who were keen to develop a wellbeing hub for people in that area. It demonstrates how rangatahi intuitively perceive the social determinants of health and their whānau as being inseparable from mental health and wellbeing.

Figure 9: Proposed design of a community block to support health and wellbeing

10.7 Recommended actions

11	**Ensure** that the dedicated and/or ring-fence 'by Māori for Māori' investment pool (recommendation 2) specifically targets maternal mental health, pēpe, tamariki and rangatahi mental health & addictions services.
12	**Create** an investment plan to utilise growth funding for services for infants, children, young people and their families/whānau – with particular attention to the Pacific and Asian populations, as the number of young people in the 0–19 age group in these ethnic groups are projected to increase over the next ten years.
13	**Support the investment plan** with a workforce development plan that specifies the actions that will be taken to increase, strengthen and support the infant, child & youth workforce with the future state in mind.

14	**Improve** the collection and use of reliable ethnicity-related performance data to help identify inequities in service provision, service utilisation and outcomes of care, and to routinely track progress over time in addressing them.

"It distresses me how much health care resource is wasted in not having clarity about where to access help, getting assessed by the right people and referrals to appropriate therapies – it's all so fragmented. Someone needs to hold this knowledge, keep it up-to-date and be a central place that people can approach to find out where best to get the help that they need"

11. IMPROVE THE PHYSICAL ENVIRONMENTS

11.1 Rationale for prioritisation

During the course of the review, we visited facilities that are not conducive to recovery. In some cases, the environments are inappropriate for some groups due to the mixture of client groups with different needs and/or age groups within the same ward. Stakeholders in particular noted times when younger people have had to be accommodated in an adult acute inpatient unit due to no other options being available.

We treat many adolescents as inpatients for, amongst others, eating disorders, and desperately need appropriate psychiatry and psychology involvement for these inpatients. No dedicated adolescent inpatient beds for eating disorders/other psychiatric conditions in the Southern DHB. They need to go to Christchurch, with already limited bed space, so it almost never happens that we are able to send a young person to them for inpatient care. Adult psychiatry wards are inappropriate for children / adolescents. – Workforce survey response

11.2 Issues

Settings don't support effective clinical practice: Many stakeholders provided examples where the physical environments did not enable them to provide contemporary, best clinical practice. In particular, the lack of spaces and equipment to help reduce people's distress and promote calm was highlighted as an issue.

Settings are not safe for staff or patients: Incident data shows that there has been a high number of health and safety events, some of which have been of a very serious nature. SDHB has recently completed an independent health and safety review, which has found that the facilities at the Wakari site in particular have a number of health and safety issues that must be addressed for the safety of staff as well as patients.

Some facilities are well past their use-by date: Over the years, investments have been made to improve the physical environments where care is provided. Whilst these investments have enabled services to continue operating from these facilities, the options to continue "patching up these run-down, out of date facilities", as one senior clinician said, have come to an end. There is a strong view that no further investment (outside of normal maintenance) should be made in certain facilities, especially those on the Wakari site and in the Fraser Building. Any investment should be directed towards alternative options that form part of the continuum of care outside of these facilities.

Some settings not welcoming, caring or enable support to be effectively provided: Feedback from those with lived experience (including families and whānau) highlighted issues such as waiting room spaces in buildings such as the Fraser building being unwelcoming, cold, sterile environments that are not appropriate for people who are already in a distressed state. People talked about feeling unsafe and also not being monitored appropriately – with long gaps between check-ins from staff.

Care could be provided while waiting: It was acknowledged that some period of waiting for support is at times inevitable. However, waiting with no support was highlighted as an issue. A number of stakeholders raised the fact that peer support could be provided to people who are in a distressed state whilst they are waiting to be seen or assessed, particularly when they are waiting in an ED and/or a crisis service.

11.3 What needs to happen

11.3.1 Wakari MH&A Inpatient Facilities

The issues with the MH&A inpatient facilities at the Wakari site are well known. A recent report by Sapere Research Group ((nd), as cited in Otago Daily Times (2020)) found that "nearly all facilities were dated and not fit for purpose, posing safety risks to patients and staff and hindering appropriate quality care of patients". Our review, although broader than just facilities, supports the findings of the Sapere report. Particularly distressing is the number and severity of the staff incidents (including serious health and safety events) occurring across the Wakari site. An independent health and safety report has found the facilities to be unsafe and to pose ongoing and significant risk to staff and patients.

We could continue providing evidence of the issues created by the inadequate physical environment at the Wakari site, but it is clear and obvious that change is required.

The DHB should clearly signal that change is going to happen. Even the Sapere report provides options for further consideration. We propose a clearer and more decisive pathway. The reviewers recommend signalling the closure of the adult mental health and intellectual disability inpatient facilities on the site. The parts of the site currently configured to be inpatient wards/units, could be repurposed for other uses but should no longer be used to provide inpatient care for people with mental health, addiction and intellectual disability needs.

While the forensic services that operate from the Wakari site formed part of the discussions about closing the site, stakeholders highlighted the fact that these types of services are more complex and require considered and careful planning in order to close them in their current form.

The reviewers understand that a change such as this would require planning and investment. It is also acknowledged that closing the site and recreating the same issues somewhere else would not be sensible. Therefore, to support this change, it is recommended a clear plan is developed which explores the following:

- Investing in primary and community service responses (with support from the DHB specialist workforce) which offer appropriate alternatives to inpatient admission (e.g., Tupu Ake).
- Develop and invest in packages of care for those patients who could more appropriately be supported in alternative community-based settings.
- Invest in the areas across the continuum of care (as outlined further in this report) in order to offer the best opportunities to manage demand further upstream.

Closing the Wakari site is not just about closing an outdated facility. It also signals that the DHB has heard the voice of consumers, respects the workforce that work at this facility,

and is serious about people's safety and wellbeing. It reinforces the fact that effective inpatient care is critical to any well-functioning mental health and addiction system. It also signals a commitment to the scale of change required to improve the system. This is not an overnight fix and will require sustained input and commitment to be realised.

Without having done the detailed planning, it is difficult to put an exact figure on when the Wakari site should cease to be used as an inpatient facility. However, building on feedback from stakeholders, we suggest that Wakari inpatient facilities should be gradually decommissioned with any remaining inpatient facilities closed to align with the timeframes for the new Dunedin Hospital becoming operational. This will require a business case to be completed – as a matter of high priority.

11.3.2 Other facilities and locations of service

The reviewers found that a number of other facilities do not support a positive patient experience of care and are likely to be reducing the effectiveness of clinical care. These include the Fraser Building in Dunedin. Feedback from consumers and whānau highlighted how the nature of the building and the waiting area in particular are neither inviting or calming places to be, especially when agitated and/or unwell.

The style of this building does not support the opportunity for staff and/or peer support workers to provide appropriate support while people are waiting and/or comfortable environments to be seen and feel cared for.

It is recommended that the EPS (crisis) service that operates out of the building be moved to a more appropriate physical location with a better community-facing entrance, waiting area and supportive clinical environment. It would be best to maintain a link to the emergency department; this will restrict the available options, but it is important to mutually support the presentation of people at ED and the easy transition to the crisis service without requiring significant travel. Alongside this shift it would be ideal to explore the co-location of the EPS and Community Mental Health Team located in the Fraser Building. If a space can be found to support the co-location of both services in the community this would be ideal.

11.3.3 Improvements in the environments operated by NGOs

The reviewers did not have the scope to undertake a full review of all NGO facilities, but the ones that the team did visit appeared reasonable and fit for purpose. It is worth noting, however, that feedback from some stakeholders highlighted the need to ensure that physical environments utilised by NGO providers are also welcoming, safe and therapeutic. Supporting NGOs to make the investment in their facilities was raised as an important issue.

11.3.4 Rural hospital network

SDHB has an opportunity to better utilise its rural hospital network to support mental health. The rural hospitals are natural hubs in the local health system and link with a wide

range of local services – and act as a link to specialist services. It is noted that some of the rural hospitals already have a relationship with the local CMHT, which could be developed further.

The local hospitals are mostly run by local trusts, which represent local communities and are responsive to new service models and opportunities for integration. Some trusts already run integrated primary care and local hospital services. Local hospital trusts are well positioned to contribute to the whole-system issues associated with localities, wellbeing and equity.

11.4 Recommended actions

15	**Signal** the intent to close the adult mental health and intellectual disability inpatient facilities located on the Wakari site.
16	**Develop** a concise plan and timeline to develop the capacity of community and alternative responses to support the closure of Wakari (options should include packages of care, step-down and alternatives to admission). This should also include links to crisis response options – as per recommendations 5, 6, 7 & 8.
17	**Work** in partnership with the Ministry of Health to develop an investment business case for the development of new adult inpatient facilities to replace the services currently provided on the Wakari site. These new inpatient facilities should be aligned in design and as much as possible in close physical proximity to the new Dunedin hospital. *Note: This does not include forensic inpatient services as this requires a different configuration.*
18	**Explore** new premises for services currently located in the Fraser building that offer easier access and improved experience of care for consumers, families and whānau.
19	**Support** the development of a plan to better utilise the rural hospital network as community wellbeing hubs, including the co-location of community and crisis mental health and addiction services.

12. RECONFIGURE SUPPORTING FUNCTIONS AND STRUCTURES

12.1 Rationale for prioritisation

In a paper entitled "Ending the endless reorganisation – building an adaptable operating model" (PwC, 2012), the authors discuss how, in many instances, organisations shift their strategy but fail to adapt their operating model. The paper goes on to show how an effective operating model acts as the bridge between an organisation's strategy and its operational resources, and the set of supporting functions and structures that enable a system to operate effectively.

The recommendations in this review amount to a significant shift in strategy and focus for the mental health and addiction system. A focus that is centred on localities, strategic commissioning, blended teams (agnostic to which organisation people work for) and cross sector intelligence and stewardship.

As such, updates to the operating model are required. It is important to note that updates to functions and structures must be supported by a process of organisational development, with associated investments in people, teams and culture. For example, it is easy to say that we now operate using a strategic commissioning approach – ensuring the relationships we have, the values we espouse and the culture we operate within aligns to this approach will drive its success or failure. As explored earlier in this report, locality-based commissioning will be central to the future health system. With this future in mind the supporting functions and structures across the MH&A system need to support the following:

1. a focus on the design of services by Māori for Māori alongside an increase in investment
2. a focus on locality-based commissioning and investment
3. a focus on ensuring the full range of care options is available across the continuum of care
4. a focus on supporting our workforce and its skills to deliver highest impact and value
5. a focus on a 'how can we help' culture
6. a focus on trust, local decision making and clear stewardship.

12.2 What needs to happen

12.2.1 Create a MH&A strategic commissioning role at the Executive Leadership Team level

The recent health reforms have indicated that localities and commissioning will be core to the future. The MH&A system requires a strong focus on localities and commissioning going forward. To support this, it is recommended a role be created with the suggested title of 'head of MH&A strategic commissioning'. The importance of the role, not just for

the MH&A system but to support the wellbeing agenda more broadly, means that this role should be included as a member of the Executive Leadership Team and report to the CEO. It is envisaged that this role is very different to current planning and funding role and hence the current funder/provider role would need to change.

An important initial task for the new role would be to review current service provision and make decisions about where to invest (given priorities suggested in this and other reviews/reports), and also, most importantly, to make decisions on what services require reconfiguration and/or decommissioning. The d-commissioning of services is often difficult, but is necessary to ensure the MH&A system is modern, agile and using the latest best practice and evidence.

12.2.2 Create a 'by Māori for Māori' commissioning function

This is described in detail in other areas of this report. It is important to reinforce in this section as it represents a key part of the supporting function and structure that will enable by Māori for Māori commissioning decisions to be made.

12.2.3 Support strategic commissioning with excellent locally oriented data and intelligence

Good strategic commissioning decisions can only be made if they are supported by robust data and intelligence. This data needs to be qualitative as well as quantitative, including people's experience of care as well as access numbers, treatment outcomes and social determinants. It also needs to be locally informed – able to deal with the nuances at a local level. This will push the boundaries of what MH&A systems have traditionally collected, analysed and used to support their decision making and commissioning intentions. For example, the data may indicate that to have the greatest impact on wellbeing services need to be commissioned which fall outside the scope of 'traditional' mental health and addiction services.

12.2.4 Disestablish the current Network Leadership Group and reconstitute as a cross-sector intelligence and stewardship group

It has become clear during the review that the Network Leadership Group (NLG) was not functioning as it was intended when it was established some years ago and that change was needed.

Stakeholders indicated to the reviewers that whilst the NLG involved good people and resulted in robust conversation, it was not effectual at creating action and was past its use-by date. Attempts to update the terms of reference and its role, function and remit appeared to constantly stumble, with little progress being made; a sure sign that the rationale for the group had become unclear and its purpose lost.

Stakeholders, including members of the NLG, acknowledged that the NLG in its current form is no longer effectual and should be disestablished. The reviewers would like to make it clear that this doesn't represent failure, but the fact that the world does move on

and that structures created at a point in time can sometimes become obsolete and no longer fit for purpose – this is certainly the case with the NLG.

In its place, the reviewers recommend that a cross-sector intelligence and stewardship group be established with representation from agencies across the district, including police, welfare, justice and consumers. The current interagency group is potentially a sensible place to start from. The group should provide advice into the new strategic commissioning role, and whilst clear terms of reference will need to be established, the group should be the cross-sector eyes and ears for the MH&A system. They should be able to take advice back to their constituent agencies/networks relating to decisions they have control over, which would improve the wellbeing outcomes for the people of the Southern district.

It should clearly be described as an advice and communication network. It should not be making investment/commissioning decisions, but should have influence over how commissioning decisions are made, particular where there are cross sector/agency issues.

12.2.5 Support the creation of strong local advisory networks

In the spirit of co-production, the review team supported the establishment of a Lived Experience Advisory Group (LEAG) as a key part of the review. This group was established, in part, due to there being a gap in the current MH&A system. It is true that some structures exist across the DHB to ensure the voice of consumers and families/whānau are included at all levels of decision making, but for the purpose of the review these were felt to be inadequate.

Throughout the review the LEAG provided expert advice and guidance, including support to develop the consumer survey and taking a lead role in the lived experience sessions at each of the four service development workshops held across the district. An output from the service development workshops was a desire from consumers to establish local consumer advisory groups which would act as the local custodians of the consumer voice. These groups would agree to have a representative on the newly constituted intersectoral group (described above) to ensure that this group and the advice to the strategic commissioning role incorporates the voice of consumers. It is recommended that the DHB provides ongoing financial support to enable the local advisory groups to meet and function appropriately. This financial input is covered via existing DHB policy and procedures, but it is recommended these be reviewed to ensure they are fit for purpose.

In addition, it is recommended that the DHB could better leverage its connections with existing family/whānau networks to obtain better input from family/whānau across the district. There are a number of existing groups that stakeholders felt were not being utilised to their full potential to ensure that this equally important aspect of 'community voice' was being included in any advice and decision making.

12.2.6 Develop a clear decision-making processes and delegation of responsibility

During the review it became clear that there is a lack of clarity regarding who has responsibility and authority to make decisions. One stakeholder stated that "it appears as though anyone at any level of the system can play the veto card – stopping ideas and proposals in their tracks".

This is somewhat understandable, as there appears to be no structured way to formalise the decisions being made, unclear delegation of responsibilities, and no framework to prioritise action. The reviewer recommends that work is undertaken to develop clearer planning and decision-making processes that are transparent, clear to all stakeholders and applied consistently. As an initial start, the review team has developed and used a criteria-driven prioritisation approach to bring some rigour to the decisions about the high-priority recommendations in this report – it may not be perfect, but it could be a useful starting point.

12.3 Recommended actions

20	**Create** a full-time mental health and addiction strategic commissioning role at the Executive Leadership Team level.
21	**Create** a 'by Māori for Māori' commissioning function, with a lead role in implementing the investment pool outlined in recommendation 2 and 11.
22	**Support** the strategic commissioning role/function with robust data and intelligence that informs local and regional decisions.
23	**Disestablish** the current Network Leadership Group and establish a new cross-sector intelligence and stewardship group.
24	**Support** the creation of strong local consumer advisory networks that are linked across the district and have representation via the cross-sector intelligence and stewardship group noted in recommendation 23.
25	**Strengthen** existing family/whānau networks as a way to meaningfully engage with and learn from them.
26	**Develop** a clear prioritisation and decision-making framework which supports the clear delegation of roles, responsibilities and accountabilities

13. SUPPORT AND DEVELOP THE WORKFORCE

13.1 Rationale for prioritisation

SDHB's most important resource is the region's workforce. This was the dominant theme from the provider survey, with more than 147 respondents (out of a total of 324) mentioning the workforce in some way. Comments included staff's genuine commitment to consumers and trying to get the best outcomes for the people that they see. Respondents also felt that the workforce have significant experience, skill, and capabilities to do their jobs, despite the circumstances that they work in.

To deliver effective mental health and addiction support requires a competent workforce with the right capacity and skills. The workforce also needs to be operating at the top of its scope. Blueprint II (Mental Health Commission, 2012) talks of the need to support our workforce with the right training and development opportunities, to stay up to date with the evidence and best-practice care. The mental health and addiction workforce are clearly highly skilled but desperately need support to enable them to operate at the top of their scope and effectively use the time that they have available. This would also support effective high-performing teams with the right people, doing the right tasks, at the right time level.

13.2 Issues

The specialist DHB MH&A workforce is under pressure: The specialist DHB MH&A workforce spoke about the increasing number and complexity of the people they support, and that many more people are now presenting with multi-faceted issues covering many areas of their lives, not just mental illness and addiction. They talked about duplicated effort, excessive workloads and an overall sense of not being able to resolve a person's issues before having to move onto the next person.

Low investment in MH&A NGO services: NGO services reported that static or reduced funding over many years for MH&A NGO services has significantly limited their ability to develop the workforce in this part of the sector. At the same time, NGOs are being asked to respond to the increasing demand for MH&A services, similar to their DHB counterparts. This situation is not fair, it is not equitable and it is not sustainable.

Substandard facilities: The issues associated with DHB staff working in substandard working environments were also raised by many stakeholders. The poor condition of some facilities has been cited as a contributing factor to consumer complaints about the standard of inpatient care, the high number of assaults and the high rates of seclusion. Ultimately, people felt that the facilities put both staff and consumers at risk – see section 9 of this report.

I think the biggest weakness is our physical environment which is extremely unsafe for patients and staff. – Workforce survey response

Staff wellbeing: Some DHB staff reported that they are subjected to assaults and harassment with little protection from the DHB. Some staff also reported that they do not receive ongoing support for their own mental health.

Excessive red tape: DHB staff talked about the large amount of time spent on 'paper work' as well as the limited visibility of important patient information. This is partly an attempt to manage 'risk', but it often fails to do so and creates a very high level of frustration amongst DHB staff who think that they are wasting time on administrative tasks that could otherwise be directed to delivering services to people and participating in service improvement activities.

It's an absolute maze of policies and procedures (literally hundreds) that are difficult to navigate. – Workforce survey response

Lack of up-to-date technology: The information technology is poor and adds to the administrative burden on staff. It also impacts on service providers' ability to communicate with one another and to work more closely together. Conversely, the greater use of tele-psychiatry consults and the provision of e-health options are a way to reach more people, free up the specialist workforce and increase consumer access to MH&A services.

It is noted that in the 2014 MH&A workforce survey (Te Pou, 2015) reported that approximately 96% of the DHB workforce and 77% of the NGO workforce wanted additional knowledge and skills to work with 'new technologies and IT'. This was selected as the number one area for general skill development.

Low investment in the peer workforce: In the same Te Pou workforce survey, approximately 84% of DHB staff supported the use of peer support. However, despite this level of support, very little progress has been made on developing this part of the workforce. The review team were given a two-page plan that was one of the outputs from a committee that was responsible for planning the development of the peer workforce. There is a sense that the DHB is not serious about the issue and that it does not understand what is required to grow, develop and support this workforce.

Lapses in professionalism: Both consumers and family members reported a number of instances where they have received less-than-optimal care, mainly because of the poor attitude of some staff, poor processes and poor communication. In one locality there was a large group of consumers who described some DHB staff as being rude, dismissive and unhelpful. In some instances, the level of dissatisfaction has led to a significant number of formal complaints directed to either the DHB or to the Health and Disability Commissioner. However, in the majority of cases, consumers have not complained and simply accepted the situation, even if they continue to be unhappy about it.

It has become clear over the course of the review that whilst the DHB has a system in place for MH&A services to assess complaints with a view to identifying any trends and making improvements, this system is not working as well as it could. For example, the review team was advised that the DHB has completely split its quality assurance activities (e.g., complaints, audits, compliance, etc) from its quality improvement activities, so that

"never the twain should meet". This is a partial explanation for why there is such a disconnect between these two activities within the DHB, but given the emphasis on the development of a learning system in this review, the issue is worth exploring in more depth, with a view to putting in place a better system.

Poor transition (discharge) planning: Poor discharge/transition planning continues to be a problem for the DHB's specialist MH&A services, as evidenced by some of the complaints and by the low level of compliance reported in the DHBs Annual Report (Quality and Performance Account, 2019/20). However, it is important to note that in recent times improvements have been made in this area as part of the HQSC Connecting Care project (see DHB performance report to the Ministry of Health in Figure 10). This is very promising progress and provides a good platform for further improvements that are designed to bring the rate closer to the 95% target that has been set by the Ministry of Health.

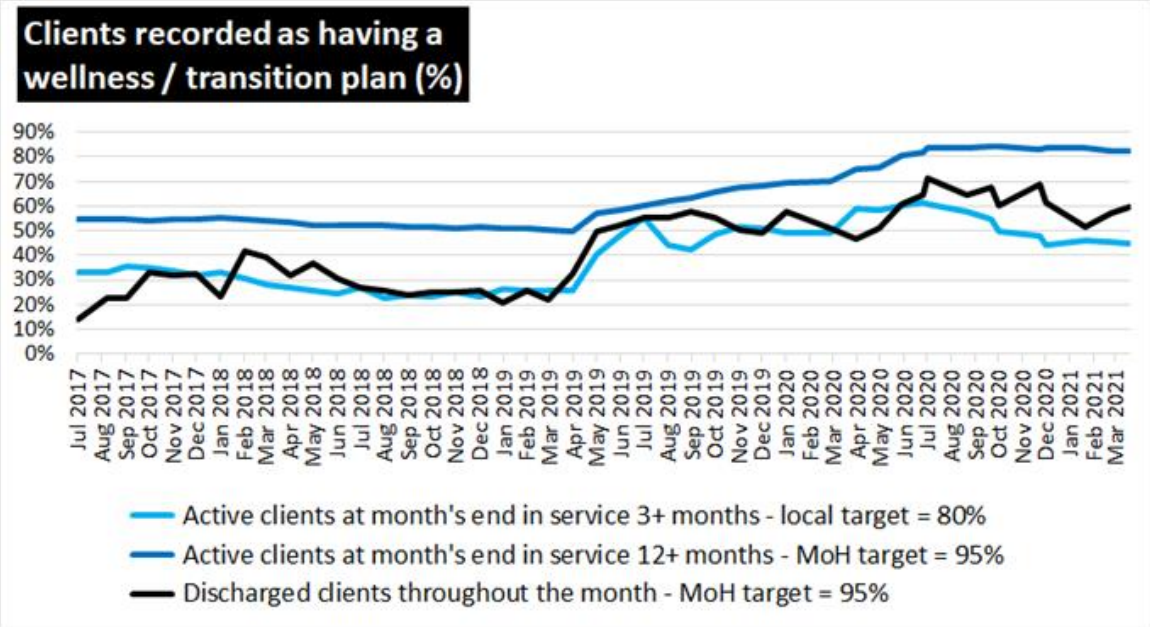


Figure 10: Percentage of people in community MH&A services who have a discharge plan (SDHB Performance Report to the Ministry of Health; Q3, 2020/21)

General practitioners are unable to easily access specialist advice: GPs reported that they would like at least one mechanism to easily access specialist DHB MH&A advice. This included a number of possible options (e.g., telephone consultation, use of an e-platform, non-urgent written advice on complex cases).

It is very hard as a GP to get to talk to anyone about a shared patient. Letters are slow/non-existent. Can't call the SMO. Case managers don't respond to calls or provide email contacts. Hard to work collaboratively. – Workforce survey response

Rurality: Long distances, geography, smaller populations and dispersed service providers combine to create a different set of challenges for the workforce, particularly if the rural teams are also carrying vacancies in key roles.

Lack of emphasis on cultural safety: Due to the lack of Kaupapa Māori, Pacific and Asian services in the district, consumers from these ethnic groups are largely accessing mainstream MH&A services and are seen by the 'mainstream' workforce. For this reason, there continues to be a need for this workforce to be culturally safe as well as offering a high-quality MH&A service.

13.3 What is working well?

There is good funding support for post-graduate nursing studies with about 30–40 DHB nursing staff studying at any one time.

13.4 What needs to happen

Changes to the MH&A system will inevitably rely on changes to the composition and skill mix of the workforce. It has been difficult for the review team to obtain good data about the funded and vacant workforce positions across the district – for baseline and benchmarking purposes.

However, based on service utilisation information from PRIMHD, Figure 11 would indicate that the DHB is seeing, on average, a higher percentage of all consumers (i.e., 65% compared to 59% nationally), and has less shared care arrangements in place with NGOs (i.e., 12 % compared to 22% nationally).

Additional analysis shows that 21% of all consumers seen by MH&A services have been with the services for five years or more, compared to 16% nationally. This is the highest percentage in New Zealand and requires further investigation.

It is important to note that this diagram does not include any data from primary care, so it is not known to what extent people's MH&A care overlaps with the support provided by general practice. However, the diagram raises the following questions:

1. How many people who are seen by DHB services still need specialist MH&A input?
2. To what extent can some people's needs be met via a better mix of primary, NGO and DHB services, including shared care arrangements?
3. How much capacity and capability do MH&A NGOs have to deliver peer support services to people who may only want that type of contact with a MH&A service?

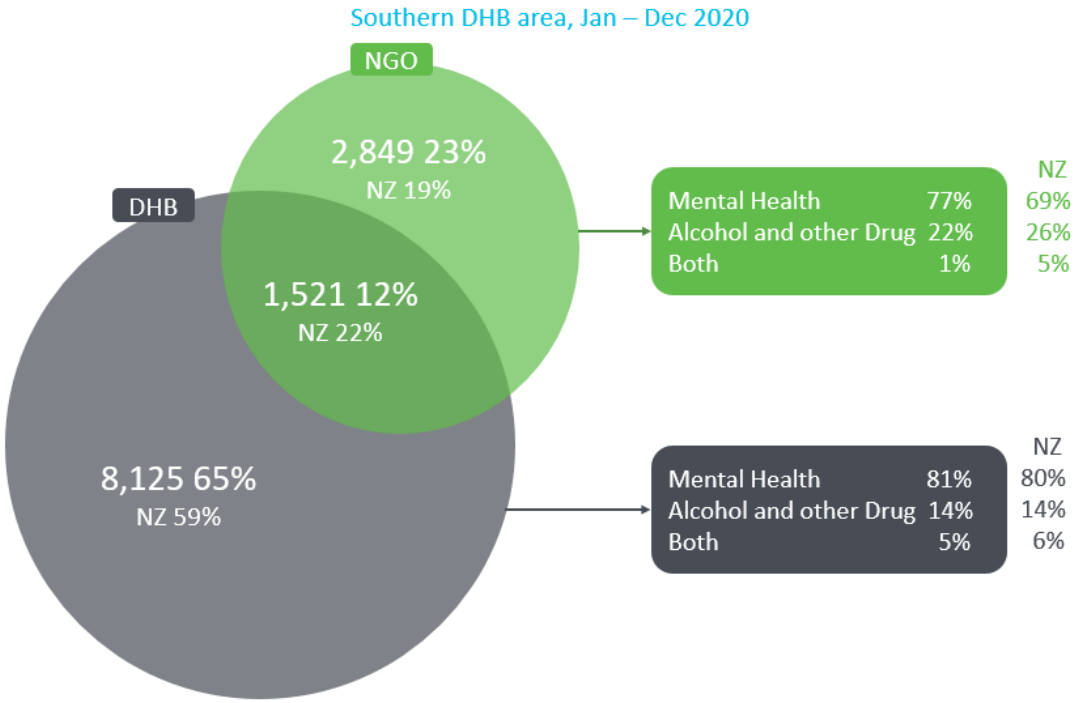


Figure 11: People seen by DHB and NGO providers compared to the NZ average (Supplied by Te Pou)

The future state calls for a rebalanced mix of community-orientated MH&A responses that are available across the life course. This was first signalled in Towards the Next Wave (HWNZ, 2011), repeated in Blueprint II (Mental Health Commission, 2012), reaffirmed in He Ara Oranga (New Zealand Government, 2018) and highlighted again in the recent New Zealand health reforms. The increased emphasis on integrated primary/community health care with timely access to specialist services on a more episodic basis is not a surprise. What is a surprise is how long it is taking to make the shift.

Below are some things that SDHB could do to develop the MH&A workforce – with the future state in mind.

13.4.1 Increase workforce capacity

Recruitment: A concerted drive is required to increase the capacity of the workforce, particularly in those teams that are carrying a high number of vacancies relative to the size of the team (e.g., Central Lakes). This will become more of an issue as a significant portion of the MH&A workforce starts to retire.

It was noted on the site visits that some teams had nursing students working with them on placement. The review team was told that the DHB is able to attract and retain undergraduate nurses because they are able to offer high-quality placements – for both enrolled nurses and registered nurses. The same principles apply for Polytechnic 'community health programmes' which also feed into the MH&A workforce. That said, the DHB's addiction services in Dunedin reported very few nursing staff.

Expand and develop existing roles: Given that this report is recommending a phased funding path for the development of Kaupapa Māori and community MH&A NGO services, there will need to be an investment in the development of the associated workforce, starting with MH&A support workers, peer workers and whānau ora navigators.

In addition, the College of Mental Health Nurses, the DHB and the PHO could agree to support the development of more **credentialled mental health nurses** in the district**.** This credentialing programme is available to any enrolled, registered nurse or nurse practitioner who is working in a primary healthcare setting, who has the knowledge, skills enhancement and experience to apply mental health and addiction assessment, referral and interventions in a primary care setting. This programme is available to both individuals and primary healthcare organisations and would complement the MH&A services that are already being provided by the Health Improvement Practitioners (HIPs) and the Health Coaches under the Access and Choice initiatives (see Figure 12).

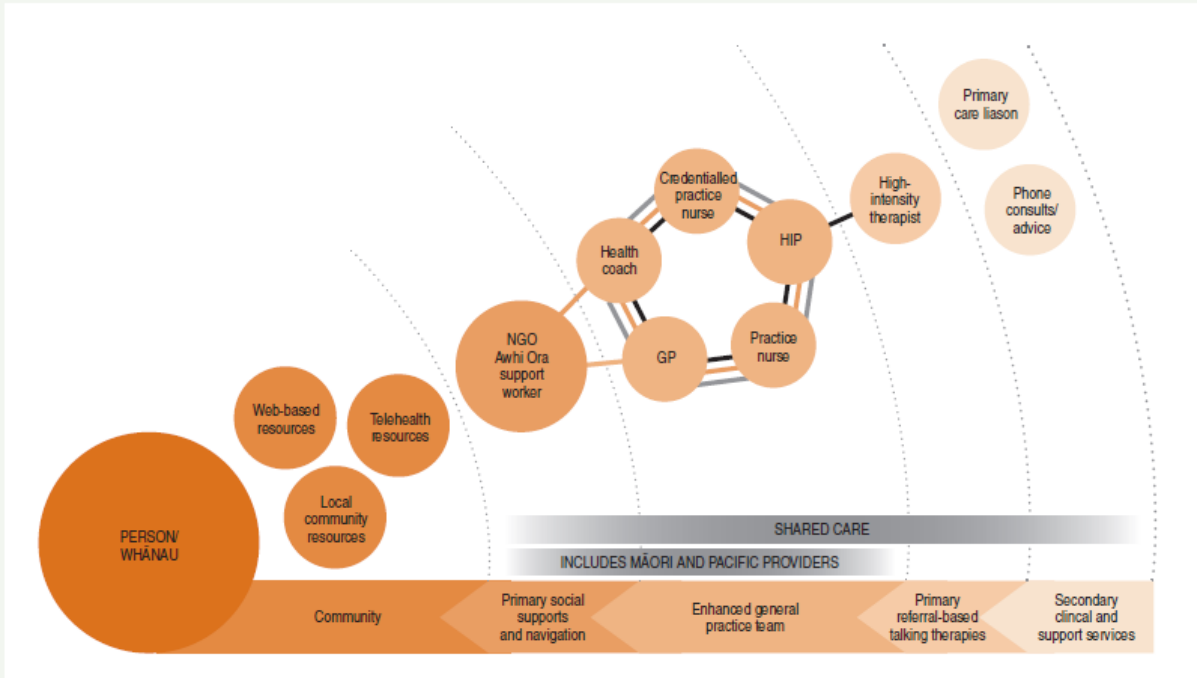


Figure 12: The integrated primary mental health & addiction model (Codyre et al., 2021)

Develop and grow the peer workforce: Identifying fast-track solutions to address workforce shortages should include a comprehensive MH&A workforce development strategy that places a much greater emphasis on resourcing the development and growth of the peer workforce. At the same time, the DHB would need to put in place the organisational and system supports that are needed for this workforce, especially if they are going to be employed in mainstream settings. Ideally, the system would have peer workers employed in both peer-run and mainstream MH&A organisations.

It is noted that SDHB held a peer workforce forum in 2019 to discuss the future of the peer workforce in the Southern district. The summary report included important comments about the definition of 'peer worker' which is worth repeating here:

It is important to understand that having experience of mental illness or addiction does not automatically make someone a peer worker. A support worker who has their own lived experience is not a peer worker. A peer is trained under a different model, with their own competencies and values sitting within peer paradigms and philosophies.

It is also noted that Gemma Griffin produced a report on the peer workforce as part of an internship at CBCT in 2019/20, funded by the Department of Internal Affairs. This report highlighted the importance of a good organisational infrastructure to support peer workers who are working within non-peer organisations:

Peer workers in mainstream organisations face very significant challenges – e.g., value fit with the organisation, lack of understanding of peer support, wrong expectations about what they will and won't do, clashes between organisational policy and peer values or models such as Intentional Peer Support, etc.

Work more collaboratively: Working in partnership with other service providers can be an effective strategy in helping to overcome workforce shortages and meet the increased demand for services. The low percentage of people who are in shared care arrangements that involve both the DHB and NGOs (and primary care) would indicate that this is an area that could be developed much more.

Look after the workforce: Staff wellbeing is both an individual and an organisational responsibility. Given the feedback from some staff about the demands of the job and concerns about their personal safety, the DHB should utilise existing research, information and resources that support the development of healthy and safe workplaces for staff.

13.4.2 Increase workforce capability

Values-informed practice: Let's Get Real (2018) outlines the fundamental values and attitudes which underpin practice across the health and disability system. These values and attitudes are evidenced by the way that staff communicate with both service users and with other health professionals. If there is sufficient evidence to indicate that a team is struggling in this space, then the organisation needs to address individual staff practice as well as the team culture, as both things will determine the extent to which the values of people who access services are prioritised by the workforce (Te Pou, 2017).

Identify and develop knowledge and skills: Given the growing complexity of presentations to MH&A services, it is important to strengthen the knowledge and skills of the current workforce by offering training and professional development opportunities in areas where further development is required and/or has been requested (e.g., co-existing problem capability in adult MH&A services).

Increase and then assess the impact of cultural competency training for the workforce: Various national cultural competency frameworks have been developed for the MH&A workforce. However, there appears to be to be very little consistency in how and when they are used. MH&A providers could use these tools to identify any skills gaps, with the aim of developing a targeted approach for ongoing cultural skill development and training for their staff.

Enable access to targeted knowledge and skills training: Once knowledge and skill gaps have been identified, the DHB could offer training sessions that include the NGO part of the sector. This would help to increase the capability of the wider MH&A system and, at the same time, foster closer working relationships between DHB and NGO services.

Increase access to psychiatric consultation liaison services: Access to timely psychiatric advice and support was highlighted by many stakeholders as being important. To fully realise the benefits of a professional advice and information line (as recommended above), it requires access to a psychiatric resource. Many other parts of the country offer phone-based access to a psychiatrist. When operating effectively, these services have been shown to, over-time, improve the capability of the caller, improve medication management and ultimately reduce the number of inappropriate referrals to specialist services.

We should have a different process for GPs that want to access a psychiatrist for consult-liaison purposes. General practitioner

It is worth noting that in discussions with HomeCare Medical (The National Telephone Helpline Service), they indicated that there is also the potential to access their psychiatric liaison service, which is currently accessible by all DHBs. This is a nationally funded contract that is provided free to DHBs via funding from the Ministry of Health.

13.5 What does this mean for Māori?

The following excerpt is taken from the Māori Manifesto: A Framework for Change - Submission to the Mental Health Inquiry Panel (Te Rau Matatini, 2018, p13), and has been slightly amended so that it is applicable to the MH&A services funded by SDHB.

The number and proportion of Māori working in health and in caregiving roles has increased in the last 20 years, although the numbers are still low in comparison to non-Māori. Increasing the Māori MH&A workforce is essential for the provision of clinically and culturally competent care.

Regulated and specialist roles are needed in the Māori MH&A workforce; the downside of graduate programmes is the length of time it takes to prepare the workforce ready for meeting the various needs of the population. Even then, new graduates require additional training, mentoring and support to socialise them to their roles and the MH&A sector safely. Furthermore, Māori MH&A professionals require appropriate cultural and clinical support, mentoring and supervision in their scopes of practice and when working in Māori communities.

The largest proportion of the Māori health workforce is in the non-regulated sector. This is a critical sector for care, community support, whānau-centred practice, cultural leadership and change; this is the sector where more could be achieved with targeted workforce investment, innovation, recognition and coordination.

Two Māori health workforce development programmes which have operated for over a decade are Te Rau Puawai and Te Rau Matatini. Together they identify a range of critical success factors that have contributed to building the Māori health workforce:

- attention to the broader determinants of Māori and the Māori health workforce
- Māori-led, focused and targeted support and interventions
- consistent investment over a prolonged period
- influence across the workforce development pipeline
- emphasis on the development of dual technical and cultural competencies
- integration of Māori student support programmes within a learning environment
- provision of comprehensive support to Māori studying health qualifications, including financial assistance; cultural and whānau support, access to Māori mentors and peer support, academic tutelage, and inclusion of communities of learning
- transitional support from student to new practitioner or professional to new environment
- broadened networks as the well qualified Māori health workforce advances their practice
- leadership to contribute to all of health through other sectors.

These factors can be replicated by SDHB, provided there is continual investment, leadership and systemic support. However, there is a need for assertive action and targets (i.e., an increase in Māori staff across all registered, non-registered, cultural and leadership roles).

13.6 Recommended actions

27	**Develop** a comprehensive mental health and addiction workforce development plan that specifies high-priority areas for development, and offers clear direction in terms of actions, particularly with regard to the peer workforce.
28	**Develop** a separate Māori mental health and addiction workforce development plan that specifies actions to increase the Māori mental health and addiction workforce based on known critical success factors.
29	**Urgently** implement health and safety measures to create healthy and safe workplaces for District Health Board mental health and addiction staff.

14. ORGANISATIONAL DEVELOPMENT AND THE ROLE OF CULTURE IN SYSTEMS

14.1 Rationale for prioritisation

The NHS Modernisation Agency (as cited in Peck, 2005) has defined organisational development (OD) as a comprehensive, connected and systematic organisation-wide development programme designed to enable an organisation to get from where it is (the current state) to where it wants to be (the future state).

This review has highlighted the many challenges facing the MH&A system in the Southern district and the reactive nature of its response to date. If the DHB wants to move from that reactive state towards a more generative state, it will have to invest in organisational development as well as investing in front-line service delivery options.

14.2 What needs to happen

14.2.1 Invest in organisational development

The individual components of a framework for high-reliability healthcare organisations (leadership, transparency, accountability, etc.) are thought to be the necessary ingredients to create (a) a culture of safety and (b) a system for continuous learning.

Health care organisations of any type or size can build on this foundation to create systems and processes that ensure better outcomes for consumers.

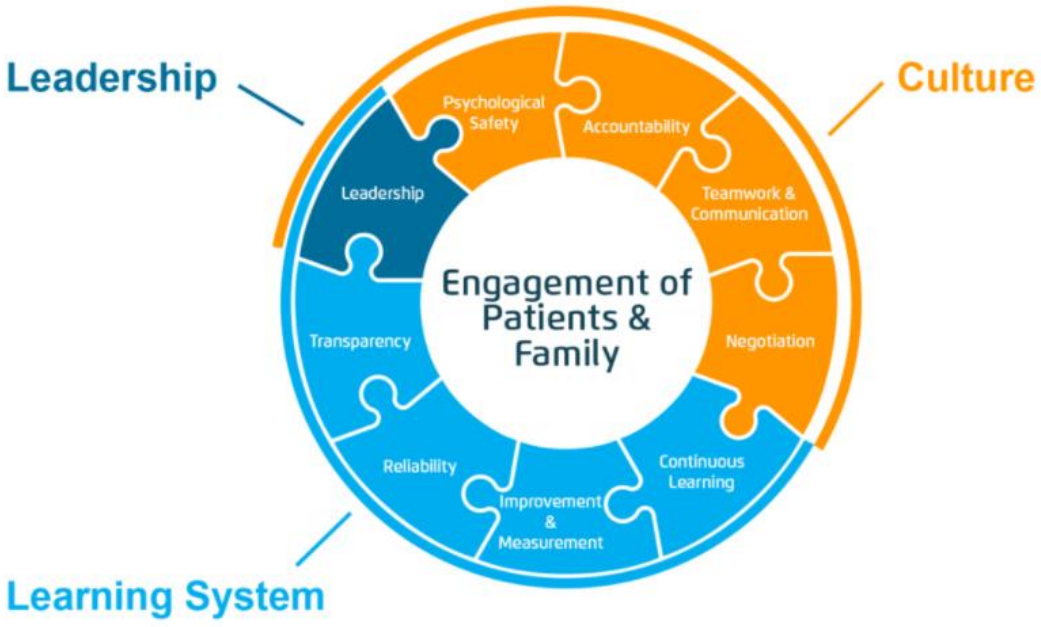


Figure 13: A framework for high-reliability organisations in healthcare (Frankel et al., 2017)

14.2.2 Develop a deeper understanding of the organisational culture

There is some evidence to suggest that organisational culture across the system may be a relevant factor in health care performance, yet articulating the nature of that relationship proves difficult. Simple relationships such as 'a strong culture leads to good performance' are not supported by the evidence. Instead, the research suggests a more contingent relationship, in that virtuous circles of high performance reinforce cultures of high expectations, as can spirals of declining performance lead to demoralisation (Scott, et al., 2003; Mannion & Davies, 2018).

This contingent relationship would indicate that we need a much more nuanced and sophisticated understanding of the cultural dynamics in the DHB and the impact on performance before we set out to influence them. For example, it is a misnomer to talk about organisational culture as if it is a single thing. Healthcare organisations are notoriously varied and have many sub-cultures within them that are based on professional hierarchies, occupational groupings and service lines. It is these sub-cultures that can either help drive the change process or choose to undermine it in defence of the status quo.

Making sense of this sub-cultural diversity and determining its impact on various aspects of the DHB's performance will be an essential part of the change process going forward.

14.2.3 Leadership

The 'Leadership Saves Lives' intervention (Linnander et al., 2021) has demonstrated that it is possible to make substantial positive shifts in organisational culture as part of a process that also aims to improve consumer outcomes. Specifically, the researchers noted significant changes in organisational culture in six of the ten hospitals that participated in the study, particularly with regard to (a) the learning environment, (b) senior management support and (c) psychological safety.

The changes were achieved though multi-disciplinary, highly diverse leadership teams (i.e., guiding coalitions) who were committed to creating change. The members modelled authentic participation, were clear about expectations and performance, and were able to manage any conflict within the group and deal with any waning motivation amongst its members. The members of these leadership teams were explicitly endorsed and empowered by the senior leadership in their organisation and were diverse in multiple ways (e.g., expertise, roles, levels of hierarchy, etc.).

The findings of this study offer useful insights as to how this approach might be applied to 'coalitions' or 'cross-functional teams' comprising a range of stakeholders who are brought together to improve consumer outcomes and make system-wide improvements in the Southern district.

14.2.4 System change

System change has emerged as a dominant theme throughout this review. There is a risk that the focus on implementing new or expanded services overshadows the opportunity to also change how the MH&A system operates. This includes shifting the beliefs and roles

of consumers, families/whānau and service providers, altering how services relate to one another across the continuum of care, creating feedback and learning mechanisms, and addressing the processes that are needed to foster and sustain success (Kania, Kramer & Senge, 2018; Foster-Fishman & Watson, 2011). These 'below the line' issues will need to be addressed as part of the change process.

14.2.5 Invest in the development of a learning system

In organisations with robust learning systems, data becomes grist for the learning process. During the course of this review, we were supplied with data highlighting the performance of the mental health and addiction system. We were also shown data from across the broader health and social care system, including police and primary care. The insights being gained from this data are clearly valuable. However, some stakeholders indicated that this data is not being used as actively as it should be to support decision-making and improvement. As one stakeholder stated, "the system collects lots of data and many reports are produced. However, they are not used to inform a system-wide culture of inquiry, learning and improvement". Other stakeholders mentioned that whilst very useful reports were produced, they were often not reviewed regularly or embedded into the day-to-day operations.

Section 12 highlights the need to invest in the right technology to support the workforce. Equally, this investment will help support improvements in data collection and the real-time reporting of this data. Collecting and analysing data is one thing. The next challenge is to embed a culture of inquiry, learning and improvement across the system. Work is needed to ensure widespread use of the data and insights across all levels of the system.

Healthcare systems never stand still. They continuously evolve and change, as the evidence changes, as the population changes, as our knowledge changes. We must always be looking for ways to improve our services and service systems. This improvement is not only the domain of an arms-length quality improvement team – it's everyone's business. Investing in the capability and capacity of the workforce in continuous quality improvement tools and techniques is important.

There are pockets of a culture of continuous quality improvement (CQI) across the mental health and addiction system, including active involvement in the national HQSC quality improvement projects – 'Zero Seclusion', 'Connecting Care' and 'Learning from Adverse Events: Consumer Family and Whanau Experience'. Two other examples within the DHB include the development of Advance Preference Statement (MAPs) and the use of the SafeSide approach to guide evidence-based care around Zero Suicide.

However, our view is that quality improvement is not embedded into decision-making at all levels in the MH&A system, nor is it given the importance that it should. People must be supported in their continuous improvement activity and be given the tools, time, resources and training to do so. It is recommended that everyone is provided with training in continuous quality improvement tools and techniques and encouraged at all levels to use this capability.

In many respects this recommendation reflects the notion of a fractal-based quality management infrastructure (Pronovost & Marsteller, 2014) that has been mentioned by clinical staff. This model relies on the leadership at every level developing and expanding their skills as follows:

Nurse and physician quality leaders should learn fundamental patient safety concepts and tools, such as how to improve safety culture and teamwork, identify safety hazards, provide patient-centred care, implement evidence-based practices, manage projects, lead change, critique data quality, and implement interventions to reduce safety risks (Provonost & Marsteller, 2014, p. 582).

14.3 Recommended actions

30	**Invest** in organisational development across the system.
31	**Develop** a deeper understanding of the culture as part of the system change process to make informed decisions about where and how to intervene.
32	**Invest** in the development of a learning system.

15. INVEST IN CHANGE

15.1 Rationale for prioritisation

A couple of years ago, Dr Ashley Bloomfield, the Director General of Health, talked about how the health system suffers from 'implementation dysfunction'. He went on to state that "we are extremely good at articulating what needs to be done but not very good at delivering on that vision".

Blueprint II (Mental Health Commission, 2012), along with other reports, has dedicated sections on making change happen. It's a known and significant challenge. To get change happening, scholars often talk of the need for a burning platform – an issue or set of issues that we cannot ignore, that must be solved, and that traditional thinking will not rectify. Tinkering is not the answer. To stop the platform burning, we need to think differently about what needs to change and step outside the norm.

The strong voice of consumers and the deep concerns from many professionals across the southern district mental health and addiction system reinforced the need for change. They told the reviewers that things needed to change, and that the status quo was not an option.

The collective recommendations made in this report are significant. It would be foolish to attempt them all at once. We must organise, stage and plan what needs to happen and map out the sequence of change. This is not an easy task; it requires planning and expertise. The task of planning and doing change also cannot be added onto people's already busy day jobs. It also the reviewers view that it cannot be 'outsourced' to people who are outside of the system – it can be supported by others but must be led from within by those who can own and lead the change. As Peter Checkland, a leading systems thinker often said, "the people who lead change must be those who will benefit from its success or be the victims of its failure".

Therefore, there needs to be careful thought put into how we invest in change. It may require additional clinical resource to free up other clinical expertise to be involved. It may mean co-opting change resource from partner organisations across the district (such as police, ambulance, NGOs, primary care) into a collective resource that has the capacity, relationships and influence to make change happen. The issues outlined in this review cannot be solved by mental health and addiction services alone – change will require partnerships to be formed, relationships strengthened and significant levels of trust and transparency to be developed.

The reviewers have experienced a system and a workforce that have made some progress, but note that it appears difficult for services to make much headway with change. There needs to be a fundamental rethink of how the DHB and its partners makes change happen across the mental health and addiction system.

The reviewers were struck by a statement made during an interview with a senior clinician: "We must focus on progress not perfection, we must start now, and we must keep taking action, not try to perfect it or we will fail".

15.1.1 Utilise co-production principles

Several comments were made by consumers throughout this review about 'co-production' being central to the successful delivery of a new mental health and addiction system model. Specifically, they wanted mental health and addiction services to change the way that services were being conceptualised, designed, delivered and evaluated as an integrated system of care. They wanted consumers to become active participants and equal partners in the change process and were of the strong opinion that any changes would fail if they were not co-produced.

According to Felner (1997, p 521) the community both defines the problem to be solved and tests the adequacy of the answer. This highlights the importance of also engaging with other stakeholders throughout the change process.

15.2 Recommended actions

33	**Create** the structures required to implement the recommendations in this report. This is likely to include local and regional structures.
34	**Engage** consumers in the relevant teams as active agents and equal partners in the change process – as per the principles of co-production.
35	**Engage** with other stakeholders throughout the change process in a genuine way via active and reciprocal partnerships.

SECTION C: CREATING THE FUTURE

16. A NEW APPROACH

There are opportunities for collaboration and working to achieve the best outcomes for people. We have a dedicated workforce and people who work at the top of their scope of practice. – Service provider

16.1 Population health and wellbeing

He Ara Oranga (New Zealand Government, 2018) has outlined a vision for the mental health and addiction system in New Zealand whereby:

- people, families/whānau and communities are well informed and have the resilience and the tools to weather adversity
- primary and community health and social services support people to build their resilience, recognise emerging problems early and provide the supports and interventions to enable people to recover rapidly
- mental health and addiction responses support people's desire to exercise control over their lives
- publicly funded agencies work together to make the best use of their collective funds to achieve the best possible outcomes and where governments of the day create a policy environment that supports this joined-up approach.

In the future, approaches to preventing and responding to mental health and addiction problems are likely to arise from a much broader base than is currently the case. Whilst there will always be a role for specialist mental health and addiction services, the future model will include an increased emphasis on the effective integration of a range of health and social services that aim to provide timely and effective care to people who are experiencing mental health and addiction problems.

The emphasis on place or localities is reflected in SDHB's Primary and Community Care Action Plan (2018) whereby locality networks will be wrapped around the Health Care Home and bring together a range of health services (including mental health and addiction) with access to specialist support. It was noted that in some instances, some services would be co-located in Community Health Hubs.

The rise of the Health Care Home model in New Zealand is a step in the right direction toward the delivery of more integrated MH&A care, but this development is still bound within the current medical model – with general practitioners at the centre of it. The notion of 'Big Community' includes general practice as a spoke on the wheel, but it places people and their whānau at the centre of that wheel.

Examples of integrated approaches to the delivery of health and social care include the following:

- The Whānau Ora Navigator approach has been identified by the Productivity Commission (2015) as a key example of an integrated approach that places whānau at the centre. Whānau Ora Navigators work with whānau and families to identify their needs and aspirations, support their participation in core sectors such

as housing, education, primary health and employment. They coordinate access to specialist services and have been identified as 'key drivers' in the Whānau Ora system (Boulton & Gifford, 2014). Most importantly, the navigators are instrumental in consolidating links of whānaungatanga; strengthening and revitalising whānau connections to natural supports.

- The Heatley Community Health Centre in downtown Vancouver, Canada, offers an example of a wellbeing hub that brings together a range of frontline services under the same roof. This integrated service is open 12 hours a day with on-call support after hours. It accepts 'walk-ins', it offers wrap-around community support services and it provides primary care, mental health services, substance use services, harm reduction and specialised care to whomever needs it – in a culturally appropriate way. An example of this type of approach in New Zealand is 'The Loft' in Christchurch. The Loft is a new way for the people of Canterbury to access a wide range of health and wellbeing services in one shared space. It is located on the first floor of the Eastgate Shopping Centre in Christchurch's eastern suburbs and is home to a broad range of social and community services, which operate alongside an Integrated Family Health Centre. The Loft exists to support the safety and overall wellbeing of children, young people and their families and is an example of what a 'Big Community' MH&A response looks like in a New Zealand context (See Figure 14).

Figure 14: The Big Community wheel of responses and workforces (O'Hagan, 2018, p 6)

Under this model, the delivery of integrated mental health and social care will become more prominent as more people start to expect a coordinated and holistic response from different parts of the health and social system. Support services will become more able to tailor and flex their response according to people's changing needs, preferences and personal circumstances, and not be stymied by rigid contract service specifications.

In an integrated, community-orientated model, addressing the social determinants of health will become the norm, as the evidence about the impact of trauma, unemployment, poverty, poor housing, loneliness and social exclusion increasingly influences our understanding of the causal factors of mental distress, as well as of the most effective response strategies to help ameliorate people's mental health and/or addiction problems, build their resilience and recover.

There will be more opportunities to create one-stop community facilities for people who have complex health and social needs that include housing, benefits, health care and other social services. There will also be scope to deliver services in more accessible and convenient community settings such schools, pharmacies, marae, churches, community hubs, work places, supermarkets and online.

It is also noted that the rural hospitals in the Southern district have the potential to play a much greater role in an integrated mental health and addiction system.

Note: The 'Big Community' MH&A model is consistent with the aims and objectives of the population health and wellbeing approach that underpins the current New Zealand health reforms.

16.2 Local communities want more voice, choice & control

Local communities want more voice, choice and control about publicly funded services and how they are delivered in their local area. Local Government New Zealand (LGNZ) has for a number of years advocated for reforms under the localism banner that would improve the way in which government in New Zealand works with a view to increasing its responsiveness to the needs and aspirations of local communities.

There are at least two critical aspects to the LGNZ concept of localism:

- One involves a more effective partnership between local and central government and a consequential willingness by the centre to incentivise local government where there is both the capability and local support to take a greater role in improving the social, education, employment, financial, housing, health and mortality outcomes for the local population.
- The other involves more effective partnerships between local councils and their communities, in particular the organisations and networks that enable communities to flourish – from business organisations to community organisations to iwi/Māori and neighbourhoods.

Figure 15 highlights that while central government can set the right conditions for localism to flourish, it takes a long time to change the culture, practices and behaviours that form the core building blocks of a strong localised approach.

Figure 15: Initiatives to strengthen localism should be subject to six key principles (UK Commission on the Future of Localism, 2018, p9. *People Power*)

Some community leaders see the establishment of the locality Health Networks under Health NZ as providing an opportunity to introduce the concept of localism to people as their local community starts to exert more influence over the commissioning of primary and community health services in their area (including MH&A services) via the Locality Networks.

In order to achieve equity of outcomes, the Locality Networks will need to have meaningful partnerships with Māori, Pacific peoples, other communities and consumers of health services (including people with lived experience of mental health and addiction) in the governance, prioritisation, planning and commissioning of mental health and addiction services in each locality.

An exemplar - The Safer Waitaki Community Coalition

The Safer Waitaki project is a whole-of-community project with a focus on community safety, including community health and wellbeing. The project was initiated in March 2013 as a way to identify and respond to the key community priorities for the Waitaki District. The community network comprises over 140 groups and organisations representing government departments, local government, NGOs, emergency services, cultural groups, health and wellbeing, mental health and addiction, education and workplaces.

Whilst the success of the network has not been formally evaluated, it utilises a collective-impact approach and is widely recognised throughout the district as being a high-functioning network. The research undertaken by the Collective Impact Forum indicates that the original five conditions for collective impact (Kania & Kramer, 2011) are not sufficient on their own to achieve meaningful population-level change and that they need to be combined with collaborative practice in order for the network to be successful.

With these conditions and collaborative practices in mind, the key features of the success of the Safer Waitaki network are thought to include the following:

- *The coalition is guided by an inter-sectoral governance group comprised of local leaders who have a strong vision and are adept at system stewardship.*
- *The 'backbone function' is provided (and paid for) by the local Council.*
- *The leadership and community development skills of the people who are employed to provide the backbone functions for the network are critical to its success.*
- *The backbone provides a mechanism for the community to identify priorities, focus on what is working (and what is not) and to get things done by maximising local resources and local expertise.*
- *The network has a number of well-established working groups that have clear goals and clear accountabilities. The working groups are disbanded when they have achieved their goals and new working groups are established in their place to respond to emerging priorities.*
- *The network is data informed, action-orientated and focused on results.*
- *It has built a culture that is based on relationships, trust and respect.*

The success of the Safer Waitaki Network (and the local MH&A network nested within it) offers a great example of what is possible when different parties come together, in an intentional way, to improve outcomes for people – with a focus on the place where they live, work and play.

16.3 What do the health reforms mean for Māori?

Partnership with Māori and the integration of Māori voice into planning and priorities will be an essential feature of the new health system in 2022. This will involve a strong role for iwi-Māori partnership boards to agree locality priorities and plans that best meet the needs and aspirations of Māori communities, and to influence regionally through their relationship with the Māori Health Authority.

This will ensure a clear focus on Māori health needs and an emphasis on achieving rangatiratanga and mana motuhake, which sees Kaupapa Māori services and options more widely available for Māori communities embedded as a core part of integrated service arrangements.

17. PRIORITISATION FRAMEWORK

17.1 Why does the DHB need to prioritise?

No matter how much money is invested into SDHB's mental health and addiction system, there would still be a need to make choices between competing demands on the DHB and the needs of the population. As a leading commissioner of MH&A services, SDHB has to make choices, on a frequent basis, about what services should or should not be funded. Even if the DHB chose to uphold the status quo and change nothing, it is assumed that this decision would be based on information that indicated that the current distribution and mix of services was the best and that no changes were required.

Given the limitations on SDHB funding, it is important that the DHB is able to satisfactorily answer stakeholder questions about why a particular service area is attracting funding and not another. There is no perfect scientific way to make these kinds of difficult resource allocation decisions, but the best approach is to develop a funding decision-making process that is explicit, based on the evidence and is guided by a consistent set of values. The evidence may not always be quantitative, but it must always be robust, convincingly justified and it must stand up to the scrutiny of even the most ardent advocate. It must also be able to withstand the tendency for some stakeholders to try and derail decisions that they do not like simply by exercising their individual 'veto' rights.

A good, transparent prioritisation process does not leave any room for individual preferences to sway important decisions about the resourcing of the MH&A system.

17.2 What are the principles that have guided the initial prioritisation process?

The principles that Synergia has chosen to guide the initial prioritisation process reflect the values that are commonly used by many other commissioning agencies and are listed in Table 5 below.

They have been selected because they not only support the decisions about what SDHB might do first, but they could form the nucleus for how the DHB makes decisions in the future about what to do next.

Table 5: Principles which have guided the prioritisation process

Criteria	Description of criteria
Hauora Māori	The need to improve Māori health outcomes is an integral part of the prioritisation process. Is the decision-making process consistent with Te Tiriti o Waitangi? Will the interventions lead to increased opportunities for Māori to provide MH&A services, access MH&A services and benefit from MH&A services?

Importance to people	This is based on how frequently people mentioned the issue in the interviews, workshops, stakeholder meetings, survey responses and individual submissions.
Impact	This is about selecting those interventions that are considered to be 'circuit breakers'. They have the potential to make a significant difference to people's mental health and wellbeing (both now and in the future) and act as positive disruptors in the current system.
Effectiveness	This is defined as the extent to which the intervention is known to produce the desired outcomes – taking into account the evidence about the benefit per person, as well as the number of people who might be benefited.
Feasibility	An assessment of the practicality of the proposed approach. Is it doable?
Equity	This is about being fair. It is about reducing remediable disparities in health status by promoting equity of access to services and equity of outcomes, particularly for those sub-groups of the population that have high rates of mental distress and/or addiction and low access.
Acceptability	Is the intervention acceptable to a wide range of stakeholders – including consumers, families/whānau, local communities, iwi partners and DHB decision-makers?

A rating system was used to provide a high-level view of the viability of various recommendations against these assessment criteria. The rating system meanings in this context are shown below.

17.2.1 Rating system for recommendations

1	Low
2	Somewhat low
3	Neither
4	Somewhat high
5	High

Higher ratings indicate more desirable support of this recommendation.

Note: A low rating on equity would indicate limited (low) support for the recommendation to reduce inequities. Whereas a high rating would indicate strong (high) support for this recommendation to reduce inequities.

The reviewers utilised this prioritisation process to assess the range of recommendations being considered in order to select those included at priorities in this final report.

17.3 A worked example: Applying the principles to the recommended actions

17.3.1 Hauora Māori – ake equity seriously

Recommendation	Hauora Māori	Importance	Impact	Effectiveness	Feasibility	Equity	Acceptability	Total
Increase funding for Kaupapa Māori providers from its current level of 2% (circa $2 million) of the mental health & addictions budget to at least 6% (circa $6 million) over the next three years	5	5	5	5	3	5	5	33/35
Create a dedicated and/or ring-fenced 'by Māori for Māori' investment pool that is used to design and commission local responses for Māori. This is much broader than Kaupapa services	5	5	5	5	2	5	3	30/35
Strengthen the function and accountabilities of the Iwi Governance Board to oversee commissioning and funding decisions related to Māori	5	5	5	5	3	5	5	33/35
Improve the collection and use of reliable Māori-specific performance data to help identify inequities in service provision, utilisation and outcomes of care, and routinely track progress over time in addressing them	5	5	5	5	3	5	5	33/35

SECTION D: APPENDICIES

Terms of Reference

For the independent review of the Southern Mental Health and Addiction System

Continuum of Care

August 2020

In Confidence

1. Overview

The DHB CEO, with the support of the Southern District Health Board, the Chairs of the Iwi Governance Committee and Southern Alliance wish to engage in an independent review of the mental health and addiction continuum of care in the South.

The purpose of the Review is to examine the current Southern Mental Health and Addiction System service configuration and delivery and:

- Bring a forward-looking lens to undertake a comprehensive review, culminating in a set of actionable recommendations that will support transformational change of the Southern Mental Health and Addiction system. It will be underpinned by robust stakeholder engagement (co-design) process and align with the direction set by the Government's decisions on the recommendations made in *He Ara Oranga* (New Zealand Government, 2018) which places tangata whaiora and whānau at the centre of the system.
- Identify and articulate what would enable the elements and culture of the system to work better, including the steps needed to redesign a continuum of care that delivers well integrated pathways; safe, equitable, purposeful and appropriate resources across the district; and recognises our rural profile with tangata whaiora and whānau at the centre of the system and brings interventions earlier and closer to home in primary and community settings. This will include advice on potential models of care for further consideration.
- Undertake this review with an equity lens to ensure that equitable outcomes for youth, Māori, Pacifica, rural and remote populations are considered underpinned by a strong commitment to understanding the needs and actions required to improve the experience of tangata whaiora, Māori and whānau, Māori who access mental health and services.
- Consider the current range of services across the mental health and addiction continuum in Southern, across all areas of the district and all populations, how they are configured, and what can/should be developed sustainably to support the people of Southern better, now and into the future.
- Identify examples of excellent work and systems, particularly those which provide a spring board to build capacity, equity and consistency across Southern.
- Review previous reviews and work undertaken, particularly in the Specialist Services, for example, Model of Care work and Rural Crisis After Hours Services, Mental Health Analysis Paper (Alma Consulting). This review may include review of complex cases.
- Undertake an evaluation that is consistent with contemporary models of care, practices, systems and service delivery, is integrated and seamless, efficient and effective, across the whole continuum ensuring transition between services reflects a system where the lived experience of service users is valued and integrated every step of the way.
- Recognises that the culture of any system is integral to achieving transformational change and is ready to embrace the challenge that will be needed. Input from staff and people with lived experience across the sector will be a key component.
- Identifies the structure and resources required to sustain leadership and sustainable change.

- Identifies a pathway to implementation of recommendations.

2. Focus of the Review

This review will be undertaken with regard to the context and direction for mental health and addiction services - as per the key strategic documents (see appendix one) listed below:

- Crown copyright New Zealand (2018) *He Ara Oranga Report of the Government Inquiry into Mental Health and Addiction:* New Zealand
- Southern District Health Board (2019) *Raise Hope Hāpai Te Tūmanako System Strategic Plan Southern Mental Health and Addiction System 2019-2023:* Dunedin New Zealand and the original Raise Hope Hāpai Te Tūmanako (2012).
- Southern District Health Board (2018) *Southern Primary and Community Care Strategy:* Dunedin New Zealand
- Southern District Health Board (2018) *Southern Primary and Community Care Action Plan:* Dunedin New Zealand
- Health and Disability System Review. 2019. *Health and Disability System Review - Interim Report. Hauora Manaaki ki Aotearoa Whānui – Pūrongo mō Tēnei Wā*.Wellington: HDSR.

The focus will be on all mental health and addiction services that are funded by the Southern District Health Board (see appendix two) with a view to identifying opportunities for system improvement including better access to services at all points across the continuum of care and better integration between primary, community and acute services.

3. Background

The Southern Mental Health and Addiction System, like many elsewhere in New Zealand, and indeed internationally, is under pressure. Whilst it is clear that the DHB faces some challenges in terms of the potentially outdated models of care and the large geographic area it covers, the Southern Mental Health and Addiction System is fortunate to have many valuable strengths to build on. Many people receive good care every day from our skilled and committed primary, specialist (secondary) and NGO workforce. For this reason it is important that the review also acknowledges existing good practice and identifies pockets of innovation and excellence so that these can be shared with the rest of the system.

However, it is acknowledged that the DHB has a number of issues and road blocks that are symptomatic of a system under pressure that it is keen to explore in more depth - with a view to developing a better understanding of the underlying root causes and how we might do a number of things better:

- The Office of the Health and Disability Commissioner has signalled concerns around the increasing number of complaints it receives related to the services that are

provided by Southern DHB, particularly the services provided by the MHAID. The pattern of issues of concern relate to discharge planning, complex case management, risk management, family/whānau engagement and communication with consumers and family/whānau. The provision of inpatient care in the Wakari inpatient units, cover in Lakes District and the interface between MHAID and the Emergency Department have been signalled as particular areas of concern.

- It is important for us to understand the culture of the system and how this impacts on outcomes for people as they access one or more services and transition between services.
- We want to ensure that we have a culture that supports engagement between the people who access and work in the Southern mental health and addiction system.
- Increasing access to services, especially for vulnerable groups, to services with lengthy wait times across the continuum, from Primary Mental Health Brief Intervention to NGOs to Specialist. It is important every part of the system is working well and to capacity, for example, if people cannot access mental health and addiction services at a primary level in a timely way this flows through and puts other parts of the system under pressure.
- Integration within and between clinical multidisciplinary teams, NGOs and Primary Health.
- It remains a challenge to find suitable support and accommodation to support accommodation needs for people. This ranges from crisis accommodation, respite through to private landlords to long term accommodation, and homes for life for long term complex people whose needs are not able to be met adequately through current configuration and funding arrangements for service providers. In Dunedin the trend continues for people who have complex and challenging behaviours to return to hospital as a result of a break down in their living arrangements with a residential provider. This puts added pressure on our inpatient resources. There are good interface processes with providers but ultimately they feel they are not adequately resourced or supported.
- Information systems have challenged and continue to challenge the mental health and addiction system and the way information systems do and do not connect across primary, NGO and DHB provided services. Within the DHB many specialist staff work with two patient management systems. Current work relates to Health Connect South and the implementation of the Mental Health Solution - moving towards Paper Less. NGOs do not have access to Health Connect South.
- Delivering an equitable service across a widespread geographic area is challenging. The increasing demand for crisis mental health services in each locality (including emergency out-of-hours crisis services) is creating a variance in service delivery levels.
- Similarly, the Model of Care, particularly for Specialist Services, varies across the District, particularly in our two main centres of Dunedin and Invercargill. Although this is a feature that has largely come about through history, it means that Tangata Whaiora are not always receiving the level of access and range of services between and across sites that is consistent.
- Likewise recruiting and retaining workforce, particularly in rural areas or in towns that have high living costs is challenging.

- Facilities, particularly the inpatient units on the Wakari site, some of which have been identified as needing urgent attention to support contemporary care given their age and condition.

4. What will the review identify?

It is critical that the review of our mental health and addiction system is undertaken in way that recognises the pressures on services and, at the same time, supports the current work to implement new models of care.

The review will take a whole of district whole of system view and consider:

1. The conditions that support current pockets of innovative and/or excellent practice.
2. The pressure points in the mental health and addiction system and their underlying root causes, identifying barriers, connectivity, gaps and opportunities for service development, configuration which is equitable across the Southern area.
3. The changes and/or improvements that need to be made to the model of care in order to better meet the needs of the population in each locality.
4. The best structure and mix/configuration of resources and services and the preferred model of service delivery in each locality.
5. What Governance and Leadership should look like in order to ensure that modern, contemporary clinical practice can be delivered effectively.

5. Key principles underpinning the Review

This review will be underpinned by the key principles set out in *Raise Hope – Hāpai te Tūmanko* as follows:

- Treaty of Waitangi principles based on the stage one report for the Wai 2575 (Health Services and Outcomes Kaupapa Inquiry) tino rangatiratanga, equity, active protection, options and partnership
- Working to eliminate societal influences on poor mental health.
- Preventing mental distress, and addiction through early intervention.
- Intervening in targeted, effective ways across the life course.
- Working as one, with a systemic approach.
- Striving to improve outcome quality, service capability, productivity, and capacity.
- Equitable outcomes for remote populations.

4.

5. The Southern DHB recognises that Māori experience significantly higher rates of mental illness, higher rates of suicide and greater prevalence of addictions. While

the prevalence of mental distress among Māori is almost 50% higher than among non-Māori, Māori are 30% more likely than other ethnic groups to have their mental illness undiagnosed. We support the acceleration and delivery of Kaupapa Māori services and options. The inclusion of whānau and significant others in the recovery pathway and building our peer support capacity and capability.

6. Methodology

The review will be sponsored by the CEO of the DHB, with the Executive Director, Strategy, Primary and Community acting as the key conduit for day to day management of the programme, accountable to the Project Steering group.

A steering group will be established as will review team will be established by Southern DHB. This team will be external to the Southern Mental Health and Addiction system with a skill set that includes extensive experience in delivering and leading mental health and addiction strategy, service development and transformation. Southern DHB will provide support to the team, liaison and access to key informants and information as requested.

The review will likely include, but is not limited to, the following components:

- A desktop review of relevant data / information / previous reviews in order to better understand the Mental Health and Addiction services that are being provided in the Southern district (including the current service mix/configuration, service utilisation patterns, referral pathways, potential gaps, feedback including complaints, population need and the population served).
- Benchmarking of existing level and mix of services against similar services nationally.
- Face-to-face interviews and/or group forums with key stakeholders in each of the four localities (Dunedin, Southland, Waitaki, South Otago and the Central Lakes areas). It is expected that the review team will physically visit these sites.
- Surveys of broader staff and key groups to obtain and triangulate views.
- Obtain the perspective of service users and family / whānau, particularly tangata whaiora, Māori and whānau Māori.
- Produce a final report which includes the findings of the review and offers recommendations relating to contemporary models of care and service delivery. The final report will also identify current pockets of excellence as well as identifying areas for possible improvement.

Input into these terms of reference has been sought from the Ministry of Health, the Health and Disability Commission, Southern Mental Health and Addiction Network Leadership Group and the, Iwi Governance Committee.

APPENDIX B: THE REVIEW PROCESS

The review began with initial scoping discussions with SDHB stakeholders. The terms of reference were reviewed with the scope of the review confirmed.

Overall, the review consisted of three main phases to the review:

1. Listening and understanding
2. Solutions and the future
3. Write up and reporting

17.4 Phase one

The listening and understanding phase involved engaging with a wide range of stakeholders across the system including DHB MH&A staff (clinical and non-clinical), NGO, primary care, addiction, other government agencies including Oranga Tamariki, Ministry of Social Development, Police and Corrections.

At the start of this phase the partnership with Māori was also confirmed as critical to the review and a process to ensure appropriate partnership and involvement in the review process established with support of the Iwi Governance Group. The partnership with Māori involved targeted discussions and three dedicated Māori Hui to be run across the district.

In addition this phase included the development of a detailed data specification which was used to help source detailed data from the Ministry of Health. It also includes the development of two survey tools. The first being for those with lived experience and the other for workforce and providers.

During this phase the reviewers also supported the establishment of a Lived Experience Advisory Group. This group supported the review with expert input from a lived experience perspective.

The majority of the engagement extended over approximately a 3 month period. Note that stakeholders continued to be engaged with across the entire review period as required.

17.5 Phase two

Phase two, solutions and the future centred on eight service development workshops across Oamaru, Dunedin, Invercargill and Cromwell. Each location was structured to have a morning session open to all stakeholders and the afternoon session being reserved for a focussed session with people with lived experience. These sessions were held over the course of one week in mid April and resulted in over 300 people attending sessions across the week.

In early May the review team presented an update to the SDHB Board which outlined the main findings of the review to date.

Key statistics from the review process

- **300+** people engaged with directly (face to face and virtually)
- **470** workforce / provider survey responses
- **200** lived experience survey responses
- **20** direct written submissions
- 250 people engaged across eight service development workshops
- 100 Māori engaged across three dedicated Māori Hui

17.6 Phase three

In early June the review entered the final phase, write up and reporting. The review team worked closely with the project steering group to review a draft report, provide feedback and accept the final report. In late June a final draft of the report was submitted to the SDHB Board for review with the final report being submitted on the 30th June 2021., thus concluding the review.

APPENDIX C: LIVED EXPERIENCE SURVEY ANALYSIS

The lived experience survey was designed with the advice and guidance of the Lived Experience Advisory group. It was deployed using Survey Monkey and hard copy paper surveys to a range of stakeholder networks across the Southern region.

The survey remained open until 30 May 2021. A copy of the survey has been attached as Appendix A.

There was an overwhelming response from the sector with a total of **348 responses** received. This highlights the significant and genuine desire to see change within the mental health and addiction sector.

Prior to analysing the data, responses were cleaned by responses to question 5 through 9. Where respondents only answered the "about you" section but did not respond to any of the qualitative responses, their data was removed.

After the data set was cleaned, a total of **266 responses** remained for analysis. This analysis is presented below.

17.7 Geography

Majority of respondents were based in Dunedin (55%), followed by Southland (18%) and then Central Lakes (11%).

LOCATION	17.7.1.1 NUMBER
Central Lakes	29
Clutha	5
Dunedin	145
Other (please specify)	10
Southland	48
Waitaki	28
Western Southland	1
GRAND TOTAL	**266**

OTHER

- Mosgiel, Otago, Taneri Plains
- Christchurch x2
- South Canterbury x2
- Not Specified
- Oamaru
- Central Otago
- Queenstown
- Invercargill

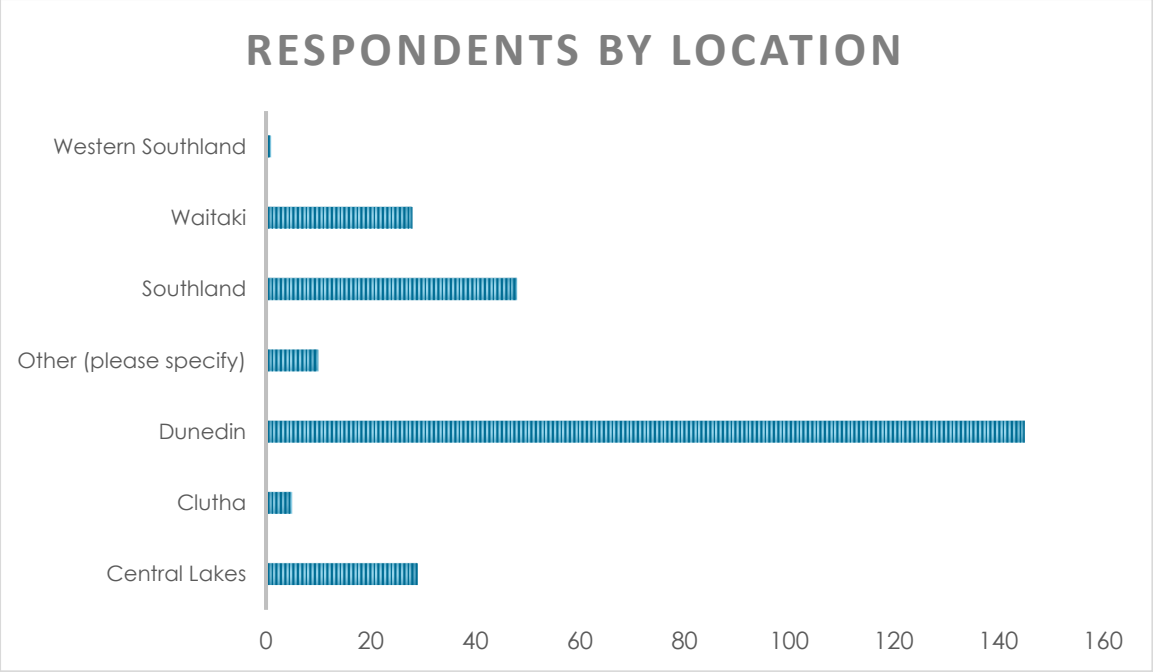


Figure 16: Number of respondents by location

17.8 Age

Majority of the respondents were aged between 18 and 64, with the highest age group being 45 to 54 years (24%), followed by 55 to 64 (18%) and 25-34 and 35-44 equally (16%).

17.8.1.1.1 AGE	17.8.1.1.1.1 NUMBER
Up to 17 years of age	7
18 to 24 years of age	32
25 to 34 years of age	42
35 to 44 years of age	42
45 to 54 years of age	64
55 to 64 years of age	47
65 + years	29
(blank)	3
GRAND TOTAL	**266**

17.9 Ethnicity

17.9.1 ROW LABELS	NUMBER
NZ European	215
Māori	32
Samoan	6
Cook Island	3
Tongan	1
Niuean	1

Chinese	6
Indian	6
Other (please specify)	32*

17.9.2 OTHER

Australian	7
Swedish	1
NZ Jamaican	1
Afro Asian	1
Greek	3
English	2
South African	1
Dutch	2
Scottish	4
Irish	2
Kiwi	4
German	2
Polish	1
Spanish	1
Russian	1
Filipino	1
European	4
French	1
Tokelauan	1

* numbers do not add up as people noted multiple ethnicities

17.10 Last accessed a service

HAVE YOU ACCESSED A MENTAL HEALTH &/OR ADDICTION SERVICE

Yes in the last 5 years	212
No, I have not accessed a mental health &/or addiction service in the Southern District	31
Yes but it was more than 5 years ago	21
Blank	2
Total	**266**

17.11 Types of services used:

TYPE OF SERVICE	NUMBER OF PEOPLE
Adult community mental health	140
Adult mental health inpatient	72
Emergency Department	71
Crisis mental health services	79
General Practitioner/doctor/primary care	155

Non-Government Organisation (i.e. community service/organisation)	65
Addiction Service	19
Forensics	9
Child & Youth service	22
Private Provider	45
Other	43

OTHER:

- Employee Assistance Programme services
- Artsenta
- Life Matters
- ACC counselling and psychology
- Mental Health Activity Centres
- Otago Mental Health Support Trust
- Waitaki Mental Health Support Group
- WellSouth
- Student Health
- Mental Health Chaplains, Church and other Chaplains
- Specialist Psychiatry
- Child disability services
- Southern Health cellphone
- Counselling
- Day Centres
- Eating Disorders inpatient service at Princess Margaret Hospital
- Te Korowai Hou ora Māori Health
- North Team OT
- Family Mental Health
- PACT
- Rata House
- Naturopath
- University Mental Health Services

For those who hadn't accessed a service, reasons as to why included:

- Cost
- Uncertainty around where to go/how to access it
- Availability of the services
- Lost faith in the service before they even got in

- Weren't considered 'bad' enough to get support
- Discrimination
- Stigma
- Haven't felt they needed to
- Recently moved to the area

17.12 System strengths

What do you believe works well and/or the strengths of the current Mental Health and Addiction sector?

Of the 266 responses, 219 people responded to this question. A total of 28 independent codes were identified and 296 codes across the dataset.

17.12.1 No strengths identified

Of those who responded, 30 felt there were no strengths in the system.

We are all humans. We all need the same respect. It's about time you started cleaning it up!

You get given all this money for mental health care but nothing changes. Positive transformational change requires people who are committed to the wellbeing of all people

17.12.2 Specific services

There were a few services that were specifically mentioned as providing good support when in need. These services included:

- Otago Mental Health Support Trust
- Rata House
- Māori Mental Health services in Southland and Dunedin

Others also mentioned private mental health supports – which were considered more accessible and respondents felt listened to. This included psychotherapists, counsellors, peer support, psycho-geriatricians.

Community and NGO services, like Artsenta and PACT were also mentioned.

The dedication of the team at community health despite being stretched by limited staffing and a high demand. The generosity of community organisations towards community driven MH initiatives

General practitioners were also identified as being very supportive and a key point of contact in navigating the mental health service. Many felt their GP was supportive and accepting of their circumstances.

"My GP is excellent - very supportive and proactive and talks to my psychiatrist."

"Unwavering acceptance from my GP"

However, many also recognised that their GP could only help so much and unfortunately, the other services were not as accessible or helpful.

"One of the strengths was my GP and a couple of the mental health staff who pushed so hard to get me help. I really appreciate their efforts. It's just a shame I wasn't able to get help in the Southland region and had to go to Christchurch."

17.12.3 The importance of peer support

Peer support was often mentioned across the responses, however it was unclear whether this was in reflection of the current system, or what respondents felt would work for them, if it was offered to them.

"I believe and know that working with an experienced Peer support/ practitioner relationship where the person who walks alongside has the knowledge, empathy and their own experience is extremely beneficial in the journey for mental wellbeing."

17.12.4 Accessible

Some respondents believe the services are accessible. This was more apparent in Dunedin with 13 of the 14 codes being from Dunedin.

Access referred to services being affordable, available and, in some cases, didn't require an appointment. Some also commented that the services that didn't put a time limit or session limit were most helpful.

17.12.5 Choice and variability

Having access to a range of services, that can be trialled to find what suits was considered important. Variety meant that in the event one service was not accessible, another could be relied on.

The range of services helps, particularly NGO and primary care when hospital staff overloaded.

There was also suggestion that access to talk therapies and psychotherapy were a welcome change to just being able to access medication.

"Being able to choose which modality you wish to use e.g psychotherapy rather than medication."

17.12.6 The support to resocialise

For many respondents, getting back into healthy habits and having activities and things to look forward to was considered important.

Adequate support is needed to get people to this point, with encouragement and passionate people in place to be successful.

Support for people that need support with their mental health. It's helped me with loneliness & being resocialised in community.

17.13 System weaknesses

"What do you believe doesn't work well and/or are the weaknesses of the current Mental Health and Addiction sector?"

Across the 266 survey responses, 55 people did not answer this question leaving 211 responses to code. A total of 58 independent codes were identified, and a total of 421 codes were made across responses. Only one person did not respond to this question.

The analysis revealed weaknesses across multiple areas of the mental health and addiction system, however access and entry criteria and the impact of wait lists and wait times were most prevalent.

17.13.1 Accessing a service

Respondents commented that there are multiple reasons why it is hard to access a service when you are in need (64).

First, the entry criteria is considered too strict for some and too confusing. Many believe that services are waiting until people are at the end of their tether and have attempted suicide before they are accepted into a service.

"Everyone says to put your hand up if you need assistance, however it is difficult to get that assistance as frequently told that the services are under pressure and that a person doesn't meet the criteria! It feels as though you need to be in crisis and attempted to harm yourself or others before the situation is considered to have any priority."

And even when in crisis, access to care is not guaranteed.

They didn't let me get in even though I attempted suicide. They said it wasn't 'lethal enough'.

There are significant wait times (53) for appointments which again compounds access issues. This means that when someone reaches out for support, potentially to prevent a crisis episode, they are not able to get the help they need.

There is little choice in what service you can access, if you can access it at all. The criteria for gaining access to services is set so high you have to be SO unwell, and I don't want to have to wait that long to get help.

This also means that people are pushed towards accessing private care and while this is accessible in terms of appointment availability, there are cost barriers with many reporting private care is too expensive and therefore cannot be accessed for long enough to help with their concerns.

Unable to afford ongoing private support so only attend a few sessions and then the cycle starts again!

17.13.2 Staff attitude and patient involvement

There is a perception that staff are "unsympathetic", "judgemental" and "don't care". People felt dismissed by staff they encountered and dehumanised. As an example, one

respondent said they had witnessed staff "laughing and talking about patients so openly in front of other patients".

"I'm not surprised this countries suicide rate is so high because the people you are told to go to for help and not in the slightest bit helpful or interested in helping you."

This level of unprofessionalism also left patients feeling unheard and that their care was not patient-centred. Instead of being approached as the present to a service, and being listened to and taken seriously, people believe their concerns are ignored. They feel the response is a product of the system, rather than being tailored to their specific needs and wants.

"Mental Health Services are not flexible in their scope of work and cannot change their scope to meet the needs of the consumers."

17.13.3 Service scarcity and no continuity

There is a perceived lack of available services, and when services are available, many felt there is not enough choice or diversity. Choice extended to the appropriateness of the clinician or services you are offered. you are given where many felt that they had to take what they could get, effectively undermining the importance of the therapeutic alliance. In some instances, when they expressed not connecting with their counsellor, they were labelled non-compliant and didn't receive further support.

There is also a reliance on the medical model and medication and holistic care options are hard to come by.

Specifically mentioned were services for:

- Youth
- Rainbow/LGBTIQ+
- Detox in the community
- Inpatient

"Can't access respite. Over-reliance on medication. Not enough talking therapy. No peer services - other DHBs have lots of these."

The services that are available lack continuity and the communication between them is poor.

Due to a lack of available clinicians, respondents recounted times where their appointments were often cancelled on them and the clinician they saw was different every time. Patient files have inconsistent notes and once "dropped" from a service, there is no follow up or effort made or support given to resocialise the individual back in to the community, and back to work.

17.13.4 Services sometimes do more harm than good

Many felt that the quality of the care provided was lacklustre to the point that they thought the service was actually detrimental to them or their loved one.

"It took me 8 years to get well as a result of these years of meaningless assistance for great suffering."

Some felt there was considerable mistreatment and they did not receive the treatment they felt they deserved. This often meant people lost faith in the system and therefore didn't reach out for help when they needed it again.

"ED is terrible when treating people with mental health issues. Been treated terribly in the ED on the several times I have been there with mental health crisis. Will not go back there again."

Respondents also felt the fact police are relied upon in some circumstances is an unsafe practice.

Finally, because of the inconsistent staffing and lack of continuity across and within services, people are often made to retell their story over and over. This can cause significant harm and risks retraumatising the individual.

17.13.5 Environment

The physical space that someone is seen is very important and currently, many feel that it is not supportive of improving mental health and addiction concerns.

Environment/premise: thought needs to be given to this, I was taken into a very small room without any windows, it caused so much anxiety that I cancelled the next appointment

People commented feeling unsafe when in care and that some of the facilities are very outdated.

There is a desire to be seen at home where there is a feeling of familiarity and comfort.

17.14 Priorities by location

The priorities identified by respondents reflect the system weaknesses highlighted in the previous section. While there are subtle differences across the locations, there are similar sentiments across the board.

17.14.1 Dunedin (139)

- Improve accessibility of services
- Increased funding
- Educate the public and invest in health promotion
- Reduce wait times
- Improve staff attitudes and approach to mental health
- Invest in community groups and services
- Create a more supportive, person-centred service
- Invest in peer support
- Increase awareness of available services
- Provide more specialist services
- Invest in better training for clinicians
- Increase staffing levels

- Improve communication across the system
- Increase capacity and capabilities of services

17.14.2 Southland (43)

- Improve access to services
- Increase funding
- Invest in community groups and services
- Provide more training to workforce
- A more person-centred and understanding service
- Reduce wait times
- Invest in Māori health
- Improve communication across the system

17.14.3 West Southland (1)

- Support group in Riverton
- Support for service staff
- Whānau and friend supports

17.14.4 Waitaki (27)

- Invest in community groups and services
- Increase staffing
- Reduce wait times
- Create a more person-centred and understanding service
- Provide more training to workforce
- Improve access to services

17.14.5 Clutha (5)

- Improve accessibility of services
- Reduce wait times
- Provide support for family and friends

17.14.6 Central Lakes (26)

- Improve accessibility of services
- More funding for services
- Increase responsiveness and improve wait times
- Invest in community groups and services

- Prioritise prevention and early intervention

17.14.7 Other (10)

- Invest in community groups and services
- Provide more peer support services
- More staff
- Financial supports for clients
- Increase awareness of available services
- Improve accessibility of services

17.15 Barriers to making change

Across the responses, there were four key barriers that respondents felt would inhibit change being made. These are presented below, in no particular order.

17.15.1 Money

Funding and having enough of it to make change is considered a huge barrier.

"Mental health poor relation of physical health. More expensive physical health interventions are being devised and practiced, especially those that can be bought with insurance. Cancers, orthopaedic wear and tear, and circulatory diseases are funded for increasingly, while mental health services get funding reduced. Politics favouring have-mores leaves the have-less with less and less."

17.15.2 Lack of staff, staff training and an attraction to the job

People believe there is not enough staff to manage the amount of people who require help.

"The system is very clearly overloaded, and waiting lists leave people trapped in dangerous places with no help."

Respondents also felt significant investment was needed into workplace training.

Finally, there is concern that there is nothing in the sector that would attract new and good staff to joining the workforce.

17.15.3 Attitudes to change and management barriers

"New Zealand, Otago and Southland especially, are rife with old fashioned ideologies and bias. It is extremely difficult for people to find help that is accepting, for things such as being trans, queer, chronically ill, poor - all of which have a higher rate for mental illnesses and addiction issues."

Respondents are concerned that the people making the decisions about change are too far removed from those accessing the services. They have entrenched attitudes which will be hard to shift.

Without having anything to attract new ways of thinking and fresh attitudes to the workforce, there is a concern the same issues will continue to pervade and no innovative thought will be applied to sector changes.

"I also think the DHB has a fear of change, in that they get stuck in the models or systems that are already in place. I think the DHB needs some strong leaders to initiate change"

Stigma

"Stigma" attached to Mental Health patients. Need mental health to be seen as normal"

There continues to be a stigma attached to mental health and until that is removed, the sector will not improve.

APPENDIX D: PROVIDER / WORKFORCE SURVEY ANALYSIS

The service provider survey was deployed using Survey Monkey to a range of stakeholder networks across the Southern region.

The survey remained open until 15 May 2021. A copy of the survey has been attached as Appendix A.

There was an overwhelming response from the sector with a total of **488 responses** received. This highlights the significant and genuine desire to see change within the mental health and addiction sector.

Prior to analysing the data, responses were cleaned by responses to question 5 through 9. Where respondents only answered the "about you" section but did not respond to any of the qualitative responses, their data was removed.

After the data set was cleaned, a total of **324 responses** remained for analysis. This analysis is presented below.

17.16 Overall

17.16.1 Geography

Majority of respondents were based in Dunedin (54%), followed by Southland (20%) and then Central Lakes (10%).

LOCATION	NUMBER
Blanks	1
Central Lakes	31
Clutha	10
District wide	19
Dunedin	175
Gore	6
Other (please specify)	1
Southland	66
Waitaki	14
Western Southland	1
GRAND TOTAL	**324**

17.16.1.1 Other

Otago-Wide	1

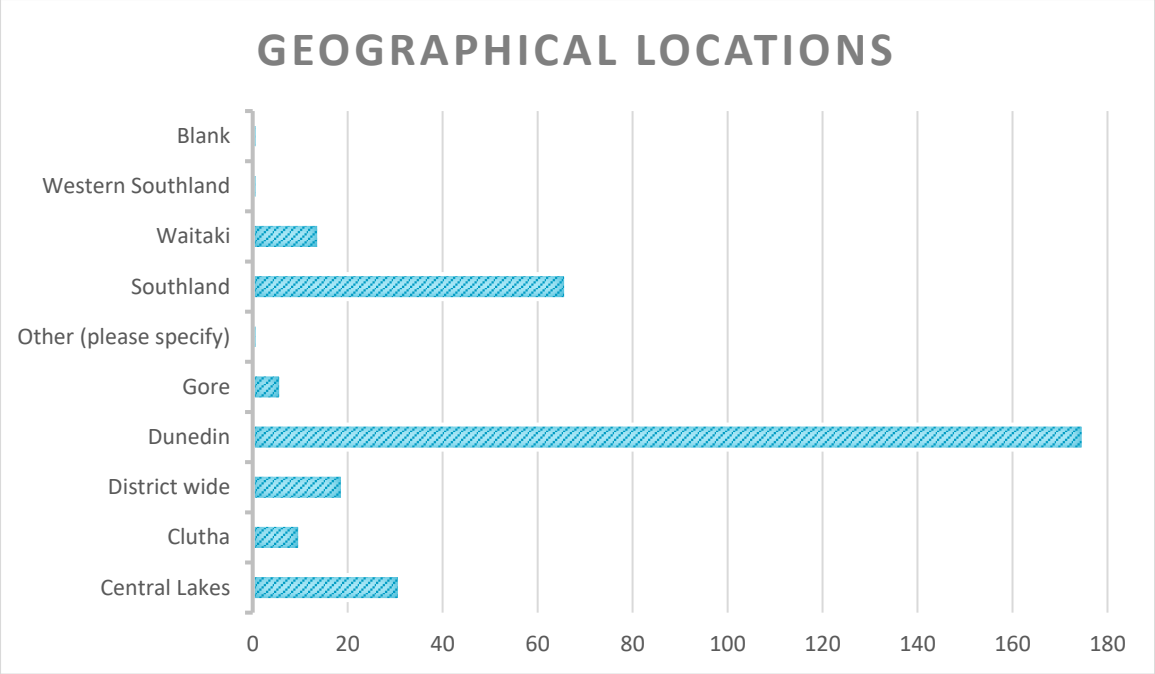


Figure 17: Number of respondents by location

17.16.2 Employment organisation

Majority of respondents' organisations were not on the list provided (99). There was good representation across the workforce with respondents from community, primary care, DHB hospital-based, private practice, and non-health organisations responding. Of note, 27 (8%) identified as working specifically for an alcohol and drug service.

	NUMBER
Alcohol and Drug Services	27
Community mental health team	74
Crisis mental health services	19
Early Intervention Psychosis	4
Emergency Department	13
Emergency Psychiatric Service	5
Non-Government Organisation (NGO)	40
Other (please specify)	99
Police and/or corrections	9
Primary Care	26
Psychiatric Consultation Liaison Service	1
Social service provider (welfare, housing)	5
Blank	2
GRAND TOTAL	**324**

17.16.2.1 OTHER

Private	3

Inpatient	18
Youth	11
Older persons	9
Education/School	6
DHB related role	17
Disability	5
Forensics (hospital & community)	5
Addictions	1
Community care (including rehabilitation, programmes, MH services)	5
Suicide prevention	1
Retired (informed)	1
Māori organisation	1
Leadership role	2
Public Health	3
Pastoral	1
Health promotion	3
Across sector	1
Admin	1
Diabetes outpatient	1
Comms	1
ACC	1
Advisory	1
Unknown	1

17.16.3 Type of Role

TYPE OF ROLE	COUNT:
Administration/management (including administration, team leaders and managers, nurse managers, advanced peer roles)	50
Clinical (including SMO, allied health, nurses, or medical practitioners)	208
Non-clinical (including support and peer workers)	39
Other (please specify)	26
Volunteer	1
	324

17.16.3.1 OTHER

Clinical/non-clinical/admin mix	3
Frontline	1
Nurse	1
Mental health/Counselling	2
Mental Health Service Coordinator	1
Māori health	2
Education	2

Health Promotion	3
Police	3
Legal	1
Employment Consultant	1
Workforce Development	1
Consumer advisor	1
Research	1
Needs assessment & service coordination	1
No clarification	2

17.16.4 FTE/Hours worked

A total of 48% of respondents work full time with the rest working part time hours mostly around 0.5-0.8 per week.

FTE	COUNT:
0	1
0.15	1
0.2	6
0.25	1
0.3	2
0.4	6
0.5	22
0.6	21
0.7	17
0.75	3
0.8	36
0.85	1
0.9	13
0.95	1
1	157
Casual	1
none specified - expected to be available all of the time.	1
Unsure	6
Blank	11
Invalid response	17
GRAND TOTAL	**324**

17.17 System strengths

What do you believe works well and/or the strengths of the current Mental Health and Addiction sector?

- **Workforce:** genuine workforce commitment and desire to do well - it is supported by other codes around workforce skill, experience and capabilities (147)
- **Network/collaboration:** The ability for organisations to work together, and to communicate with each other to try support their clients (35)
- Nothing (16)
- **Teamwork:** colleagues work well together (15)
- **Access:** there is access to services (13)
- **Community services:** the community services are considered a strength (9)
- **Patient-centred:** individual practitioners and some organisations have a person-centred focus underpinning their work (8)
- **Good once in:** Service are good, but only once you have managed to access them: once people are in the system, the care they receive is good (8)
- **Responsive:** referrals are responded to quickly (7)
- **Training:** Training is made available for workforce (6)
- **Communication:** Those within the sector communicate well and have good relationship (6)

Of the 324 who responded, a total of 13 left the strengths question blank and 3 were "not able to comment". A further 20 people felt there were no identifiable strengths.

A total of 174 different codes were identified, with 478 codes tallied across the responses.

The workforce was the dominant theme across the survey, with more than 147 respondents mentioning the workforce in some way. This included their genuine commitment to the patients and trying to get the best outcome. Respondents also felt the workforce have significant experience, skill and capabilities to do their jobs. However, many commented that they do a good job "despite their circumstances". This meant the system barriers and challenges, and excessive workloads are detrimental to the efforts of those who work within the sector. The other subthemes across the workforce included:

- Culture,
- Skill
- Supportive of each other
- Stable
- Knowledgeable
- Committed
- Willingness to learn
- Well-trained

The next most common theme was around networking and collaboration. This was defined as the ability for the workforce and their organisations to work together and to communicate across the system to support their clients. This, however, was only mentioned 35 times which is much less than the most commonly mentioned theme.

"There are opportunities for collaboration and working to achieve the best outcomes for people. We have a dedicated workforce and people who work at the top of their scope of practice."

17.18 System weaknesses

"What do you believe doesn't work well and/or are the weaknesses of the current Mental Health and Addiction sector?"

Across the 324 responses, a total of 95 independent codes were identified, and a total of 867 codes were made across responses. Only one person did not respond to this question.

The analysis revealed significant concerns across multiple areas of the mental health and addiction system.

17.18.1 Lack of staff and resource

Most notably, a lack of staff and resources was mentioned 112 times (35%). This referred to a lack of people in the workforce, with no perceived attraction to being in the service. Respondents mentioned high turnover. These shortages consequently mean there is a lack of choice of staff/specialist for clients and they are having to just take and accept whoever can see them. This theme also included the lack of bed and space shortages that impact the effectiveness of the system.

Within this theme, there were mention of specific parts of the system. This included:

- Addictions (7)
- Community (4)
- Eating disorders speciality (1)
- Health promotion resources (1)
- Older persons mental health (1)
- Rural (1)
- Youth (1)

"Workload continues to grow in community settings whilst resource remains unchanged"

17.18.2 Lack of services

There is also a perceived lack of the services needed to meet the ever increased demand (26) being seen in the region. 86 respondents mentioned a lack of services. This also included specifics, including:

- Addiction (1)
- Allied Health (2)
- Community (14)
- Culturally appropriate services (3)
- Respite care (4)

- Rural services (5)
- Speciality services (4)
- Youth (11)

In addition to the lack of services, some respondents also felt the ones that are available do not meet the needs of those who need help. The system is seen as being both too acute focused (13) where there are no options for those with mild to moderate illness. However, others felt there was also a lack of crisis support (9), no afterhours care (5) and it doesn't reach those who are hard to reach (5).

17.18.3 Access barriers

There are a range of access barriers that were addressed in the responses (70). This referred to issues around geography and transport issues with the vast landscape of the Southern Region being mentioned. There are also concerns about equity where Māori and Pacific People are not supported to get into services, and this is reflected by a lack of specific funding.

Finally, there is also a GP shortage which means people can't get in to see them and therefore can't get referrals elsewhere.

Access barriers, coupled with the lack of staff and resource means there are long wait lists and wait times to access services (42).

17.18.4 Siloed system

The system is perceived as fragmented and fractured (37) where everyone works in their own space with little desire to collaborate.

This expanded beyond just mental health and addiction, where the holistic needs of a person accessing a service are not well addressed.

The relationship between the community and hospital services is thought of as "us and them" with no common language or vision across the system. There is a perception that SDHB is not willing to shift its focus towards community and value their involvement in the provision of mental health and addiction services.

"While the service (MHAID) has one title it is a fractured service and feels siloed, it feels like the just in time business model"

17.18.5 Bad communication and lack of continuation

The siloed system is exacerbated by poor communication processes (37). This also includes a lack of up-to-date technology systems (20) which impacts service providers' ability to work together.

There are also issues around sharing information and potential privacy issues that this can cause.

This impacts the patients' journey across the system. There are significant issues with inconsistent care and the lack of continuity (32) across the spectrum of services and the transitions are not seamless. This is seen through convoluted referral pathways and a lack of follow up, discharge planning, and transparency around whether any action has been taken.

"Very hard as a GP to get to talk to anyone about a shared patient. Letters are slow/non-existent. Can't call the SMO, case managers don't respond to calls or provide email contacts. Hard to work collaboratively."

Excessive bureaucratic red tape

The services are inundated with a "maze of policies and documentation" that make doing the job at hand cumbersome and time-consuming. The sheer volume of paperwork and documentation that has to be done for each patient is excessive and detracts from the time that could instead be spent with the patient.

This was all thought to be reflective of the risk averse practices that pervade, where the system is more worried about watching their own backs, legally, than providing appropriate care. This wastes time and resource and ends up causing more harm than good. An example given was keeping patients in the inpatient ward for longer than necessary.

"It's an absolute maze of policies and procedures (literally hundreds) that are difficult to navigate."

17.18.6 Medical model dominance

Respondents are frustrated by the reliance on the traditional medical model that continues to pervade the treatment of mental health and addiction patients. There is an overwhelming dependence on using medication rather than brief intervention and talking therapies.

This also influences the perception that the system focuses too heavily on treatment rather than prevention. The services are working as an ambulance at the bottom of the cliff rather than working further upstream to prevent crisis scenarios in the first place.

17.18.7 Underfunded and underpaid

Respondents believe the mental health and addiction sector is severely underfunded and the workforce is underpaid.

Similarly, any funding that does become available is unlikely to be used on anything innovative or may challenge the status quo.

17.18.8 Poor facilities putting staff at risk and leading to inappropriate care

It is widely agreed that the inpatient and hospital facilities for mental health and addiction patients are grossly inadequate. The facilities are run down and are not fit for purpose.

Ultimately, people felt this put staff and patients at risk. For staff, they are subjected to assaults and harassment with little protection. Some also reported that they do not receive ongoing support for their own mental health.

"I've worked for this service for over 20 years and I feel staff need more support when it comes to the abuse and aggression we get from the clients we work with - it's exhausting, unfair and it's not nice but often we don't get the support from management / the service to talk with our clients about it not being ok to abuse staff."

For patients, the lack of fit for purpose facilities means there are often circumstances of inappropriate care going on. For example, children are placed in the adult mental health unit, mental health patients overflow into other medical departments, patients with addiction issues are placed in mental health settings and high seclusion rates.

"The architecture of all wards other than 9C is absolutely hopeless. Conditions in 10A are particularly sad for a small vulnerable group. It is clear that lack of appropriate ICU area increases requirement for seclusion and means some patients with known unpredictable violent behaviour are managed in the open area. This poses a risk to staff and other patients. There is damage to the therapeutic environment."

17.18.9 Addictions as the add-on rather than the equal

While there are significant challenges across the system, there is genuine concern that the addictions sector is not afforded near as much attention and funding that is needed to support the complex patients.

It's attachment to the mental health sector, while often overlapping, can be detrimental where the stigma of people with addictions is greater than that of people with mental health issues and a lack of integration across the two areas.

"Some staff in other Mental Health teams seem to view addiction through pejorative eyes. "we help sick people, addicts are bad people.""

17.19 Priorities by location

The priorities identified by respondents reflect the system weaknesses highlight in the previous section. While there are subtle differences across the locations, there are similar sentiments across the board.

17.19.1 Dunedin (173)

- More staff to improve caseloads and capacity
- Cultural shift – including valuing mental health and addiction staff, looking towards innovative responses
- More services – specifically around community based peer support and crisis café
- A holistic approach to care
- Management changes including a refresh and removal of entrenched workforce
- Funding
- Invest in technology

- Invest in the facilities to improve them
- Funding specifically for child and youth mental health supports
- More transparency and clarity around employment processes
- Reduce cumbersome paperwork so focus can be redirected to the client
- Accessible and continual training for staff
- Improve the communication and transition across services in different settings
- Invest in addictions with detox programs and community based settings

17.19.2 Southland (66)

- Improve access to community services, including NGOs and primary care
- Increase staff FTE
- Holistic view of mental health
- Change of management and management structures
- Improve connection between management and those on the frontline
- More funding, with clear visibility around where it is being directed
- Invest in equity and improved outcomes for Māori
- Remove access barriers and make every door the right door
- More therapeutic options

17.19.3 Gore (6)

- Communication & cohesion
- Counselling services
- Specific focus on young people
- Increase staffing levels
- Supported accommodation and community service access
- Funding

17.19.4 West Southland (1)

- Whānau involvement
- Respite
- Education for treatment

17.19.5 Waitaki (14)

- Reduce wait times
- Increase staffing levels
- Whānau involvement and educations

- Increase links across sector - relationship
- Focus on early intervention - low to moderate focus, younger, in schools, and in family homes
- Streamline documentation including improving technology

17.19.6 Clutha (10)

- More funding, for staff and for services
- Technology
- Training
- AOD staff and services
- whānau focused support and education
- range of staffing options
- respite, ongoing support, supported accommodation

17.19.7 Central Lakes Priorities (31)

- Wait times
- Local respite, support
- Collaboration and cohesion across services
- Boundaries for, and more, staff
- Early intervention
- Increased staffing
- Holistic lens model and funding to fit
- After hours and 24 hour support, especially for crisis
- Equity - access for Māori
- Access (virtual and face-to-face) to other services, like brief intervention, not just specialist or medication
- Technology
- Strategic focus

17.19.8 District-wide (18)

- Funding including flexible contracting, more focus on community
- continuity, relationship across sector, including communication remove siloes, aligned processes
- technology investment
- prevention/early intervention, peer support
- youth based services
- respite services

- access to services across the area - inequalities
- more access and services in community

17.20 Barriers to making change

"I fully appreciate that it isn't an easy task to change systems, the attitudes that maintain them; the funding structures that support them, and that change takes time. However, transparency, education, evidence - demonstrable positive outcomes from trials can address some of the barriers. Involvement of key service users, service providers and working together helps!"

Across the responses, there were eight key barriers that will inhibit change being made. These are presented below, in no particular order and there are considerable cross overs between them.

17.20.1 Money

As expected, funding is considered a huge barrier to making change. Not only that the system doesn't have enough money in it, but there is also a lack of visibility about where money goes to. The media and sector reports about increased funding to mental health create an expectation within the workforce and community and when they don't see that money filter through, they become more despondent and frustrated.

17.20.2 Lack of staff

There is concern that there is not enough experienced staff to support change to happen. There is also no way to attract new staff into the sector.

The staff that are left to support the change are tired, overwhelmed and are at constant risk of burnout and being assaulted.

17.20.3 Attitudes to change and inertia

"Influential staff who cultivate cultures of indoctrination around ineffective systems and processes."

Respondents are concerned that the entrenched attitudes and culture within the sector will be too hard to overcome. This links into the medical model dominance discussed in the weaknesses section, where those with the loudest voices have an ulterior motive.

However, many felt these attitudes spread across both management and staff. There is a sense of fear across the sector that any change would mean a job loss. This fear can get in the way of the ultimate goal which is to support people with mental health and addiction needs.

17.20.4 Community expectation

Related to the above, respondents felt the community's expectation on what can be achieved can be detrimental and can set the system up to fail.

17.20.5 Management

Respondents expressed concern that the current management within the system lack the leadership skill to navigate such a challenging task. They don't feel they have the

experience necessary and there is no one keeping them to account to ensure change is realised.

Management also alluded to the demands of the Ministry of Health that leads to excessive politics and red tape on management's ability to do better for their community. Instead, they are tied up with "ministry requirements".

"A major focus on meeting MoH KPIs rather than dealing with local issues"

Patch protection and a hesitancy to collaborate

"Patch protection is still alive and well in this region. any change will be met with resistance from both the NGO and DHB provided services. It has been talked about for a long time but will require significant investment and time to get right"

The funding mechanisms that pervade the system discourage collaboration and make working together to improve outcomes for community very difficult.

Similarly, some felt the relationship between DHB and NGOs will be a barrier and they will not be able to work together to overcome the challenges.

17.20.6 Strategy

There is a concern that stakeholders will not share the same vision for change and therefore it will be thwarted before it has begun.

Similarly, some worry about the disconnect between the people making decisions and developing the strategy and the people who are either working on the ground delivering the services or using the services. They think that whatever is developed might not meet the needs of those who will use and work in the service.

17.20.7 Time

Finally, it takes time and a long term commitment which many feel will run out of steam before real change is realised.

"There will be many barriers, it will be effectively moving the old guard out who have been there for 20 + years and bringing in new transformational thinkers and designers, but to get better outcomes for whānau we need to be brave and courageous."

APPENDIX E: DATA ANALYSIS MAPS

As part of the review we analysed data from across the system including mental health and addiction access information, service utilisation, emergency department data, inpatient and also the Age/Sex register. Below are a set of one page summarises that helped us understand the data at a locality level. Note: Some of the data is not collected and/or represented at a locality level so we have made some assumptions to represent it in this way. An additional detailed report is available summarising the various analysis that was undertaken.

Summary of Southern District Health Board's Mental Health and Addiction (MHA) services: Central Lakes

June 2021

SYNERGIA

Key points

Area:

Central Lakes locality encompasses the TLAs of Central Otago District and Queenstown-Lakes District.

Mental Health and Addictions services:

This encompasses publicly funded secondary MHA services which are recorded in the Ministry of Health's PRIMHD dataset. Some MHA services are not included here, such as calls to crisis lines or primary mental health care.

Sources:

Southern DHB supplied data:
Southern DHB provided information on FTE, beds available, mental health and addiction teams, and the budget for these services.

Ministry of Health administrative data:
PRIMHD, National Minimum Dataset (NMDS), and the National Non-Admitted Patient Collection (NNPAC), for the financial years 2017/18 to 2019/20 for Southern DHB.

Statistics New Zealand:
Summary population data was taken from the Statistics New Zealand website.

Inpatient based support

- There were **192 people** who received inpatient care in PRIMHD.
- They had a total of **4,357 bednights**, which is an average of **22.7 per person**.
- **1,608 (36.9%)** of the bednights were in Southland hospital, and **2,749 (63.1%)** were in Wakari Hospital.
- The activity type 'Mental health acute inpatient or equivalent occupied bed nights' made up **68.4%** of the bednights.

Inpatient defined as:
Team type description is 'Inpatient Team'; team setting description is 'Inpatient based'; activity unit type is 'BEDNIGHT'; activity unit count was not 0; activity setting is 'Inpatient'; activity type was not 'T35' ('Did not attend').

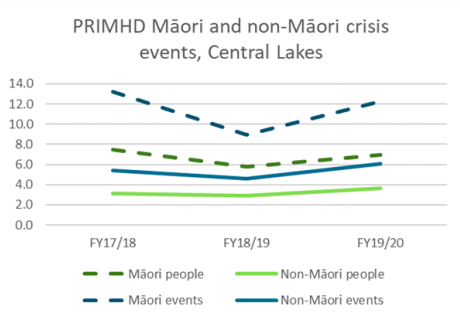
Community based support

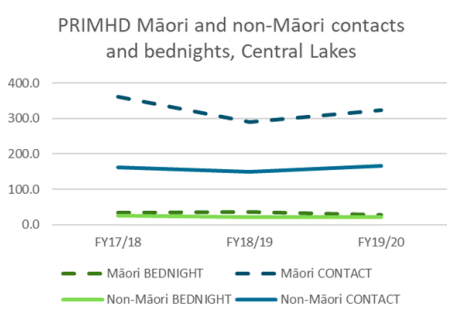
- There were a total of **2,314 people** who accessed community-based support in PRIMHD.
- These people had **28,714 events**, or **12.4 events each**.
- Child and Youth teams had **25.8%** of the events, and **22.8%** of the patients.
- The most common activity type was 'Individual treatment attendances: family/whānau not present', making up **57.7%** of events.

Community defined as:
Team type description is 'Community Team'; team setting description is 'Community based'; activity unit type is 'CONTACT'; activity unit count was not 0; activity setting is not 'Inpatient'; activity type was not 'T35' ('Did not attend').

Mental Health and Addictions care

This data is for patients who live in Central Lakes, rather than services provided in Central Lakes.





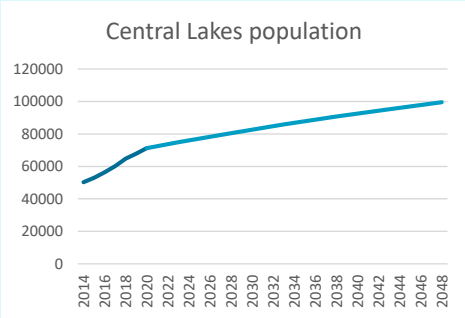
Use of services: A total of **2,734** people who lived in the Central Lakes locality used any PRIMHD service in the three years.

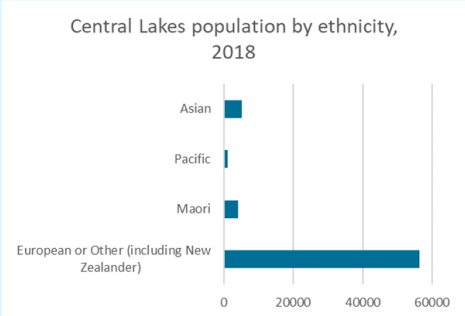
Of those, **1,919** only appeared in one year, **589** used services in two years, and **226** people appeared in all three years.

Crisis event patients: Of the **602** patients with crisis events, only 66 patients (**11%**) had events in more than one year, and only **4** patients had events in each year.

Population

Growth: Central Lakes is forecast to grow by **24%** from 2018 to 2028. The 65+ age band is expected to grow by **57%** in this time.





Population by age, 2018 and 2028

Central Lakes	2018	2028	Change
0-14 years	10,400	11,700	13%
15-19 years	2,730	3,950	45%
20-24 years	3,880	4,000	3%
25-29 Years	7,170	6,540	-9%
30-34 years	6,250	6,750	8%
35-39 years	4,850	7,060	46%
40-64 years	20,100	26,100	30%
65 years and over	9,300	14,600	57%
Total	**64,700**	**80,500**	**24%**

Embargoed until 3.00pm Friday 6th August 2021

Summary of Southern District Health Board's Mental Health and Addiction (MHA) services: Waitaki

June 2021

SYNERGIA

Key points

Area:

Waitaki locality encompasses the TLA of Waitaki District.

Mental Health and Addictions services:

This encompasses publicly funded secondary MHA services which are recorded in the Ministry of Health's PRIMHD dataset. Some MHA services are not included here, such as calls to crisis lines or primary mental health care.

Sources:

Southern DHB supplied data:
Southern DHB provided information on FTE, beds available, mental health and addiction teams, and the budget for these services.

Ministry of Health administrative data:
PRIMHD, National Minimum Dataset (NMDS), and the National Non-Admitted Patient Collection (NNPAC), for the financial years 2017/18 to 2019/20 for Southern DHB.

Statistics New Zealand:
Summary population data was taken from the Statistics New Zealand website.

Inpatient based support

- There were **115 people** who received inpatient care in PRIMHD.
- They had a total of **1,908 bednights**, which is an average of **16.6 per person**.
- All of the bednights were in Wakari hospital.
- The activity type 'Mental health acute inpatient or equivalent occupied bed nights' made up **51.5%** of the bednights.
- The number of bednights dropped from **757** in 18/19 to **372** in 19/20, a drop of **51%**.

Inpatient defined as:
Team type description is 'Inpatient Team'; team setting description is 'Inpatient based'; activity unit type is 'BEDNIGHT'; activity unit count was not 0; activity setting is 'Inpatient'; activity type was not 'T35' ('Did not attend').

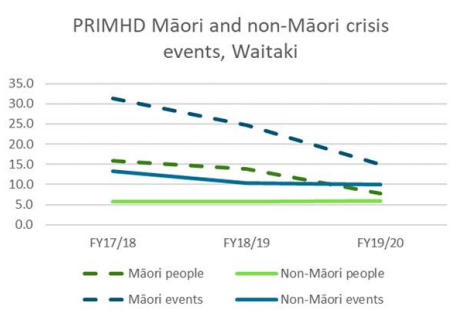
Community based support

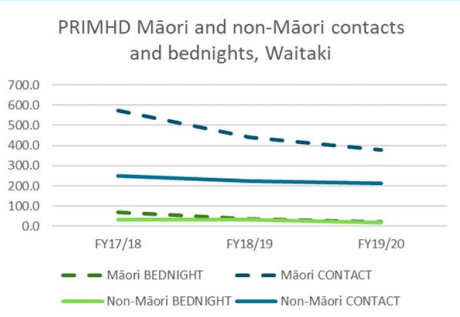
- There were a total of **1,210 people** who accessed community-based support in PRIMHD.
- These people had **13,612 events**, or **11.2 events each**.
- Child and Youth teams had **26.7%** of the events, and **20.2%** of the patients.
- The most common activity type was 'Individual treatment attendances: family/whānau not present', making up **64.0%** of events.

Community defined as:
Team type description is 'Community Team'; team setting description is 'Community based'; activity unit type is 'CONTACT'; activity unit count was not 0; activity setting is not 'Inpatient'; activity type was not 'T35' ('Did not attend').

Mental Health and Addictions care

This data is for patients who live in Waitaki, rather than services provided in Waitaki.





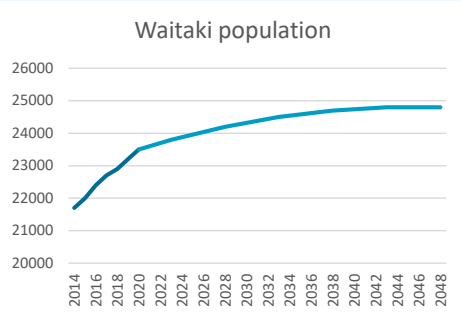
Use of services: A total of **1,434** people who lived in the Waitaki locality used any PRIMHD service in the three years.

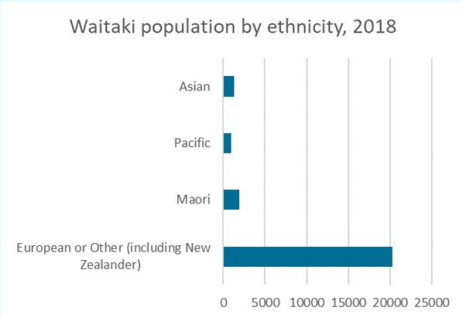
Of those, **918** only appeared in one year, **323** used services in two years, and **193** people appeared in all three years.

Crisis event patients: Of the **370** patients with crisis events, 60 patients (**16%**) had events in more than one year, and **8** patients had events in each year.

Population

Growth: Waitaki is forecast to grow by **6%** from 2018 to 2028. The 65+ age band is expected to grow by **27%** in this time.





Population by age, 2018 and 2028

Waitaki	2018	2028	Change
0-14 years	4,200	3,900	-7%
15-19 years	1,300	1,390	7%
20-24 years	1,020	1,000	-2%
25-29 Years	1,260	1,120	-11%
30-34 years	1,200	1,300	8%
35-39 years	1,190	1,480	24%
40-64 years	7,600	7,400	-3%
65 years and over	5,200	6,600	27%
Total	**22,900**	**24,200**	**6%**

Embargoed until 3.00pm Friday 6th August 2021

Summary of Southern District Health Board's Mental Health and Addiction (MHA) services: Dunedin/Clutha

June 2021

SYNERGIA

Key points

Area:

Dunedin/Clutha locality encompasses the TLAs of Dunedin City and Clutha District.

Mental Health and Addictions services:

This encompasses publicly funded secondary MHA services which are recorded in the Ministry of Health's PRIMHD dataset. Some MHA services are not included here, such as calls to crisis lines or primary mental health care.

Sources:

Southern DHB supplied data:
Southern DHB provided information on FTE, beds available, mental health and addiction teams, and the budget for these services.

Ministry of Health administrative data:
PRIMHD, National Minimum Dataset (NMDS), and the National Non-Admitted Patient Collection (NNPAC), for the financial years 2017/18 to 2019/20 for Southern DHB.

Statistics New Zealand:
Summary population data was taken from the Statistics New Zealand website.

Inpatient based support

- There were **1,172 people** who received inpatient care in PRIMHD.
- They had a total of **37,408 bednights**, which is an average of **31.8 per person**.
- **37,075 (99.1%)** of the bednights were in Wakari hospital, and **333 (0.9%)** were in Southland Hospital.
- The activity type 'Mental health acute inpatient or equivalent occupied bed nights' made up **30.9%** of the bednights.

Inpatient defined as:
Team type description is 'Inpatient Team'; team setting description is 'Inpatient based'; activity unit type is 'BEDNIGHT'; activity unit count was not 0; activity setting is 'Inpatient'; activity type was not 'T35' ('Did not attend').

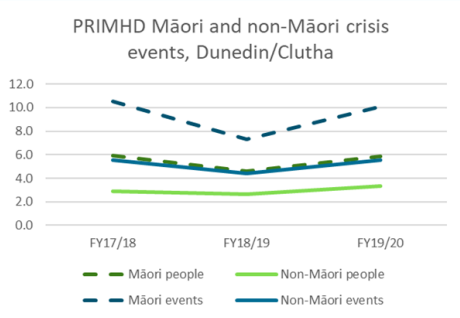
Community based support

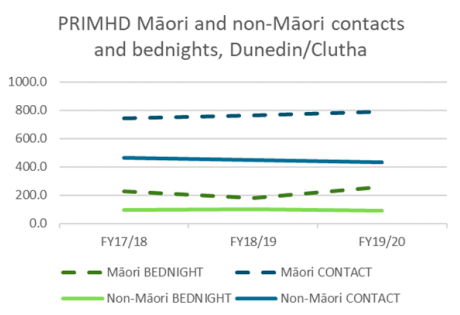
- There were a total of **7,350 people** who accessed community-based support in PRIMHD.
- These people had **148,456 events**, or **20.2 events each**.
- Child and Youth teams had **6.8%** of the events, and **10.7%** of the patients.
- The most common activity type was 'Individual treatment attendances: family/whānau not present', making up **78.2%** of events.

Community defined as:
Team type description is 'Community Team'; team setting description is 'Community based'; activity unit type is 'CONTACT'; activity unit count was not 0; activity setting is not 'Inpatient'; activity type was not 'T35' ('Did not attend').

Mental Health and Addictions care

This data is for patients who live in Dunedin/Clutha, rather than services provided in Dunedin/Clutha.





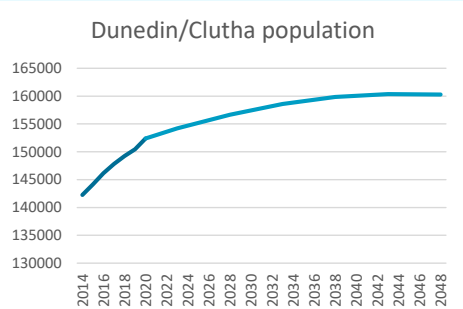
Use of services: A total of **9,459** people who lived in the Dunedin/Clutha locality used any PRIMHD service in the three years.

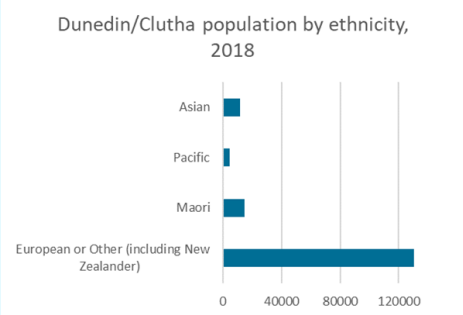
Of those, **5,425** only appeared in one year, **2,210** used services in two years, and **1,821** people appeared in all three years.

Crisis event patients: Of the **1,211** patients with crisis events, 185 patients (**15%**) had events in more than one year, and **40** patients had events in each year.

Population

Growth: Dunedin/Clutha is forecast to grow by **5%** from 2018 to 2028. The 65+ age band is expected to grow by **35%** in this time.





Population by age, 2018 and 2028

Dunedin/Clutha	2018	2028	Change
0-14 years	23,700	21,450	-9%
15-19 years	12,980	13,740	6%
20-24 years	16,160	15,840	-2%
25-29 Years	9,690	9,030	-7%
30-34 years	8,710	9,690	11%
35-39 years	8,100	9,560	18%
40-64 years	46,100	45,150	-2%
65 years and over	23,850	32,250	35%
Total	**149,250**	**156,650**	**5%**

Summary of Southern District Health Board's Mental Health and Addiction (MHA) services: Southland/Gore

June 2021

SYNERGIA

Key points

Area:

Southland/Gore locality encompasses the TLAs of Southland District, Gore District and Invercargill City.

Mental Health and Addictions services:

This encompasses publicly funded secondary MHA services which are recorded in the Ministry of Health's PRIMHD dataset. Some MHA services are not included here, such as calls to crisis lines or primary mental health care.

Sources:

Southern DHB supplied data:
Southern DHB provided information on FTE, beds available, mental health and addiction teams, and the budget for these services.

Ministry of Health administrative data:
PRIMHD, National Minimum Dataset (NMDS), and the National Non-Admitted Patient Collection (NNPAC), for the financial years 2017/18 to 2019/20 for Southern DHB.

Statistics New Zealand:
Summary population data was taken from the Statistics New Zealand website.

Inpatient based support

- There were **485 people** who received inpatient care in PRIMHD.
- They had a total of **14,718 bednights**, which is an average of **30.3 per person**.
- **13,932 (94.7%)** of the bednights were in Southland hospital, and **786 (5.3%)** were in Wakari Hospital.
- The activity type 'Mental health acute inpatient or equivalent occupied bed nights' made up **94.7%** of the bednights.

Inpatient defined as:
Team type description is 'Inpatient Team'; team setting description is 'Inpatient based'; activity unit type is 'BEDNIGHT'; activity unit count was not 0; activity setting is 'Inpatient'; activity type was not 'T35' ('Did not attend').

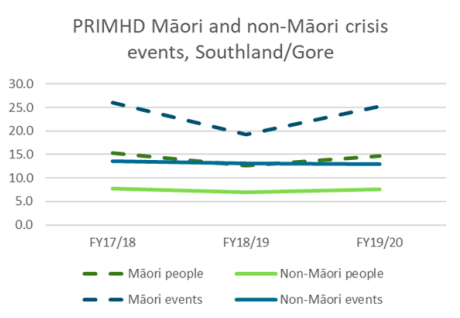
Community based support

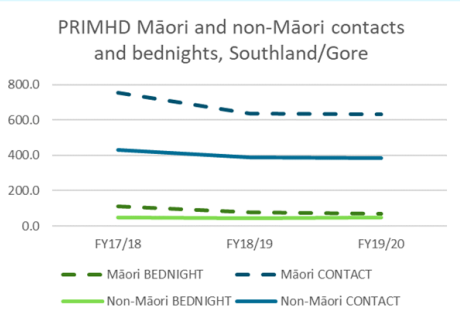
- There were a total of **4,891 people** who accessed community-based support in PRIMHD.
- These people had **106,391 events**, or **21.8 events each**.
- Child and Youth teams had **17.5%** of the events, and **32.5%** of the patients.
- The most common activity type was 'Individual treatment attendances: family/whānau not present', making up **51.6%** of events.

Community defined as:
Team type description is 'Community Team'; team setting description is 'Community based'; activity unit type is 'CONTACT'; activity unit count was not 0; activity setting is not 'Inpatient'; activity type was not 'T35' ('Did not attend').

Mental Health and Addictions care

This data is for patients who live in Southland/Gore, rather than services provided in Southland/Gore.





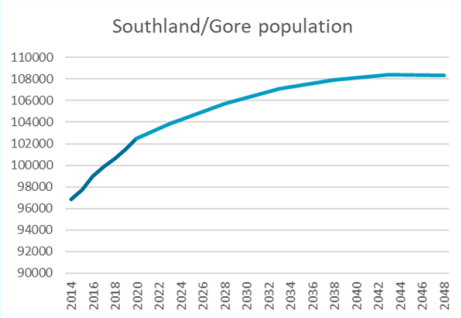
Use of services: A total of **5,948** people who lived in the Southland/Gore locality used any PRIMHD service in the three years.

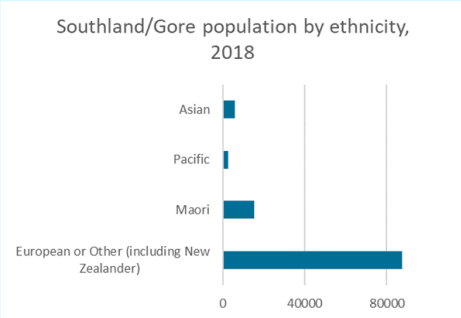
Of those, **3,797** only appeared in one year, **1,350** used services in two years, and **801** people appeared in all three years.

Crisis event patients: Of the **2,137** patients with crisis events, 339 patients (**16%**) had events in more than one year, and **76** patients had events in each year.

Population

Growth: Southland/Gore is forecast to grow by **5%** from 2018 to 2028. The 65+ age band is expected to grow by **38%** in this time.





Population by age, 2018 and 2028

Southland/Gore	2018	2028	Change
0-14 years	19,850	18,300	-8%
15-19 years	6,110	6,630	9%
20-24 years	5,630	5,690	1%
25-29 Years	6,630	5,720	-14%
30-34 years	6,490	6,490	0%
35-39 years	6,160	7,310	19%
40-64 years	32,900	32,650	-1%
65 years and over	16,750	23,100	38%
Total	**100,600**	**105,700**	**5%**

Embargoed until 3.00pm Friday 6th August 2021

APPENDIX F: BLUEPRINT RESOURCING TABLES

Below is the analysis of resourcing against Blueprint I resourcing guidelines. Whilst published in 1997 these resourcing guidance still represent some of the best guidance available on the population based resourcing should be for a mental health and addiction system. The tables are shown overall for Southern and then for each TLA.

RESOURCE GUIDELINES - UNIT PER 100,000 POPULATION					
Service component	**Unit**	**0-14**	**15-19**	**20-64**	**65+**
Inpatient services	Beds or care packages	1.3	3	24.8	5.3
Specialist day care services	Places	0	0	0	4
Community based day and residential service	Beds or care packages	3.7	8.35	69.1	0
Community based mental health teams	FTE	16.6	20.75	49.22	13
Community support services	FTE	0	2.2	30.5	1.3
Consumer advisory services and consumer run initiatives	FTE	0	0	3.4	0
Families advisory services and family run initiatives	FTE	0	0	2.1	0
Advice and support for consumers and families	FTE	0	0.4	0	0.6
Access to newer anti-psychotic medication	People	0	31.2	175.7	18.1
Alcohol and drug detoxification services	Beds or care packages	0	0.2	2.8	0
Alcohol and drug residential treatment services	Beds or care packages	0	0.9	9.1	0
Alcohol and drug community based teams	FTEs	0	0.9	13.95	1.4
Methadone treatment	Places	0	10	140	0

Total population of Southern						
Service component	**Unit**	**0-14**	**15-19**	**20-64**	**65+**	**Totals**
Inpatient services	Beds or care packages	0.8	0.7	51.8	3.0	56
Specialist day care services	Places	0.0	0.0	0.0	2.3	2
Community based day and residential service	Beds or care packages	2.2	2.0	144.4	0.0	149
Community based mental health teams	FTE	9.8	4.8	102.9	7.4	125
Community support services	FTE	0.0	0.5	63.7	0.7	65
Consumer advisory services and consumer run initiatives	FTE	0.0	0.0	7.1	0.0	7
Families advisory services and family run initiatives	FTE	0.0	0.0	4.4	0.0	4
Advice and support for consumers and families	FTE	0.0	0.1	0.0	0.3	0
Access to newer anti-psychotic medication	People	0.0	7.3	367.2	10.3	385
Alcohol and drug detoxification services	Beds or care packages	0.0	0.0	5.9	0.0	6
Alcohol and drug residential treatment services	Beds or care packages	0.0	0.2	19.0	0.0	19
Alcohol and drug community based teams	FTEs	0.0	0.2	29.2	0.8	30
Methadone treatment	Places	0.0	2.3	292.6	0.0	295

Dunedin						
Service component	**Unit**	**0-14**	**15-19**	**20-64**	**65+**	**Totals**
Inpatient services	Beds or care packages	0.3	0.4	19.8	1.2	22
Specialist day care services	Places	0.0	0.0	0.0	0.9	1
Community based day and residential service	Beds or care packages	0.8	1.0	55.3	0.0	57
Community based mental health teams	FTE	3.4	2.5	39.4	2.8	48
Community support services	FTE	0.0	0.3	24.4	0.3	25
Consumer advisory services and consumer run initiatives	FTE	0.0	0.0	2.7	0.0	3
Families advisory services and family run initiatives	FTE	0.0	0.0	1.7	0.0	2
Advice and support for consumers and families	FTE	0.0	0.0	0.0	0.1	0
Access to newer anti-psychotic medication	People	0.0	3.7	140.6	4.0	148
Alcohol and drug detoxification services	Beds or care packages	0.0	0.0	2.2	0.0	2
Alcohol and drug residential treatment services	Beds or care packages	0.0	0.1	7.3	0.0	7
Alcohol and drug community based teams	FTEs	0.0	0.1	11.2	0.3	12
Methadone treatment	Places	0.0	1.2	112.0	0.0	113

Clutha

Service component	Unit	0-14	15-19	20-64	65+	Totals
Inpatient services	Beds or care packages	0.0	0.0	2.6	0.2	3
Specialist day care services	Places	0.0	0.0	0.0	0.1	0
Community based day and residential service	Beds or care packages	0.1	0.1	7.3	0.0	7
Community based mental health teams	FTE	0.6	0.2	5.2	0.4	6
Community support services	FTE	0.0	0.0	3.2	0.0	3
Consumer advisory services and consumer run initiatives	FTE	0.0	0.0	0.4	0.0	0
Families advisory services and family run initiatives	FTE	0.0	0.0	0.2	0.0	0
Advice and support for consumers and families	FTE	0.0	0.0	0.0	0.0	0
Access to newer anti-psychotic medication	People	0.0	0.3	18.5	0.6	19
Alcohol and drug detoxification services	Beds or care packages	0.0	0.0	0.3	0.0	0
Alcohol and drug residential treatment services	Beds or care packages	0.0	0.0	1.0	0.0	1
Alcohol and drug community based teams	FTEs	0.0	0.0	1.5	0.0	2
Methadone treatment	Places	0.0	0.1	14.7	0.0	15

Southland

Service component	Unit	0-14	15-19	20-64	65+	Totals
Inpatient services	Beds or care packages	0.1	0.1	4.7	0.3	5
Specialist day care services	Places	0.0	0.0	0.0	0.2	0
Community based day and residential service	Beds or care packages	0.2	0.2	13.0	0.0	13
Community based mental health teams	FTE	1.1	0.4	9.3	0.7	11
Community support services	FTE	0.0	0.0	5.8	0.1	6
Consumer advisory services and consumer run initiatives	FTE	0.0	0.0	0.6	0.0	1
Families advisory services and family run initiatives	FTE	0.0	0.0	0.4	0.0	0
Advice and support for consumers and families	FTE	0.0	0.0	0.0	0.0	0
Access to newer anti-psychotic medication	People	0.0	0.6	33.2	0.9	35
Alcohol and drug detoxification services	Beds or care packages	0.0	0.0	0.5	0.0	1
Alcohol and drug residential treatment services	Beds or care packages	0.0	0.0	1.7	0.0	2
Alcohol and drug community based teams	FTEs	0.0	0.0	2.6	0.1	3
Methadone treatment	Places	0.0	0.2	26.4	0.0	27

Waitaki

Service component	Unit	0-14	15-19	20-64	65+	Totals
Inpatient services	Beds or care packages	0.1	0.0	3.2	0.3	4
Specialist day care services	Places	0.0	0.0	0.0	0.2	0
Community based day and residential service	Beds or care packages	0.2	0.1	8.8	0.0	9
Community based mental health teams	FTE	0.7	0.3	6.3	0.7	8
Community support services	FTE	0.0	0.0	3.9	0.1	4
Consumer advisory services and consumer run initiatives	FTE	0.0	0.0	0.4	0.0	0
Families advisory services and family run initiatives	FTE	0.0	0.0	0.3	0.0	0
Advice and support for consumers and families	FTE	0.0	0.0	0.0	0.0	0
Access to newer anti-psychotic medication	People	0.0	0.4	22.4	1.0	24
Alcohol and drug detoxification services	Beds or care packages	0.0	0.0	0.4	0.0	0
Alcohol and drug residential treatment services	Beds or care packages	0.0	0.0	1.2	0.0	1
Alcohol and drug community based teams	FTEs	0.0	0.0	1.8	0.1	2
Methadone treatment	Places	0.0	0.1	17.8	0.0	18

Invercargill

Service component	Unit	0-14	15-19	20-64	65+	Totals
Inpatient services	Beds or care packages	0.1	0.1	8.1	0.5	9
Specialist day care services	Places	0.0	0.0	0.0	0.4	0
Community based day and residential service	Beds or care packages	0.4	0.3	22.7	0.0	23
Community based mental health teams	FTE	1.8	0.7	16.2	1.3	20
Community support services	FTE	0.0	0.1	10.0	0.1	10
Consumer advisory services and consumer run initiatives	FTE	0.0	0.0	1.1	0.0	1
Families advisory services and family run initiatives	FTE	0.0	0.0	0.7	0.0	1
Advice and support for consumers and families	FTE	0.0	0.0	0.0	0.1	0
Access to newer anti-psychotic medication	People	0.0	1.1	57.7	1.8	61
Alcohol and drug detoxification services	Beds or care packages	0.0	0.0	0.9	0.0	1
Alcohol and drug residential treatment services	Beds or care packages	0.0	0.0	3.0	0.0	3
Alcohol and drug community based teams	FTEs	0.0	0.0	4.6	0.1	5
Methadone treatment	Places	0.0	0.3	45.9	0.0	46

Queenstown-Lakes						
Service component	**Unit**	**0-14**	**15-19**	**20-64**	**65+**	**Totals**
Inpatient services	Beds or care packages	0.1	0.1	8.3	0.3	9
Specialist day care services	Places	0.0	0.0	0.0	0.2	0
Community based day and residential service	Beds or care packages	0.3	0.2	23.1	0.0	24
Community based mental health teams	FTE	1.2	0.4	16.5	0.6	19
Community support services	FTE	0.0	0.0	10.2	0.1	10
Consumer advisory services and consumer run initiatives	FTE	0.0	0.0	1.1	0.0	1
Families advisory services and family run initiatives	FTE	0.0	0.0	0.7	0.0	1
Advice and support for consumers and families	FTE	0.0	0.0	0.0	0.0	0
Access to newer anti-psychotic medication	People	0.0	0.6	58.7	0.9	60
Alcohol and drug detoxification services	Beds or care packages	0.0	0.0	0.9	0.0	1
Alcohol and drug residential treatment services	Beds or care packages	0.0	0.0	3.0	0.0	3
Alcohol and drug community based teams	FTEs	0.0	0.0	4.7	0.1	5
Methadone treatment	Places	0.0	0.2	46.8	0.0	47

Central						
Service component	**Unit**	**0-14**	**15-19**	**20-64**	**65+**	**Totals**
Inpatient services	Beds or care packages	0.1	0.0	3.3	0.2	4
Specialist day care services	Places	0.0	0.0	0.0	0.2	0
Community based day and residential service	Beds or care packages	0.1	0.1	9.3	0.0	10
Community based mental health teams	FTE	0.6	0.2	6.6	0.5	8
Community support services	FTE	0.0	0.0	4.1	0.1	4
Consumer advisory services and consumer run initiatives	FTE	0.0	0.0	0.5	0.0	0
Families advisory services and family run initiatives	FTE	0.0	0.0	0.3	0.0	0
Advice and support for consumers and families	FTE	0.0	0.0	0.0	0.0	0
Access to newer anti-psychotic medication	People	0.0	0.3	23.6	0.7	25
Alcohol and drug detoxification services	Beds or care packages	0.0	0.0	0.4	0.0	0
Alcohol and drug residential treatment services	Beds or care packages	0.0	0.0	1.2	0.0	1
Alcohol and drug community based teams	FTEs	0.0	0.0	1.9	0.1	2
Methadone treatment	Places	0.0	0.1	18.8	0.0	19

Gore						
Service component	**Unit**	**0-14**	**15-19**	**20-64**	**65+**	**Totals**
Inpatient services	Beds or care packages	0.0	0.0	1.8	0.1	2
Specialist day care services	Places	0.0	0.0	0.0	0.1	0
Community based day and residential service	Beds or care packages	0.1	0.1	4.9	0.0	5
Community based mental health teams	FTE	0.4	0.2	3.5	0.3	4
Community support services	FTE	0.0	0.0	2.2	0.0	2
Consumer advisory services and consumer run initiatives	FTE	0.0	0.0	0.2	0.0	0
Families advisory services and family run initiatives	FTE	0.0	0.0	0.1	0.0	0
Advice and support for consumers and families	FTE	0.0	0.0	0.0	0.0	0
Access to newer anti-psychotic medication	People	0.0	0.2	12.5	0.5	13
Alcohol and drug detoxification services	Beds or care packages	0.0	0.0	0.2	0.0	0
Alcohol and drug residential treatment services	Beds or care packages	0.0	0.0	0.6	0.0	1
Alcohol and drug community based teams	FTEs	0.0	0.0	1.0	0.0	1
Methadone treatment	Places	0.0	0.1	10.0	0.0	10

List of Abbreviations

CAMHS	Children & Adolescent Mental Health Service
SDHB	Southern District Health Board
CMHT	Community Mental Health Team
CRS	Crisis Resolution Service
CRT	Crisis Resolution Team
DHB	District Health Board
ED	Emergency Department
FTE	Full time Equivalent
GP	General Practitioner
LEAG	Lived Experience Advisory Group
MH&A	Mental Health & Addiction
NGO	Non-Government Organisation
PHO	Primary Health Organisation

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