Te Hurihanga – Time for Change

Implementation Evaluation

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Contents

1. Key Messages – Implementation Evaluation Summary

An intensive programme of work was begun in March 2021 to support the transformation of the mental health and addiction system in the Southern region. The programme was a direct response to findings from a comprehensive review of the system that had identified a number of gaps in support for tangata whaiora experiencing mental health and/or addiction.

The recommendations from the Review resonated with the sector. A programme implementation team was established by Southern District Health Board (SDHB) with a budget for implementation of a phased series of actions over 18 months. Throughout the implementation timeframe the team engaged with the sector, with those with lived experience and with local communities to progress change.

In just under two years a range of projects to improve mental health and addiction support have been implemented. Throughout this time the programme team mobilised themselves to progress agreed plans while also navigating the uncertainties of the structural changes within the health system.

An implementation evaluation was undertaken between late January 2023 and August 2023. The purpose of the evaluation was to document the programme and its implementation, identify strengths and challenges of implementation, and identify ways to improve implementation.

Key findings of the evaluation are outlined below organised by the key questions orienting the evaluation.

What was the programme of work?

The programme incorporated a number of actions designed to improve the mental health and addiction system in Southern. Actions were based explicitly on the Review recommendations in Time for Change - Te Hurihanga.

Central principles orienting all programme actions were:

- Equity-first thinking, and
- Co-design

A programme team was established with funding to support implementation plans. Dedicated roles within the programme team of a Pou Tātaki – Project Manager Equity Lead and a Project Manager lived experience were key structural features of the programme. They ensured these core principles remained in focus across all projects.

For the purposes of the evaluation, projects within the programme were divided into Foundation projects and Domain specific projects.

There were five Foundation projects. These were projects that could be progressed relatively quickly to set the scene for change. There were six domain specific projects. These were projects of work designed to inform and influence change in particular areas, such as establishment of crisis support services, child and youth co-design, and non-clinical day programmes.

The projects are outlined in the figures below. Each project is described in more detail in subsequent sections of this report.

Figure 1: Foundation and Domain Specific Projects

Foundation Projects [5]	**Domain Specific Projects [6]**
Ring fencing of money for Māori services (1 million) and co-development of an investment framework	Crisis Support Service in Queenstown and Central Lakes, and Waitaki
Disestablishment of the network leadership group [NLG] and establishment the Cross Sector Group	Peer support services
Signal closure of Ward 11	Co-design in child and youth
Commission external support for an organisational development programme for Mental Health, Addiction and Intellectual Disability service [MHAIDS] to support cultural change and to grow leadership capability, and	Co-design a contemporary model of care for non-clinical day programmes

Foundation Projects [5]	Domain Specific Projects [6]
Increase clinical leadership positions [4] in specialist services	Expansion of Alcohol and Other Drugs – Dunedin
	Intensive Community Support and residential Access (to support closure of ward 11)

Programme implementation was overseen by a Leadership Group, chaired by Clive Bensemann, an Auckland based Psychiatrist who had been the previous chair of the independent steering group that had supported the Review.

The team also engaged with the sector through the Cross Sector Group and the four district Mental Health and Addiction Networks. Engagement with Networks was seen as an opportunity for the programme team to understand local issues, to maintain the momentum for change, and share information about programme progress.

How effective was implementation of projects within the programme?

The programme progressed all Foundation projects and actions associated with domain specific projects over the implementation timeframe. While there were some delays in implementation, all projects were progressed across the implementation timeframe.

Criteria to assess implementation effectiveness were developed to enable stakeholders to rate projects on common dimensions. High ratings across these criteria are indicative that stakeholders judged implementation of projects as very effective.

Two surveys were developed to gather feedback from the Cross Sector Group and a broader mental health and addiction group. Interviews were also conducted with members of the programme team, the overall chair of the Mental Health and Addiction Networks, and eleven other stakeholders from the mental health and addiction sector.

Figure 2: Ratings by stakeholders according to programme criteria

Evaluation Criteria - Implementation	**Findings**
Timely Communication	The timeliness of communication by the programme team was rated the highest of all implementation criteria. This suggests that stakeholders felt they got information about the programme when they needed it. The Cross-Sector Group rated this dimension higher than the broader stakeholder group in surveys.
Implementation of actions	The majority of respondents from the Cross Sector Group and the broader sector group rated implementation of actions within the project they were most engaged with as good or very good[1].
Engagement with Iwi Māori	Engagement with Iwi Māori was rated lowest of all dimensions. This is indicative of the limited Māori engagement across projects, and limited engagement of Māori within the mental health and wellbeing networks across Southern.
Lived Experience participation	Participation of people with lived experience was seen as a core feature of the programme. Survey feedback and interviews indicated that integrating lived experience throughout the programme was important structurally and practically.
Opportunities for co-design	Feedback in interviews and from the surveys indicated that, for most projects, co-design meetings were well facilitated, and processes of engagement acknowledged the value of lived experience. However, co-design in child and youth was limited by the

[1] Given the diversity of projects respondents were asked to focus in on one project they had been most closely involved in.

Evaluation Criteria - Implementation	Findings
	lack of inclusion of the range of groups who work with children and young people.

What were the strengths of implementation?

A number of strengths of the implementation process were identified in the evaluation. They include:

- Resonance of implementation action with the sector. The programme of work reflected the Review recommendations. There was strong buy in and support from the sector for change.
- Executive Leadership within Te Whatu Ora to champion change. The Executive Director played a key role in providing authority and legitimacy to the programme of work.
- Dedicated funding for implementation. The establishment of a dedicated programme team and funding was welcomed by stakeholders. It indicated to them that Te Whatu Ora was serious about change.
- Lived Experience Leadership and Engagement. The appointment of a project manager lived experience to lead and coordinate co-design processes, the Lived Experience Workforce Plan, and Peer Governed services was important structurally and practically in progressing projects.
- Co-design as a core design feature of the programme. The inclusion of co-design processes as a central approach across all domain-specific projects was seen as a key strength of the programme. Co-design was seen as a mechanism for supporting local communities to identify what was important to them.
- Collaboration and dialogue to lead change. The programme team worked collaboratively to support implementation plans but did not prescribe how projects would be implemented. The changes co-designed or implemented through Time for Change Te Hurihanga were regularly profiled in programme updates and newsletters. The programme team drew on networks to support dissemination and spread of messages. Respondents to the survey rated timeliness of communication very highly.

What were the Challenges of Implementation?

- A lack of genuine of co-design in child and youth. While co-design was seen as a strength of programme design, stakeholders involved in child and youth co-design viewed it as limited in inclusion of diverse voices and lacking in comprehensiveness.
- Limited engagement of Iwi Māori There were identified limits in iwi engagement due to shifts in iwi governance structures arising from the restructure of the health system, and because of limited number of Māori in capacity of the Māori workforce in the Southern region.
- Perceived rigidity of contracting processes. Commissioning processes within SDHB / Te Whatu Ora were not set up to encourage collaborative ways of working across services. This was seen as limiting the capacity to be responsive to tangata whaiora.
- Variable skills in collaborative ways of working in groups. The programme team encouraged collaborative planning to address local needs. However, the capacity and capability of groups in some districts in planning and process facilitation inhibited authentic local engagement in some instances.
- The limited influence of the Cross Sector Group. The Cross Sector Group was established to provide strategic insights and share information across the region. However, several stakeholders indicated the group had an unclear purpose and mandate. The group became a mechanism for sharing implementation progress, rather than a source of strategic insights, and/or advice.

What learnings can be drawn to inform improvement of ongoing Implementation?

- Create a Whole of Programme Strategy map: The programme of work is more than the sum of its parts. Some ideas to focus future work may include:
    - How best the programme team can progress implementation of discrete projects while also maintain the vision to transform the mental health and addiction system.
    - Share more widely the milestones and review points.
    - Assess our progress along the way and include processes support to continuous improvement.
    - Provide a balanced representation of progress and learnings from implementation. Acknowledge the learnings from the first 18 months of implementation, including the aspects of

implementation that have not worked well and identify next steps.

- Involve those with lived experience.
    - Build capacity and capability across all parts of the mental health and addiction sector to better engage with those with lived experience.
    - Ensure the potential for power imbalances are addressed early on when involving people with lived experience in consultation and discussion.
    - Do not exclude the voice of those with lived experience through processes and language used.
- Engagement with Iwi Māori
    - Consolidate relationships with Te Aka Whai Ora for guidance and leadership on engagement with iwi Māori.
    - Schedule Co-Design meetings well in advance:
    - Plan a schedule well ahead for co-design and workshops as otherwise too much of a burden on community and participants.
    - Maintain co-facilitation approach, if possible, with a lived experience facilitator and Māori co facilitator.
    - Consider offering mechanisms for support for people who attend co-design workshops.
- Strengthen Monitoring and Evaluation:
    - Doing something well is important, but the team, Te Whatu Ora, the sector, and the community will need evidence that change is an improvement.
    - While not a central focus of this report it will be important for the team to consider monitoring and evaluation mechanisms that can be put in place across all funded services, that allow collation, and aggregation according to key indicators and measures of change.
    - These mechanisms will strengthen opportunities for learning and reporting, and accountability.
    - Commissioned services have contracts they are required to report against, but with no programme team there is no mechanism to join up reporting mechanisms and understand the difference the services are making to key mental health outcomes. It is recommended that in the June 2023-June 2024 financial year the programme team alongside the services identify outputs and outcomes that align with contractual requirements for delivery and intended outcomes.

    - Identify ways to strengthen data collation and synthesis as a basis for programme planning, decision making and reporting.
- Continue to identify ways to grow and support the lived experience workforce to support good process and design, implementation and evaluation of services.
    - Support capability building for people who join groups in a lived experience role through training programmes. This will enable them to have a stronger voice in discussions, in advocacy and in decision making.
    - Build in lived experience to all monitoring and evaluation mechanisms.
- Collaborative Commissioning Approaches:
    - Explore creative ways that support collaborative contracting arrangements to support integration and joined up service delivery.

2. Introduction

Time for Change - Te Hurihanga Review was a comprehensive, independent review of the mental health and addiction system undertaken in the Southern region. The review was based on extensive consultations across the sector and included the perspectives of 800 people with lived experience, whānau, carers and other mental health and addiction system stakeholders.

The report was released on the 6th August 2021. It outlined a vision a mental health and addiction system that would better meet the diverse needs of the community across the region.

While the review focused on ways to transform mental health and addiction services, it identified a number of gaps in the system. The current system was found to be fragmented, overloaded, uncoordinated, and difficult for some people to access. The report nominated 35 recommendations that - if implemented - will contribute to a more equitable, fair, person-centred, accessible and effective mental health and addiction system.

Time for Change – Implementation Plan

SDHB began a programme of work to implement recommendations from the Review. Seven million dollars was allocated by SDHB Board to the implementation over one year from January 2021. One million was ring-fenced for Māori, including the design and delivery of Kaupapa Māori services.

The implementation plan was strongly guided by the priorities identified in the Review. A commitment to equity first thinking and practice, and co-design underpinned programme design and implementation. Given the nature and scope of the changes required, activities were phased to encourage stakeholder buy in and to avoid unnecessary burden on the sector.

The change effort was ambitious with a number of projects to be delivered within the year. It took time to establish the programme structure and to convert the Review into an action plan. Major structural changes to the health system were also underway at the same time as the establishment of the programme of work.

Agreement from SDHB Board was obtained to extend the timeframe 6 months to end of June 2023. A further extension (by Te Whatu Ora) of one year to June 2024 was granted in recognition of the scope and scale of change required, and achievements to date.

In late January 2023 an implementation evaluation was commissioned. This piece of work is the subject of this report. The Review was undertaken by an independent evaluation consultant between late January and July 2023.

The evaluation combines elements of an internal and external evaluation. The programme team provided necessary programme documentation and shared their reflections and experiences with implementation. These are included in this report. The external evaluator conducted interviews and surveys with representatives of the mental health and addiction sector and synthesised these components alongside internal programme reports.

This report

This report describes the programme of work of the Time for Change Te Hurihanga programme, assesses implementation effectiveness and presents feedback from stakeholders from the mental health and addiction sector across the Southern region. The report also identifies implications and recommendations to support ongoing implementation.

The Implementation evaluation was designed to assess progress of Time for Change Te Hurihanga actions so far, identify strengths and weaknesses, and document learnings to support implementation in the next 6-12 months.

Te Hurihanga Time for Change

The 2021 Time for Change – Te Hurihanga Review ("The Review") pointed to a need for significant changes to the system to improve the experience and outcomes for people with mental health and addiction issues.

The Review identified specific ways to strengthen the system and acknowledged the deep commitment and passion for change of those within the sector and the community. People were frustrated with the gaps in the system and wanted change.

The consultation process was extensive as summarised in the figure below.

Figure 3: The Review process

Specific areas of concern were raised in the Review. They included:

- Māori being significantly disadvantaged by the mental health and addiction system.
- A lack of Kaupapa Māori services that support the personal and cultural needs of tāngata whaiora (a person seeking health) and whānau.
- Limited options for people in crisis and a lack of local support options.
- Lack of Alcohol and other Drug addiction services for young people,
- Limited access to specialist advice and/or support from senior medical officers, and
- Outdated and inappropriate physical settings and facilities, and inadequate technologies to support system accountability and learning.

Central to the Review was the emphasis on equity for Māori. Māori are over- represented within the mental health and addiction system, and yet the availability of Kaupapa Māori approaches and other culturally appropriate support remain limited. The Review found that data availability about the performance of services for Māori was also lacking. The findings from the Review echo the findings from The Health and Disability system review [2019] that found that Māori have not been well supported by the health and disability system in New Zealand.

While it was clear that structural changes were needed to improve access, pathways and outcomes, there were also important philosophical and practical changes required to better support tāngata whaiora.

The key features of the mental health and addictions system and the vision for change are captured in the figure (table) below. The table summarises the current state [left hand side of the diagram] and the future state [right

hand side of the diagram] identified by those who participated in the Review.

Figure 4: Transitioning from the 'current system' to the 'future system'
[reproduced from page 16 Time for Change Te Hurihanga]

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

Recommendations from the Review

The Review highlighted a range of ambitious and wide-ranging recommendations.

The 35 recommendations were clustered under 8 themes, which reflect substantive changes required in the philosophy and approach to mental health and addiction, and more practical recommendations for change. The eight themes were:

- Hauroa Māori- Take equity seriously.
- Fix gaps in the continuum of care.
- Adopt a life-course approach and design services accordingly.
- Improve physical environments.
- Reconfigure supporting functions and structures.
- Support and develop the workforce.
- Organisational development and culture.
- Invest in change.

The Review identified a range of actions, under what was termed, 'fix now' priorities. These are recommendations that could be progressed within the first year of implementation.

Objectives of the implementation programme

The objective of implementation activities for the 18-month implementation programme was to initiate and implement a range of improvements to better support tangata whaiora experiencing mental health and/or addiction.

It was anticipated that successful implementation will lay the foundation for the transformation of the mental health and addictions system. Models of care will be developed, based on co-design with communities to ensure that services contracted to provide support work alongside communities to address local needs.

There will be a resolute focus on mental health and wellbeing, including:

- a focus on equity for Māori and support for Kaupapa Māori services,

- support for early intervention and prevention,
- improved settings that support recovery and wellbeing
- improvements in the way people can access to services,
- expanded options for support, and
- better integration of support provided by schools, non-government organisations (NGOs), specialist service providers, whānau and the wider community.

3. Structure of the Programme

Leadership and Funding

The Review made a strong case for investment in change to deliver agreed outputs and outcomes. A business case was approved by the Southern District Health Board for funding to support the initial year of implementation with a dedicated implementation team.

Seven million dollars was allocated to implement Time for Change Te Hurihanga across a year period.[2] One million dollars of the 7 million was ring fenced for Kaupapa Māori services.

The Executive Director for Mental Health and Addictions and Intellectual Disability Services, Southern DHB was a central champion for the change programme. The Executive Director left the position in June 2023[3].

The Programme team

The initial appointment to the Programme team was the programme management role. Each team member was progressively brought onto the team over a period of 2-3 months with most of the team working in a part-time capacity alongside other work or responsibilities[4]. Each individual was responsible for supporting implementation of a particular project or projects with the oversight of the programme manager. The Programme team met weekly throughout the implementation period.

Time was taken to develop and strengthen relationships and engagement across communities, including Marae and Māori communities and organisations with the change programme. A Leadership Group was established to provide guidance and leadership for the programme implementation team.

The Review noted the commitment and passion of the sector for change. With the disestablishment of the Network Leadership Group [NLG], a Cross Sector Group was formed. It was envisaged that members of this group

[2] This initial programme timeframe was extended by six months in recognition of the impact of Covid-19 and achievements to date. A further extension was granted to June, 2024.
[3] The Group Director of Operations Te Waipounamou currently provides executive leadership to MHAIDS and to Te Hurihanga Time for Change .
[4] The programme manager, and Pou Tātaki are full-time positions.

would provide knowledge and expertise to guide programme implementation, and champion the programme across their networks. The team identified ways to maintain engagement and support existing groups such as, the four Mental Health and Addictions Networks.

This 'behind the scenes' foundation work is often not documented in implementation progress reports. However, it is seen as critical to build buy-in to change efforts and to maintain the momentum for change. In this way, the programme team are not merely present to support implementation plans, but catalyse change through supporting the sector to participate, engage and support new ways of working.

The programme team, and their respective roles are outlined in Figure 5.

Figure 5: Programme Implementation team Roles

Title	**Role in the implementation programme**
Kaiwhakahaere-programme manager	Overall management and coordination of the programme The role is in partnership with the Pou Tātaki
Pūkenga Kaupapa, Clinical leads	Clinical leadership for the projects. In particular, crisis support co-design (Queenstown and Central Lakes and Waitaki), Child and Youth
Pou Tātaki – Project Manager, Māori Equity Lead Equity partner, Time for Change Te Hurihanga	The mahi involves the equity for Māori focus and to provide tikanga Māori guidance and direction across all aspects of the Time for Change - Te Hurihanga programme and projects. Advise, support, and contribute to the design, planning and presentation of projects alongside all Time for Change - Te Hurihanga project managers with a clear emphasis on designing-in equity for Māori and designing-out inequitable practices. Ensure the programme is guided by tikanga Māori based process, when and where relevant including whānau, marae and community engagement. The Pou Tātaki role is a partnership with the Programme Manager. The agreed aspiration is to role model authentic partnership approaches and to work

Title	Role in the implementation programme
	collaboratively in the spirit of Te Tiriti o Waitangi. This is the Time for Change Te Hurihanga essential guide to internal and external working relationships, community engagement, and to promote an inclusive culture across the Time for Change Te Hurihanga programme of work.
Pūkenga Kaupapa, Project Manager with lived experience	Project management: Peer led services codesign for Southern model of care, and commission for Dunedin and Invercargill Peer support hub codesign, and commissioning Consumer, peer support and lived experience workforce development plan, and commissioning
Pūkenga Kaupapa, Project Manager	Project management and support for a variety of projects including: Alcohol and Drug services, Intensive community services, Waitaki crisis support, and Non-clinical Day programmes review of model of care
Clinical Project Manager	Project lead for 'Intensive Community Support' (working on processes and pathways to transition people from long hospital stays to the community). Other projects include clinical leadership in other service development initiatives and projects, for example non-clinical day programmes codesign.
Senior Communications advisor	Support the team in their communications needs. This can range from drafting communications plans and media releases to drafting FAQs and information about projects. Manage the Time for Change – Te Hurihanga website and SharePoint site and write this newsletter as well as the MHAID staff newsletter
Administration	Overall administration and support

"We have the right team and people that can bring different expertise and different perspectives. And we've had to build that over time.... It was a matter of pulling together the right team together and ensuring that we have different perspectives around the table to keep us on track." [Te Whatu Ora Representative]

Principles Underpinning Programme Implementation

There were two central principles that underpinned the programme of work that made up Time for Change- Te Hurihanga. They were:

- A commitment to Equity First thinking and practice, and
- Co-design and engagement of people with lived experience

Equity First

The Review highlighted the continuing disadvantage of Māori in the mental health and addictions system. The newly established Te Aka Whai Ora, Māori Health Authority, will take a proactive approach in this work.

The Review highlighted decision-making principles to address inequity for Māori in accessing mental health and addiction services and their health outcomes.

- Are the decision-making process consistent with Te Tiriti o Waitangi principles?
- Will the changes lead to increased opportunities for Māori to provide mental health and addictions services, access those services and benefit from those services? [Time for Change – Te Hurihanga Review]

The Programme team recognised the structural, systemic and practical barriers that may contribute to Māori experiences of mental health and

addiction. One of the initial actions of the programme was to allocate 1 million dollars of the 7 million to support "by Māori for Māori Kaupapa Māori services across the Southern region."

The team recognised that Kaupapa Māori services offer a different way of working centred strongly in culture, and whānau relationships. And they recognised that a te ao Māori worldview needed to be embedded in the work.

The existing Iwi Governance Group had been disestablished when the national health system changes came into effect in 2021. With the establishment of Te Aka Whai Ora it was clear that there was an opportunity to move from Iwi Māori engagement to Iwi Māori leadership across the mental health and addiction system. Te Aka Whai Ora will lead the change to increase investment in hauora, tikanga informed funding of new services, and promotion of Māori innovation and partnerships for Māori in the Southern region.

The Te Hurihanga implementation programme built in structures to support Equity First thinking. Core to a commitment to Equity First thinking is acknowledging the responsibilities and commitments to Te Titiriti o Waitangi.[5]

From its inception the programme team made an explicit commitment to developing authentic partnership approaches. Practically this meant that the programme manager and the Pou Tataki/Equity Lead discussed and consulted with each other on all matters from the start.

An important piece of work led by the Pou Tataki in the Programme team was the development of the Health Equity for Māori investment framework. The framework is based on the importance of listening and documenting the voices of whānau, hapū, iwi to ensure that solutions that are implemented for tāngata whaiora and their whānau achieve greater improved outcomes.

[5] Notes: 'Partnership' is recognised as a relationship between the Crown and Māori, in which both parties act with respect towards one another, work together and are flexible about different structures where organisations are not meeting the needs of one another. Partnership requires the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the health and disability system for Māori. Whakamaua: Māori Health Action Plan 2020–2025 (Ministry of Health 2020c). Transforming our Mental Health Law A public discussion document 2021

The framework has 5 components:

- Strategic priority – Health equity for Māori. Make a firm commitment upfront to equity to ensure that those who experience the most disadvantage in the system and poorest health outcomes are prioritised.
- Health equity action – We must translate our commitment to action
- Health equity leadership – Commit to role modelling pro-equity action through the programme of work
- Partner with community organisations – Work alongside Māori and wider community organisations on a more grass roots level
- Eliminate institutional racism – Eliminate structures and systems that intentionally or not disadvantage a specific group.

The principles and practices included in the framework provide a call to action to the mental health and addiction sector. And the framework is applicable beyond the sector as a basis for framing project development, co-design and implementation of a range of health initiatives.

A Te Tiriti o Waitangi tool was also developed to support equity-first thinking. This Te Tiriti o Waitangi framework is seen as a living document, subject to change and refinement. It provides guidance in taking an Equity First lens for transformation of the mental health and addictions services and system. The framework was shared with key stakeholders in the first six months of 2023. The principles-based framework is included in Figure 6.

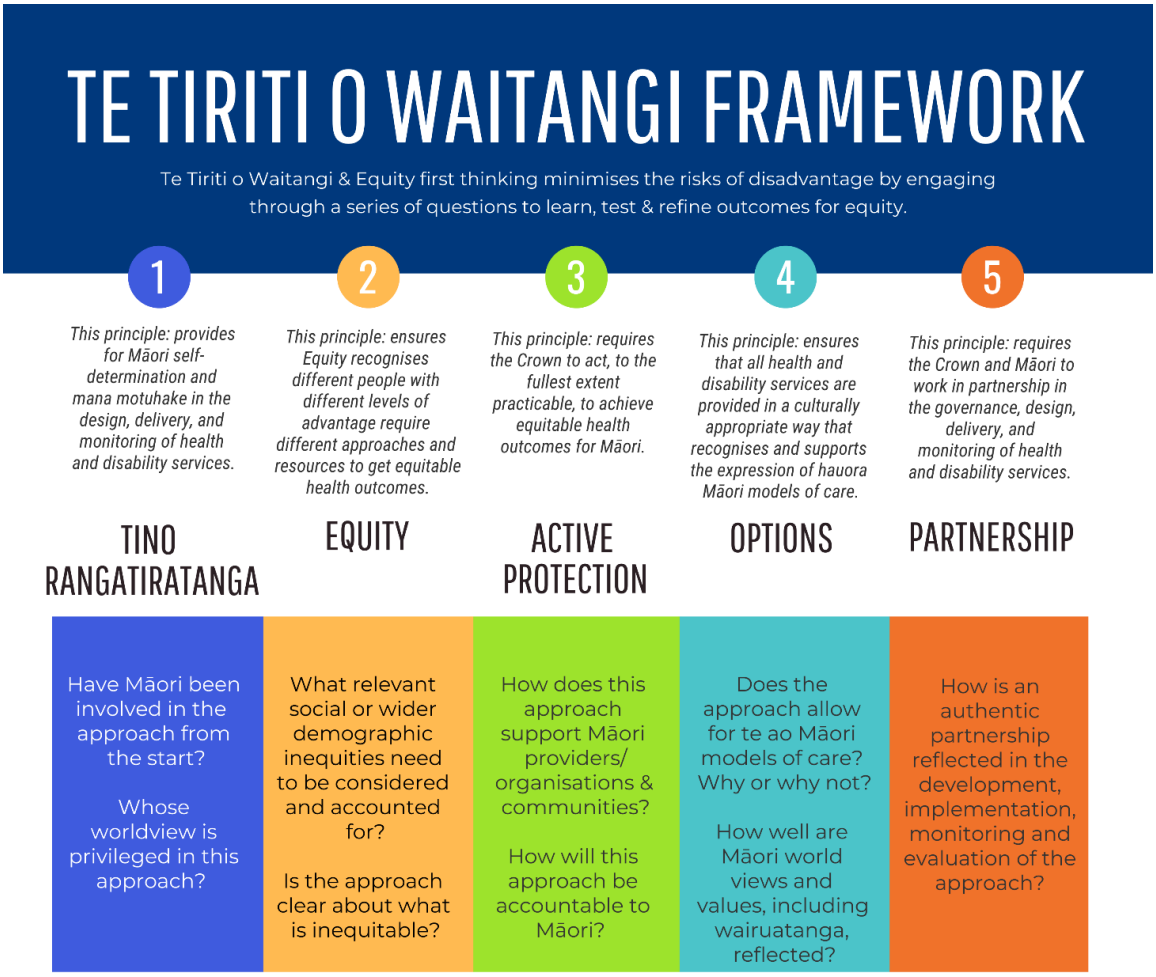


Figure 6: Te Tiriti O Waitangi framework

Co-Design

A second key principle underpinning the programme was co-design. One of the most notable strengths of the programme was that co-design was threaded through project planning, design and implementation.

The programme team adopted the Auckland Leadership Lab Co-design methodology to guide co-design. This approach incorporates the 4 intersecting phases of most co-design methodologies but embeds cultural values into the process.

The diagram below illustrates the interconnecting components of co-design.

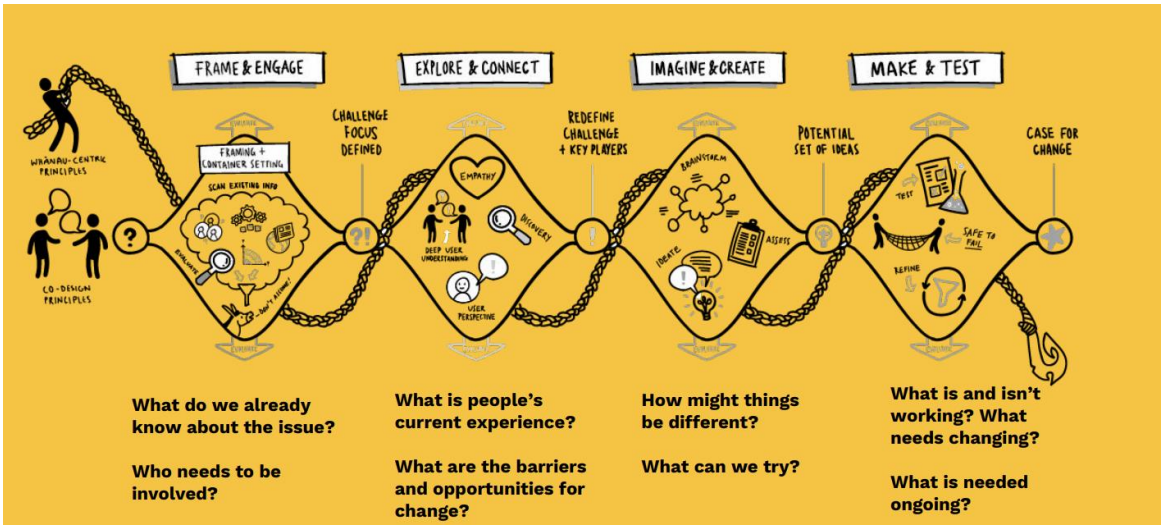


Figure 7: Source - Auckland Leadership Lab - Co design

Most projects within Time for Change – Te Hurihanga progressed through the co-design process to generate a model of care to inform commissioning. While not all co-design processes adopted by the Programme team followed this exact structure, the experiences and insights shared by diverse stakeholders within the groups were explored, documented and shared for review.

The workshops were designed and led to:

- Establish connections and relationships, and for people to feel comfortable to share their experiences,
- Gather feedback on the experience of people currently accessing the service, of lived experience workforce working within the current services,
- Understand the gaps in services and identify ways in which these could be improved, and
- Korero on what the Model of Care would look like
- People were informed of how the feedback would be used and where people can access the summary documents. There was invitation to reconnect for any follow up reflections and feedback.

Support for Implementation

While the Programme team were responsible for delivering on project commitments, implementation was practically supported through the guidance of three key groups:

- Time for Change Te Hurihanga Leadership Group,
- Time for Change Te Hurihanga Cross Sector Group, and
- The four Region specific Mental Health and Addictions Networks.

Each group had a distinct role, but groups often overlapped in membership. The programme team envisaged that the groups would share information and updates with their wider networks.

Time for Change Te Hurihanga Leadership Group

The Time for Change Te Hurihanga Leadership Group, referred to from this point as the Leadership Group was responsible **for providing leadership to support the delivery of the programme workplan. T**he group was initially established for a period of 12 to 18 months to track alongside the agreed implementation timeframe of the programme. A review was scheduled every 6 months to assess the need for continuation and to update the Terms of Reference (if required).

The Leadership Group provided oversight of implementation actions, maintained momentum throughout implementation, and assisted the team in addressing any implementation challenges.

There were ten members on the group. Membership included people in a lived experience role with expertise in co-design, Māori and whanau, non-government organisations (NGOs), the executive director of MHAIDs, and local leaders from wider mental health and addiction networks. The group was independently chaired by Dr Clive Bensemann, an Auckland based Psychiatrist who had been the previous chair of the independent steering group which had supported the Review.

The group met for one hour each month, or more often if required. While group members did not have the delegation in terms of investment decisions, they were able to raise awareness of emerging opportunities or challenges within the mental health and addiction sector and make recommendations.

The Executive Director and the programme manager provided regular updates to the Leadership Group to inform discussions and scheduled other presentations to provide feedback to the group as required. Programme progress reports were submitted to the Leadership Group.

Time for Change Te Hurihanga Cross Sector Group

A Cross Sector Group was established as a collaborative forum to share insights and information about opportunities, gaps and risks in mental health and addiction services across the region.

It was envisaged that the group would become **champions for the changes** being implemented through Time for Change Te Hurihanga, sharing information about implementation widely across their own networks, within their services or settings, and across the community.

Group meetings offered opportunities to discuss important issues with colleagues across the region. The group were able to stay up to date with implementation progress of Time for Change Te Hurihanga across the entire region and in specific districts. Group discussions also provided an opportunity for the Programme team to hear what was happening on the ground and get an understanding of the reactions of local stakeholders to co-design activities, contracting and other implementation actions.

While the Cross Sector Group had no delegation in terms of investment, their knowledge and expertise were seen as a key driver for prioritising recommendations. An example of their strategic work was the development and agreement of principles for investment at its workshop 25 February 2022.

The principles informing investment which were agreed by the group were:

- The changes will reduce inequity.
- Changes will enable greater numbers of people to be supported.
- The changes are consistent with Time for Change report and recommendations.
- Changes are no less effective (or may be more effective) than other service models.
- The changes will enable earlier intervention.

- Changes will not disadvantage those with severe and complex needs.

The group met every six weeks. The Cross Sector Group had a broad membership and 30-34 members, however the meeting numbers dropped over time. There were at times up to 7 people with a lived experience of mental health and addiction represented on the group.

Benefits of the Cross Sector Group

"The biggest benefit with that group is they just they kind of hold the sector together from the different perspectives primary, iwi, lived experience and having an external chair. The optics of it, in the fact that we keep meeting meant that people can pull too far away from their respective lobbying and advocacy. It was helpful in ensuring that if we heard from external stakeholders that they didn't know what was going on, we could point them back to their representative." [Te Whatu Ora representative]

Network groups

There are four Mental Health and Addictions (MH&A) Networks in the Southern region.

- Waitaki MH&A Network (Waitaki district).
- Central Lakes MH&A Network (Queenstown and Central Lakes and Central Otago districts combined).
- Ōtākou MH&A Network (Dunedin City).
- Future Directions MH&A Network (Southland, Invercargill City and Gore).

The purpose of the MH&A Networks is to provide a forum for networking, advocacy and identifying and pursuing opportunities at a local level. Members use their knowledge and expertise to provide collective advice and guidance around issues and opportunities for mental wellbeing.

The MH&A Networks share information with other colleagues and groups outside the Network. Network representation on the Cross Sector Group provides an avenue to escalate discussion of particular local priorities.

"The Networks in the Southern region continue to play an important role in identifying and helping to develop priority areas for change and improvement. The cooperation that has built around Time for Change Te Hurihanga has the potential to be a springboard for much healthier relationships and cooperation for mental health reform and ongoing services in the Southern region." [Survey response]

4. Evaluation Approach

An evaluation of implementation of Time for Change Te Hurihanga was commissioned in late January 2023. The focus of the evaluation was to work alongside the Programme team to:

- document the implementation programme,
- assess implementation effectiveness, including strengths and challenges of implementation, and
- identify learnings about system reform in mental health and addictions in the Southern Region.

An evaluation framework was developed to focus evaluation by the Programme Manager in late 2022. This framework was used as a guide for the implementation evaluation.

Purpose of the Evaluation

The purpose of the evaluation was to review implementation across the first 18 months of Time for Change Te Hurihanga. Specific tasks were to assess progress against implementation plans, identify strengths and weaknesses and synthesise learnings to inform improvements.

The focus of the evaluation was on the process of implementation rather than the outcomes of implementation. Given the implementation timeframe, it was premature to focus on improved service delivery or improved outcomes for those experiencing mental health or addiction challenges[6].

The implementation evaluation focuses on addressing four main questions:

- What was the programme of work? [Description of the programme, its rationale and delivery mechanisms]
- Did the programme do what it intended to do? How effective was programme implementation? [Comparative assessment of project

[6] It is acknowledged that there will need to be a plan put in place to monitor and assess outcomes as programmes of work or services are established.

plans, communications and documentation with implementation and philosophy underpinning the programme]

- What were the strengths and weaknesses of implementation? [Analysis and synthesis of stakeholder views about the implementation of Time for Change Te Hurihanga].
- What learnings can be drawn from implementation to inform improvements? [Synthesis of all information].

Key Audience and Stakeholders

The key audience for this report is the Leadership Group and the Group Director of Operations Te Waipounamu, Te Whatu Ora, Southern.

A wider group of stakeholders may also be interested in this report, including members of the Cross Sector Group and the four MH&A Networks. A summary report will be prepared for wider dissemination of key messages.

Evaluation Design

The design of the evaluation was collaborative and independent. It was collaborative in that the evaluator worked with the Programme team to gain an understanding of the programme and to document their experiences of implementation. As the evaluator was not involved during the whole implementation timeframe she relied on information – written or verbal – shared by the programme team.

A lot of activity has occurred over the past 12 months. The programme team had very comprehensive records of process and implementation of initiatives, and the evaluator used these as the basis of understanding the programme and describing implementation activities.

While the evaluation was collaborative, it was also independent in that the evaluator conducted interviews and analysed the survey and interview data. Findings and interpretations were 'tested' with the Programme team and with other stakeholders in progress presentations. The evaluator was not involved in the programme or implementation in any way, or involved with the sector, and had no influence over any aspect of the programme.

The initial timeframe for the implementation review was from late January to June 2023. This was extended to September 2023.

Scope of the evaluation

The purpose of Time for Change Te Hurihanga in the longer term is to transform the mental health and addiction system in the Southern region. The first year of implementation focused on co-designing, developing and contracting model of care for contracting, or frameworks that will contribute to improved outcomes for tangata whaiora.

Given the scope of the evaluation on implementation processes, this report makes no assessment of the extent to which the deliverables achieved their intended outcomes. Getting good data about service delivery and outcomes will be important to monitor progress and as a basis for making judgements about the difference services and/or initiatives are making to tangata whaiora and whānau across the region.

Data Collection Methods and Analysis

The design of the evaluation was a mixed methods design, including qualitative and quantitative methods.

Three data collection or retrieval approaches were used to inform key claims made in this report, The main methods were document review, three surveys, and semi-structured interviews.

- **Document review**: The evaluator reviewed secondary documentation about Time for Change Te Hurihanga, and materials developed and produced by the implementation team, including media releases, reports, and printed communications retrieved from the Time for Change Te Hurihanga page on Te Whatu Ora website.

- **Implementation Feedback Surveys**: Three surveys were designed to elicit feedback on implementation from different stakeholder groups – the Leadership Group, the Cross Sector Group, the wider network of Mental Health, Addictions, and Intellectual Disability Services Directorate (MHAIDS) and community stakeholders. Each survey included a core set of common questions and other differentiated items tailored to the stakeholder group. Surveys were received from 39 people across the three groups.

- **Interviews**: Semi-structured interviews of 45 minutes to 90 minutes in length were conducted with key stakeholders. This included interviews with the eight members of the programme implementation team, the Te Whatu Ora Relationship Manager, the

Executive Director MHAIDS, and John MacDonald as Chair of the Chairs of the four Mental Health and Addiction Networks. Eleven other interviews were also conducted with survey respondents who indicated interest in participating in an interview.

Analysis of evaluation data

Document analysis was performed using interpretive content analysis. The material was compiled, sorted and then coded according to implementation questions.

Thematic analysis was employed for analysis of the **interview data**. All interviews were digitally recorded, and transcripts prepared based on a combination of Otter AI (Artificial Intelligence) [an Artificial intelligence programme] and manual methods of transcription. A summary of each interview was prepared as soon as possible after the interview to capture key messages.

Interview data was entered into NVivo software [QSR International Party limited] to support management and analysis. Initially interviewee comments were coded according to interview questions and then with the overall evaluation question. Codes were then clustered into key categories (for example strengths of implementation, challenges of implementation). Following the coding and categorisation of all transcripts, key categories of meaning [e.g. perceptions of the programme] were then organised so all raw data pertaining to that category were clustered under the category heading. Notes taken during the interviews were also used to sharpen focus on key messages in each category.

Surveys were analysed using descriptive statistics. Ratings were compared between the two groups. An ANOVA was conducted to assess difference between groups on ratings of programme dimensions[7].

Given the small number of respondents and the intended use of the survey responses, no further analysis was undertaken.

Limitations of the Evaluation

The evaluation for Time for Change Te Hurihanga was commissioned in January 2023. The original plan for the evaluation was that the external

[7] While the total number of people who participated in the surveys was not large, there was a sufficient number of respondents to conduct a test of significance for group comparison.

evaluator would offer support for internal evaluation that would be undertaken by the programme team. With time pressures around implementation, the external evaluator agreed to take a fuller role in March 2023 under the same conditions as the prior contract, but with an extension of time.

There are a number of limitations in the evaluation process that need to be acknowledged. This report largely presents **a retrospective account of implementation** from the beginning of implementation to June 2023. As the evaluator began her work in late January, more than six months of activity had already begun. As the evaluator is not from the mental health and addiction sector, it took time to develop an understanding of the system, and of each of the projects within the wider programme of work. This is not necessarily a limitation in terms of the interpretations made in this report but is likely to affect the sophistication and depth of interpretations presented in this report. The evaluator acknowledges several limitations in the evaluation some of which relate to the structure of the evaluation task, and some which relate to methodological elements.

Equity First and Evaluation

The programme has a strong commitment to equity-first thinking and practice. An appreciation and understanding of the explicit and more nuanced aspects of te reo Māori and tikanga based approaches is key to a balanced representation of the programme.

This may have been compromised in this instance as the evaluator is Pakeha and had only recently returned to live in New Zealand at the time of the evaluation. She acknowledges that she has an inadequate understanding of te ao Māori and a very limited understanding of te reo.

While this is not a methodological limitation per se, it is a cultural weakness which may have methodological implications. Reflection by the programme team has identified that it would have valuable to designate Pou Tikanga to work alongside the evaluator to ensure that tikanga based approaches and te reo Māori explanations were clearly understood and presented within the context of the numerous social situations of tangata whaiora, whānau including kaimahi Māori and community.

Engagement of lived experience in the evaluation

The scope and scale of the evaluation meant that there was limited opportunity to engage in hearing the perspectives of people with lived experience.

The evaluator reviewed documentation from six individuals working within the programme in a lived experience role, a document which highlighted their reflections. The evaluator also interviewed the Project Manager lived experience on two occasions, and interviewed another individual who was in a lived experience role on the Cross Sector Group. Given the centrality of co-design across the programme of work, this is an acknowledged as a limitation in scope and in comprehensiveness of this evaluation.

Specific limitations in instrumentation

Survey Construction

The best way to get reliable survey data is to maintain an interested and energised respondent. Respondents who are asked to answer questions about things about which they know little quickly lose focus and motivation. Overburdening respondents with too many questions likewise lead to poor data.

Construction of the implementation feedback survey posed some challenges. It would have been preferable for all respondents to rate each of the implementation projects according to specified criteria. However, this would have added additional time to survey completion, and may have posed a risk in terms of participants' rating projects they had little knowledge of. This would have contributed misleading information.

Therefore, a decision was made to ask each respondent to choose the project with which they were most closely associated, and then respond to the survey respectively. This was seen as the best way to gain reliable data across all questions in the survey, with all ratings based on informed respondents.

Survey Identification

One of the survey questions asked participants to identify the perspective they were coming from responding to the survey, that is as provider, person with lived experience etc. In the description that went with this item it suggested that a person with lived experience included people with personal lived experience or whanau experience.

It became apparent after distribution by Te Whatu Ora, that the conflation of person with lived experience and whanau experience was not appropriate. Some earlier co-design work in peer led services had

identified that personal and family experience of mental health and addiction are quite different and may require different approaches.

Given the limited number of stakeholders the surveys were distributed to, this is unlikely to have an impact on interpretations from the evaluation surveys. However, this is noted here as it is an important consideration for further work.

Survey Responses

The surveys were distributed by Te Whatu Ora to the Cross Sector Group and to the 4 Mental Health and Addiction Networks in the Southern Region. The Programme team envisaged that the survey would be sent more widely out from these Networks to a broader group of stakeholders.

However, it became clear that the surveys had not reached all stakeholder groups as intended. The response rate on the initial distribution list for the Cross Sector Group was nearly 50%. The response rate on the broader stakeholder group is not known as it was distributed by Te Whau Ora through established distribution lists and was subsequently sent on further to other people in their personal networks. This was not necessarily consistent practice across all those who received the survey. There were 34 total respondents to the two surveys[8].

There are a wide and diverse group of stakeholders in the mental health and addiction sector. This report only represents an assessment of the views of those who responded to surveys or interviews.

[8] An additional survey of the leadership group was also undertaken. Only 5 responses were received. The evaluator used the open-ended comments but did not incorporate the analysis of ratings due to the small number of responses.

5. Change projects implemented within Time for Change Te Hurihanga

This section provides an overview of the projects that make up the change programme of Time for Change Te Hurihanga.

The Time for Change Te Hurihanga Review identified a number of recommendations that would be required to transform the mental health and addiction system. It was clear that implementation of all recommendations would not be possible in a year timeframe. Instead, priority themes were identified for phased implementation. Initially, the team focused on getting some solid foundations for change in place. For example, the ring fencing of funding for Māori and the investment framework, and the disestablishment of the Network Leadership Group [NLG].

Foundation and Domain Projects

The programme of work is divided into Foundation projects and Domain projects in this report. Foundation projects were pieces of work to set the stage and accelerate change, for example ring fencing of money for Māori services and the investment framework, and the creation of the Cross Sector Group. They were relatively early 'quick wins' identified from the Review that could be progressed without extensive consultation.

The domain projects are specific initiatives implemented to improve outcomes in specific areas or domains, such as child and youth, crisis support, and non-clinical day programmes and so on.

There were five projects that were classified as **Foundation projects**.

- Ring fencing of money for Māori services (1 million) and co-development of an investment framework
- Disestablishment of the Network Leadership Group and establishment the Cross Sector Group
- Signal closure of Ward 11

- Commission external support for an organisational development programme for MHAIDS to support cultural change and to grow leadership capability, and
- Increase clinical leadership positions [4] in specialist services.

The **Domain projects** were the specific focus of the evaluation.

There were six domain projects to be progressed over the implementation timeframe. Each domain project had a dedicated lead within the programme implementation team. The overall programme manager took responsibility for keeping projects on track and providing updates and reporting. The domain projects are:

- Crisis Support Service in Queenstown and Central Lakes, and Waitaki
- Peer support services
- Co-design in child and youth
- Co-design a contemporary model of care for non-clinical day programmes
- Expansion of Alcohol and Other Drugs – Dunedin
- Intensive Community Support and residential Access (to support closure of ward 11)

Foundation Projects

Foundation projects are briefly outlined below. The description presented here has been largely drawn from existing programme documentation, communications and reports.

Scope by Māori for Māori investment – Agree the investment and process in partnership.

The Review revealed an uneven, and inequitable mental health and addictions system for Māori. Māori are disadvantaged by services that do not provide culturally aligned support, and do not engage meaningfully with whanau as first navigators. [opinion].

$1m of the $7m of the budget has been ring fenced for Kaupapa Māori services. Te Aka Whai Ora (the Māori Health Authority) are leading a process of engagement with Iwi on priorities for this investment. A draft

Kaupapa Māori investment framework for Hauora Māori was developed, led by the Pou Takaki Programme team. The framework is entitled, Ngā Puna. Puna meaning a natural spring, water source. The framework references the centrality of Māori as the primary source of knowledge.

Signal the current network leadership group [NLG] will be disestablished and a new Cross Sector Group created.

The NLG was disestablished. A Cross Sector Group was established and meets six-weekly. The purpose of this group is to be an advisory and communication network and to help maintain inter-organisational connections.

Commission external support to deliver organisational development programme.

It was recognised that everyone in the sector in all roles need to be brought along for the change to be sustained. Leadership Lab has been engaged, and a programme is underway with the Directorate leadership team, Mental Health, Addictions, and Intellectual Disability directorate[9] (MHAIDS), to support cultural change and strengthen leadership.

Increase clinical leadership positions in specialist services.

Four clinical leadership positions in MHAIDS have been established and recruited to. The purpose of these positions is to build leadership capacity. They will lead quality improvement initiatives and have an important role in improving the tangata whaiora and whanau experience of mental health and addiction services.

Domain Projects

Co-design in child and youth

Four co-design processes were undertaken in Central Lakes, Dunedin, Southland[10] and Waitaki in the early parts of 2023. Consultations across co-design meetings convened by the Programme team identified a number

[9] MHAIDS provide specialist services and was previously known as the Southern DHB MHAIDS.
[10] Originally co-design was not planned for Southland as the region had prioritised peer led services. This gap in co-design in child and youth was raised by local service providers and opportunities for co-design were then provided.

of key changes that will improve outcomes for children and young people. They included:

- Improve access to support early.
- Reduce wait times for young people needing support.
- Strengthen availability of counselling and support across a wider group of schools and community agencies.
- Increase access to mental health assessment and to specialist services.
- Enhance support for young people outside metropolitan areas.

At the time of preparing this report decisions on investments were still to be made.

Establish a 5-bed mental health crisis respite care facility in Dunedin

The crisis respite facility opened in September 2022. The service provides accommodation, respite care and community support. Referrals come through Mental Health, Addiction and Intellectual Disability services [MHAIDs] or General Practitioners.

The service is run by PACT. The team of clinical staff and trained mental health support workers provide adults experiencing acute mental distress with 24-hour residential support. There is now the capacity to offer crisis respite beds for 1,825 nights per year, instead of 365 nights per year. Since the opening in September 2022 to the end of April 2023 62 tangata whaiora have used the respite facility.

Before this time PACT only had a one bed unit available in Dunedin for crisis respite care.

Increase crisis support options to support the Queenstown and Central Lakes and Waitaki regions.

Queenstown and Central Lakes:

The Queenstown and Central Lakes crisis support service opened in March 2023. The model of care was developed using co-design principles with the community and clinicians. The service provides support for adults experiencing a mental health crisis or urgent care need [Crisis Support

brochure]. While it predominantly provides crisis support for adults aged over 18 years and over, support is not limited to those over 18 years of age.

The service is provided by Central Lakes Family Services. It sits alongside the 24/7 regional crisis response service provided by Mental Health and Intellectual Disability service, Te Whatu Ora Southern. The crisis support service means there are more support options closer to home for people experiencing mental distress. A new respite facility to provide short term respite is planned but work on this has not begun as yet.

A draft monitoring and evaluation framework was developed to inform monitoring and performance improvement.

Waitaki:

A co-design process has been undertaken with local stakeholders and people with lived experience in 2022 and in early 2023 a model of care was developed.

The Request for Proposal (RFP) to provide the crisis support options that align with the model of care opened mid-August 2023. There has been a delay in decisions on next steps as Te Whatu Ora and Te Aka Whai Ora are formed.

Establish project to support the transition of clients to new services.

The Review recognised that people were living in the long stay inpatient service because of a lack of appropriate community services or other appropriate options. The planned closure of Ward 11 was signalled in 2021 and a project lead was engaged to commence the transition planning.

The project lead engaged with tāngata whaiora, whānau and staff throughout the transition period.

Comcare Trust was announced as the new provider in December 2022 and the service will provide flexible, intensive community housing and support services. Transition will take time: It is anticipated to take up to 18 months to complete. Comcare has completed its initial recruitment. This will bring their local staffing number to ten.

Three tāngata whaiora have transitioned from Ward 11 since April 2023 and are being supported by Comcare in the community. The Ward 11 team and Comcare Trust continue to work together and each tāngata whaiora has a

tailor-made combined support package with Comcare and Te Whatu Ora put in place before their move into the community.

Expansion of Alcohol and drug services in Dunedin.

Te Kaika commenced as the service provider for an innovative community-based alcohol and drug service in October 2022. The service provides specialist alcohol and other drug addiction services within a Te Ao Māori framework.

The contract funds an additional seven full time equivalent (FTE) staff, and includes wānanga, whānau ora approaches, therapeutic interventions and peer support delivered in culturally appropriate and aligned ways. It is available to all adults with moderate to severe and/or complex addiction issues, with a specific focus on connecting with Māori and whanau. The service is following a developmental and phased approach over time.

Expansion of drug and alcohol services for Southland

There was an identified need to expand community-based methamphetamine treatment and support services in Southland. A new kaupapa Māori alcohol and drug service was launched in Otago and Southland in May 2023. The service provider is

Nga Kete Matauranga Pounamu (NKMP). They are a mana whenua mandated Kaupapa Māori provider who has offered addiction services in the southern region for more than 20 years. The new capacity will enable the health system to be more responsive to community needs. A Te Ao Māori Framework underpins the service approach.

Growing, developing and supporting the consumer, peer support and lived experience (CPSLE) workforce.

Stakeholders gave a very strong message through the consultation process in the Review that they wanted to be able to access peer support. The workforce needs to be developed to enable this to happen, and a co-design process was established to develop a CPSLE Workforce Development Action Plan.

The project manager, lived experience, in the Time for Change programme produced a background paper and a Draft Action Plan, and circulated it throughout the sector. The Plan was discussed at 8 workshops held in Cromwell, Dunedin, Invercargill and Oamaru. At each location there was one workshop for people with lived experience, and one for the community

(including people with lived experience). Feedback was documented and the plan was finalised in October 2023.

One of the key actions of the Southern Consumer, Peer Support and Lived Experience (CPSLE) Workforce Development Action Plan 2023 - 2025 was the creation of a hub to support the CPSLE workforce.
An RFP process to identify a suitable provider was undertaken, and it is anticipated that the new provider will be announced before the end of 2023.

It is anticipated that the hub will be funded for 1 – 1.5 FTE (full-time equivalent staff) and will connect CPSLE workers and volunteers across both peer and mainstream organisations. It will also have a role in providing some training and supervision for the workforce, and co-ordinating information about other training and resources to improve practice.

Implement peer led service in at least one location

The need to develop more peer support services was identified in the national mental health inquiry, He Ara Oranga, and the Review (2021). The project team held 11 workshops across Southern to co-design what the new peer support service would look like. Eight of the eleven workshops also included co-design of the peer workforce plan.

Every workshop was co-facilitated by a person with lived experience, and there were several workshops for people with lived experience only. This ensured there was a safe space to hear the voices of people with lived experience of mental health and addiction issues.

The Pou Tataki Equity Lead for Time for Change -Te Hurihanga, together with a facilitator with lived experience, co-facilitated every workshop, to ensure a safe space for everyone to participate in the co-design.

Life Matters Suicide Prevention Trust has been contracted to provide a peer-support services in Dunedin. Mind and Body have been contracted to provide peer support services in Invercargill. The peer support services to be delivered are based on the values, principles, and objectives that align with the model of care developed from co-design.

The service will be open access, by self-referral or referral from other services. It will be available to individuals, groups and to any person experiencing mental distress and/or addiction issues. It will be put into

place in a phased way. The planned start date for peer support services is 1 November 2023 with the service to be fully operational by February 2024.

The new service will raise awareness and understanding in communities of the support they can receive through an education/outreach programme into the community. The service will focus on supporting adults. Peer support will be offered individually, in groups and to any person in mental distress or experiencing addiction.

Review of non-clinical day programmes

At the end of May 2023, a model of care for non-clinical day programmes in Southern was developed. It was based on what tangata whaiora, the community and providers in co-design identified as important. People will be supported to find and build on their strengths through a range of non-clinical activities.

Since May, 2023 the Pou Tataki - Project Manager and Equity Partner, Relationship Manager Planning & Funding – Mental Health & Addictions Southern District, and a Lived Experience Advisor, have begun visiting the Southern non clinical Day Programmes facilities to reconnect with tāngata whaiora (a person seeking health) who are using the services and the contracted providers to discuss how best to move towards the new model of care.

Contracted providers will move towards implementing the new model of care and a review of progress is expected to be completed by the end of 2023.

Logic Map of the Projects

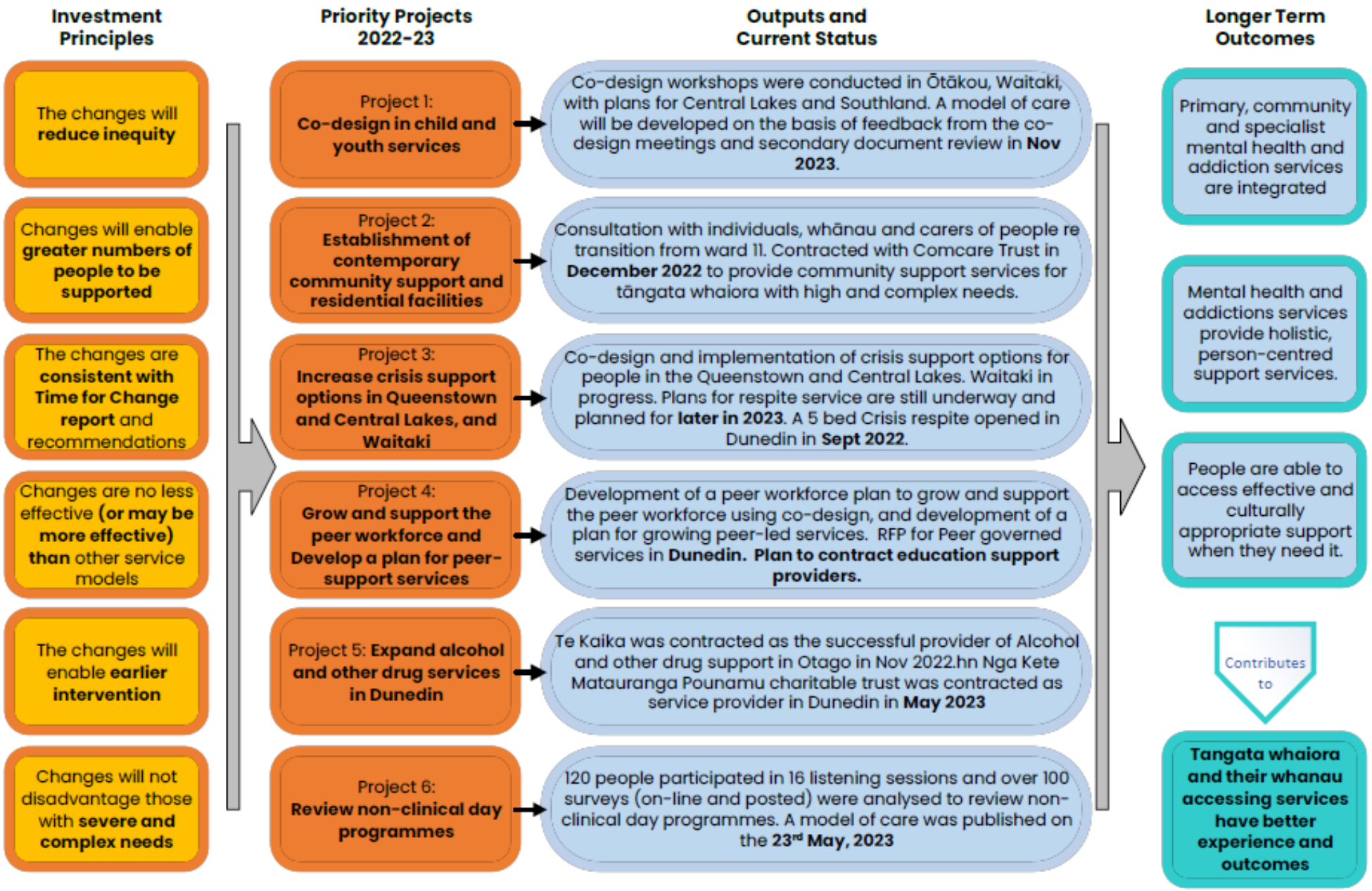
There are a range of significant projects that make up the Time for Change Te Hurihanga programme. They were identified in Time for Change as priorities for change. The programme team used these recommendations directly to inform their programme of work.

The mental health and addictions sector is diverse, and it is likely that while some will have knowledge of all of these pieces of work, others will only be familiar with those that they have been involved with, or with which they are most engaged.

The diagram on the next page summarises the six major domain projects and documents status - as at August 2023. This implementation

evaluation has focused on the domain projects, and learnings from implementation of the programme.

Figure 8: *Te Hurihanga Programme Summary September, 2023*



6. Implementation Evaluation Findings

This section presents findings from the implementation review. It is structured under three headings:

- Implementation effectiveness - criteria, findings, strengths
- Challenges in implementation
- Learnings and opportunities for improvements

The programme as a whole was intended to support a vision outlined in the Review quoted below.

> The Vision: "*A significant reframing of the mental health and addiction system that is person, whānau and community centred…embraces 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. And a system that supports people to work together as one system." [Time for Change – Te Hurihanga]*

A lot has been achieved in 18 months to progress changes in the system that in the longer term will support this vision. Mental health and addiction stakeholders from across the region have been engaged in shaping new ways of working that align with recommendations from the Review.

Criteria for assessment of effectiveness

The Programme team identified a set of criteria for implementation success that were explored within the surveys and in the interviews. These criteria reflect the underpinning principles orienting Time for Change Te Hurihanga, and related elements associated with good programme implementation.

They were:

- The timeliness of communication [by and through the Programme implementation team]
- Actions taken to progress projects
- Engagement of iwi Māori
- Participation of people with lived experience, and
- Opportunities for co-design.

Stakeholders were asked to rate each criterion for the project they had been most involved in from 1-5, with 1 being very poor to 5 being very good. High ratings across these criteria would be indicative that stakeholders judged implementation of the project as very effective.

Overall Assessments of implementation

The following claims are made from a synthesis of survey findings, interviews and document review.

> The **overall programme of work has been implemented strongly** in terms of alignment with recommendations, and coherence with wider reforms in the mental health and addictions system in New Zealand. The majority of respondents from the Cross Sector Group and the wider sector group rated **implementation of actions within the project as good or very good**[11].
>
> Stakeholders who participated in this evaluation were **supportive of the programme of work undertaken by the programme team**.
>
> The **timeliness of communication was rated highest by the Cross Sector Group** of all dimensions in the survey. This suggests that stakeholders felt they got information when they needed it. Timeliness of communication was the second highest rating by those in the broader group.
>
> The changes co-designed or implemented through Time for Change Te Hurihanga were **regularly profiled in programme**

[11] Given the diversity of projects respondents were asked to focus in on one project they had been most closely involved in.

updates and newsletters. These updates documented progress in each project area. Feedback about specific projects within the programme of work highlights a more nuanced appreciation of the effectiveness of implementation, including both strengths and challenges of the implementation process.

The **engagement of people with lived experience** in projects was viewed as a positive aspect of implementation. This was the most highly rated dimension by the broader stakeholder group in the survey and rated highly by many in the Cross Sector group. The dedicated role of the project manager lived experience was noted by some as key to successful implementation of projects.

The **opportunity for co-design was welcomed** as a principle that was embedded across all projects, **however there were limitations in implementing co-design in child and youth**.

Engagement with Iwi Māori was rated lowest across all dimensions. This is indicative of the limited Māori engagement across projects, and limited engagement within the mental health and wellbeing networks across Southern.

Survey Feedback on programme implementation

The broader stakeholder group appeared to have less knowledge of implementation projects and progress than the Cross Sector Group members. Three of the 17 respondents from the broader stakeholder group indicated they either did not know enough to rate implementation or felt they had not been engaged.

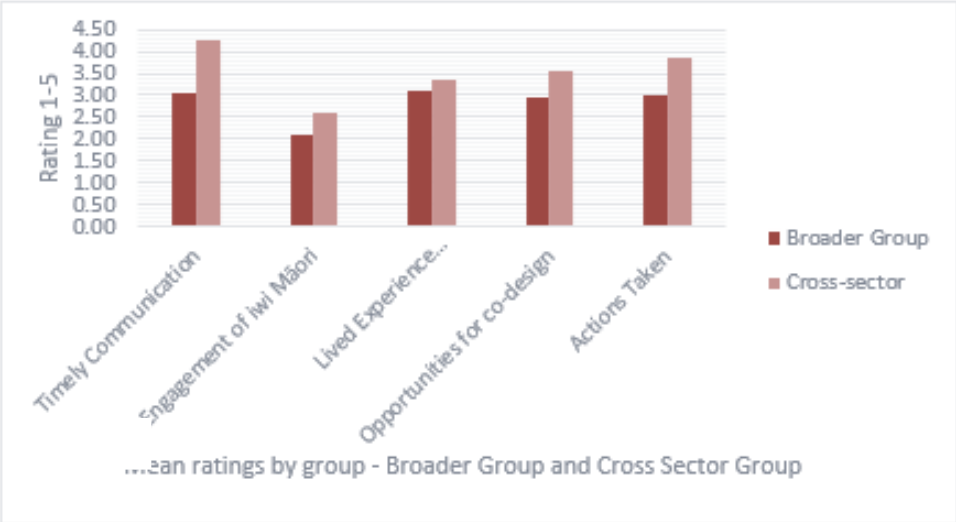
Several respondents from the broader survey group rated most of the criteria [dimensions of success] near the middle of the scale, indicating they did not have strong positive or negative opinions. For this group only two criteria reached a positive rating over 3 out of 5, they were positive about opportunities presented for lived experience participation in the programme and felt communication about the programme had been timely.

A number of respondents used the opportunities in the open text comments to praise the Programme team for their expertise and commitment in progressing implementation of changes that will improve outcomes for tangata whaiora.

Figure 9 indicates the relative ratings on 5 key criteria, negative to positive of two groups, 1) The Cross Sector group and 2) the Broader Stakeholder group. This figure shows that across all five criteria, the ratings of the Cross Sector group were higher than the broader stakeholder group. This indicates the Cross Sector group had a higher level of positivity for these aspects of the program.

While 'Timely Communication' was viewed very positively by both the Cross Sector group and the Broader Stakeholder group, both groups rated 'Engagement of iwi Māori' the lowest of the five criteria.

Figure 9: Ratings of programme criteria by group



In the remaining sections of this report, the strengths and challenges of implementation are presented.

Each of the success criteria are referenced, but discussion is not limited to these criteria. Reference is also made to factors within the wider implementation context that supported or inhibited implementation. Some of these factors were outside the influence or control of the Programme team but provide a context for the wider issues that affected implementation. They are important to document as they may also influence the capacity of projects to achieve intended outcomes.

Strengths of Implementation

"Much work has been done with Tamariki and Rangatahi services, clinical crisis support, and ensuring our most vulnerable people (homeless, chronic mental health and addictions) have support and do not fall between the cracks. Access to free counselling, per support and clinical assessment. [There are] better links to referral pathways between all services. These are just some needs to build on."

Resonance of Implementation actions with the sector

The Time for Change Te Hurihanga Review indicated that the sector was eager and committed to change. When the implementation programme began there was strong support for the design, development and implementation of actions to achieve better outcomes for those experiencing mental health or addiction.

Feedback from stakeholders about the Review were strongly positive. The recommendations resonated with stakeholders across the sector. Many of these same stakeholders had been part of consultations, interviews or made submissions to the Review. They could see the alignment between existing gaps that affected tangata whaiora with mental health and addictions and what was planned as a response to those gaps.

Not only were the recommendations welcomed, the way in which the change was framed in the Review reflected the values of key stakeholders. Several interviewees commented that the language used in the report reinforced values they held. For example, interviewees spoke about the importance of equity, integration, early intervention and prevention, person-centred support, and co-design. One stakeholder in the child and youth space commented:

"I got excited when I read it. I think they talked about … first of all health equity and talked about adopting a life course approach and designing services accordingly. It demonstrated interest in supporting

development of a sustainable workforce. And, lived experience, and they talked about fixing the gaps and a continuum of care…and they were using the words integrated, collaborative, codesign, and also talking about bringing together the social services, health and education."

There was strong alignment between the programme plans/actions and the Time for Change Te Hurihanga Review. The programme team took the recommendations and 'fix now 'priorities to shape plans for implementation within the first year. The Review provided legitimacy for the actions taken in the programme, and the sector welcomed these changes. The changes were seen as providing a strong foundation to progress transformational change across the region.

Leadership within Te Whatu Ora to champion change

The scope and scale of the suggested changes identified in the Review were extensive and transformative. Recommendations in the Review said that there were some actions that could be commenced immediately and others that would require more time.

A phased and staged approach was identified as the most efficient and effective way to progress priority recommendations, to bring stakeholders along with the change, and to reduce the potential for confusion.

The Executive Director of Mental Health, Addictions and Intellectual Disability Services, Te Whatu Ora, Southern was a keen champion for the programme of work. She was an experienced mental health leader, having been engaged in a range of leadership roles across New Zealand.

The Executive Director was highly regarded for her knowledge of the wider mental health and addictions system and her understanding of the Southern region. Her leadership and stewardship of Time for Change Te Hurihanga implementation was seen as extremely important to the programme of work. Given the structural changes and uncertainty associated with evolving changes to the health system, this leadership is

likely to have been critical in providing the necessary authority for change and accelerating implementation.[12]

One of the mental health and addictions stakeholders commented on the 'refreshing boldness' of the leadership of Time for Change Te Hurihanga. This individual felt that there was a real opportunity to tackle some of the existing challenges through new ways of working.

> "I remember some early meetings about Time for Change Te Hurihanga. We were talking about what real change meant, what that would look like, what an integrated pathway might look like, and the potential to shift some of the ways services are commissioned- to focus on what was needed, not just what we had always done."

The Executive Director left the position in June 2023. An interim Director MHAIDS was appointed but has been unable to take up the post to date. In the meantime, the newly appointed Group Director of Operations, Te Waipounamu, Te Whatu Ora has been providing oversight of the programme.

Dedicated Funding for Implementation

The agreed implementation plan was ambitious. Recommendations emphasised the importance of integration, of cultural appropriateness, of a person-centred approach, and of joined up collaborative approaches.

The allocation of funding for a dedicated Programme team and funding to support implementation did not naturally follow from the acceptance of findings from the Review. The Executive Director (MHAIDS) developed a business case to support targeted funding for implementation.

For some stakeholders the dedicated resourcing for implementation and a Programme team was evidence that the health system was serious about change. While some suggested they had been initially sceptical about 'yet another review,' the commitment of the Board of Southern DHB to

[12] Li, S.A, Jeffs, L., Barwick, M., & Stevens, B. (2018). Organizational contextual features that influence the implementation of evidence-based practices across healthcare settings: a systematic integrative review. Systematic reviews, BMC

implement recommendations was a tangible indicator that change was needed, and that it would be resourced.

The dedicated funding for a Programme team was highlighted as a critical positive in supporting implementation of a range of agreed actions. Without investment there would be an inability to progress decisions about investment and disinvestment. The Board of Southern DHB demonstrated that it was serious about their intent to deliver by establishing a team that could progress actions in a coordinated way.

A mental health and addiction service provider explained:

> "It was the first time I think in a long time that people recognised that actually to make something happen you've got to have people make it happen. People can't just do it in their day jobs because that is going to tax the sector over and over again. So, that was really good to have funding to support implementation."

The programme manager was appointed to the team first. Other members of the team were brought onboard that had the knowledge and skills to lead specific projects and advocate for particular perspectives.

Feedback gathered during this evaluation indicated that the knowledge and skills of the programme team were highly regarded. Most praised the systematic and structured approach to implementation and the skills of the programme manager in driving the programme. While the programme manager did not have a substantive background in mental health or addiction, she brought strong skills in programme management and programme coordination. An internal stakeholder within Te Whatu Ora shared this view.

> "Programme management was key to pulling implementation off, and the programme manager ensured the principles and ways of working that underpinned Time for Change -Te Hurihanga were integrated through the programme. It was clear that not all recommendations in the Review

could be enacted within a year, so a sub-group of key priorities were identified. The programme manager has made sure that key underpinning principles of Time for Change Te Hurihanga were woven into the architecture of the programme."

The insert box below presents additional feedback from other stakeholders about the effectiveness of the implementation team.

Time for Change – Te Hurihanga has a strong programme implementation team

"The programme team and leadership were very effective. There were clear goals and timelines implemented at the beginning, the team were task oriented and focused on moving forward to achieve the desired outcomes." [Cross Sector Group]

"Te Whatu Ora staff have been fantastic in this process." [Cross Sector Group]

"The programme implementation team didn't just go and talk to people, they listened to people and actioned what they were told." (Broader stakeholder group)

"The ability to take a project managed approach to developing the project has been a real strength (of implementation). (Broader stakeholder group)

Co-design as a core design feature

The term, co-design is defined in diverse ways, but a central premise is that designing effective support for people with mental health and addiction needs to engage and involve those people in defining and designing what that support looks like. Co-design is not consultation, nor is it is just an opportunity for information provision. It is active participation and engagement.

In the last quarter of 2022, the code of expectations for health entities' engagement with consumers and whānau was launched at Parliament. Section 2.1 of the code emphasised the importance of co-design across all

levels of the system, including design, development of priorities, implementation and evaluation.

The Oranga Hinengaro - System and Service Framework, 2023[13], reinforced the importance of co-design in improving the design and delivery of mental health and addiction services in Aotearoa.

> "Embracing the incorporation of lived experience leadership and peer support into design, planning and service delivery can guide the system's pathways to transformation. Tāngata whaiora must be at the forefront of the transformation of the mental health and addiction system and services, and peer support is a critical component of a transformed system and service landscape."

A co-design approach was adopted where possible throughout Time for Change Te Hurihanga, and was a central principle orienting the programme of work. This indicates that there is good alignment of the programme with recommendations and guidelines included in key health policy documents.

Co-design draws on the **expertise of communities** - those with lived experiences of services and carers, wider whānau, service providers and other stakeholders. Bringing these voices and experiences together helps identify the current challenges, develop creative strategies to address challenges, and identify opportunities for improvement.

The programme team were committed to shift the way service models and models of care were designed by building in a robust co-design process. Co-design workshops gave people an opportunity to have a voice and also to prioritise what was important to them.

The co-design process for peer support, Waitaki crisis support, and for non-clinical day programmes incorporated two or more workshops in each district. The sessions were co-facilitated by a person with lived experience and Pou Tātaki, Māori Equity Lead which ensured it was embedded in tikanga process, creating opportunities for connections

[13] Ministry of Health. 2023. Oranga Hinengaro System and Service Framework. Wellington: Ministry of Health

through whanaungatanga amongst participants and allowing space for whakaroaro (reflection).

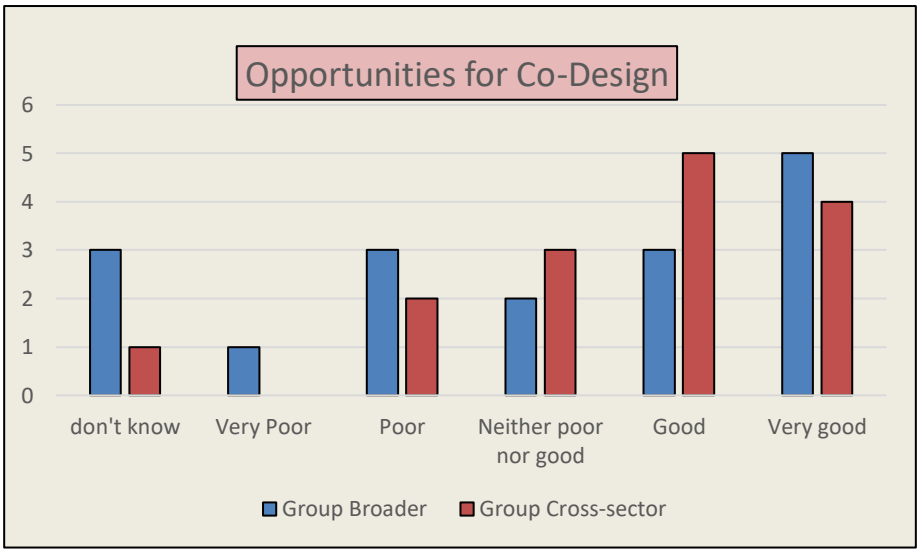
The combination of Pakeha and Māori and wahine-tane (male and female) facilitators with strengths in facilitation and co-design created the basis for an inclusive environment. Summary documents of meetings were prepared in plain language.

Feedback in interviews and from the surveys indicated that, for most projects, co-design meetings were well facilitated, and the processes of engagement acknowledged the value of lived experience. A person with lived experience who was contracted to support co-design expressed a need for consideration for debriefing for those that attend co-design meetings. Creating a supportive environment, providing access to appropriate resources and support, and establishing clear boundaries and protocols for sensitive discussions are essential.

In circumstances where it was judged important to expedite projects (such as, the establishment of the Crisis Support Service in the Queenstown and Central Lakes area and the implementation of contemporary intensive support facilities) key local stakeholders were consulted (as distinct from co-design methodology used for other projects), and existing gaps and plans identified.

Figure 10 shows the ratings on 'opportunities for co-design' for both the Cross Sector Group and the broader stakeholder group. Ratings indicated that both groups perceived that opportunities for co-design were good or very good within projects.

Figure 10: Mean ratings of Opportunities for co-design



The lower ratings are reflective of experiences of those involved in child and youth co-design. For these respondents the process had not been inclusive and from their perspective did not represent a genuine co-design process. The challenges in implementing co-design in child and youth are discussed later in this report.

Several respondents shared positive views about the explicit inclusion of co-design as a programme strategy in open-ended comments on programme surveys. One stakeholder praised the Programme team's work regarding the process of co-design as exemplary.

> "Excellent community consultation and the co-design process should be the blueprint for this type of work. Reports published continued to accurately reflect the voice of the community and accurately reflect their needs and aspirations for their people and for their community."

A number of open-ended comments provide further support for the value of the co-design approach adopted in Time for Change Te Hurihanga. A sample of open-ended responses to questions is presented below.

"**Co design with communities and utilisation of local knowledge** has been fantastic. Not everything is about what happens in metropolitan areas. Te Whatu Ora staff have been fantastic in this process. [Locality chair, survey]

"The co-design process means services have been designed by the community for the community meeting their needs and providing services that are needed and are closer to home…The project team didn't just go to talk to people **they listened to people and actioned what they were told**. [Survey]

"There was a **genuine commitment to co-design** by the programme implementation team and they tried to get the right people in the room."

"I am really impressed with the co-design element, to ensure we **best respond to community needs."**

"Co-designing to commissioning process has been great. [Cross Sector Group]

"The co-design process means services have been **designed by community for the community** to meet their needs and providing services that are needed closer to home. Seeing more services launching to meet the needs of Māori is very positive."

"Having **tangaga whaiora involved in designing day programmes** was great. They told us what they wanted, and this made is a true co-design process."

The Southern Peer Services Model of Care co-design process is summarised here. This is an excellent example of innovative, person-centred approach to codesign a new model of care.

Collaboration and Dialogue to lead change

The Programme team were focused on supporting implementation of projects, not prescribing how projects would or should be delivered. The decision to employ co-design and the team's commitment to regularly share progress updates across the sector reflected the importance of engaging the sector and tailoring change solutions to local needs.

Several stakeholders shared the view that the use of this inclusive approach had brought people together to discuss what was required and had maintained the momentum of change.

Members of the Cross Sector Group and the wider mental health and addiction stakeholder groups commended the Programme team's focus on opening up discussion through the MH&A Networks and sharing regular programme updates through the Te Whatu Ora website and through communication by email.

Communication and Voice

"Communication with the updates from the programme team have been good."

"Engagement with each other and the community (has been a strength)" (broader stakeholder group)

"I have felt there was a genuine opportunity to have voice." (broader stakeholder group)

"[One of the strengths has been] genuine planning for community, health and well-respected services to work hand in hand, resulting in a better working relationship, and understanding of needs and ultimately a better result for the person needing support." (broader stakeholder group)

Timeliness of Communication

Interviewees and respondents to the survey were asked to comment on the communication processes used by the Programme team.

Timely communication refers to stakeholders feeling they know about the programme and progress when they need to know about it. This is an important aspect of implementation.

There was a statistically significant difference in the reports of the broader stakeholder group and the Cross Sector Group on timeliness of communication[14]. On a five-point scale the mean rating of the Cross Sector Group ($M=4.27$), was significantly higher rating than the mean rating of the broader stakeholder group ($M=3.06$), $F(1, 30) = 5.64$, $p<.05$. Meetings of the Cross Sector group were scheduled every six weeks, while the broader group met less frequently. The frequency of Cross sector group meetings and regular access to direct programme updates from the programme team may explain the higher rating on timeliness of communication.

The communication mechanisms used by the programme team are seen as a strength of the programme. The programme updates available to the sector on the Time for Change Te Hurihanga website and in general communications were helpful to stakeholders in understanding the progress of projects.

[14] There was a sufficient number of respondents in both the Cross sector and broader sector group to calculate a test of significance of ratings between the groups.

Lived Experience Engagement

The Time for Change Te Hurihanga Review recommended that people with lived experience [15] be engaged as 'active agents and equal partners in the change process." [Recommendation 34]. The value of lived experience engagement in the design, planning, implementation and evaluation of projects is not in question. The focus here is the authenticity of lived experience engagement across the programme.

The evaluation found that a strength of Time for Change Te Hurihanga implementation was the inclusion of lived experience across the programme of work. The importance of leadership in lived experience in the programme was evident in the appointment of a dedicated project manager position [.6 EFT] to support lived experience co-design and lead peer led services. The project manager lived experience has been pivotal in sustaining the lived experience lens across the entire programme of work.

The individuals who were contracted to support lived experience in a lived experience role felt genuine efforts had been made to 'walk the talk' of lived experience and co-design in service improvement.16 Two people with lived experience were appointed to the Leadership Group, and four others became members of the Cross Sector Group.

The value of Lived Experience Engagement

"Gathering lived experience and whanau voice has been a real strength" [Cross Sector Group]

"Co-design with communities and utilization of local knowledge (has been a strength). Not everything is about what happens in the major cities." [Cross Sector Group]

[15] Having 'lived experience' refers to people who have previous or current experience of mental distress or of mental health conditions and/or substance-related or gambling harm. Lived experience refers to the knowledge, insight and expertise gained through direct experience.

"These individuals (people with lived experience) have shared insights into the challenges and barriers they face when seeking mental health and addiction support, but also the opportunities to better support them."

The project manager lived experience has managed specific pieces of work such as the codesign of a Southern Peer Support Services model of care, and its implementation in Dunedin and Invercargill, codesign and implementation of the peer support hub, and development of the CPSLE workforce Plan.

Figure 11 shows the ratings of lived experience participation in projects undertaken within Te Hurihanga Time for Change by members of both the Cross Sector group and the broader sector group There was positive support for engagement of people with lived experience in the projects. However, there was variability in ratings of the level of lived experience participation in projects.

While most respondents to the survey rated lived experience participation as good or very good, there were a few respondents who either didn't know enough to assess this dimension or felt the level of lived experience participation was poor. In some projects, notably child and youth co-design, there was limited lived experience participation, and this may account for the lower ratings. A summary of the number of respondents rating this dimension is included in Figure 11.

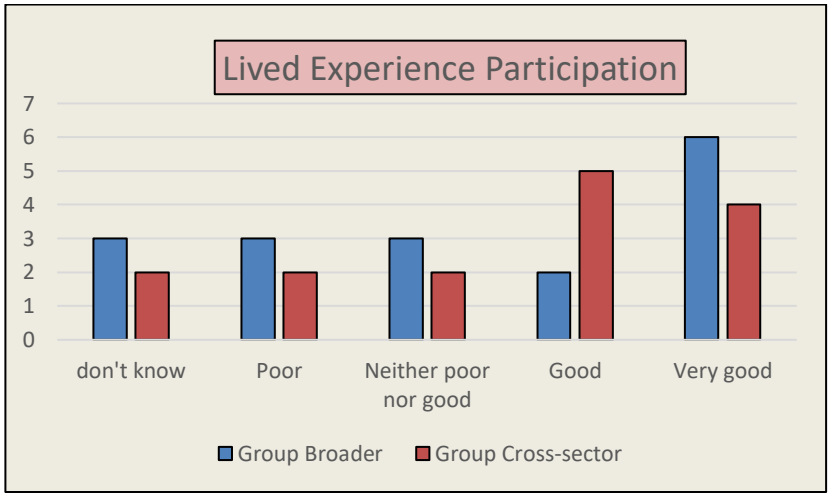


Figure 11: Ratings of Lived Experience participation in the programme

Those appointed to the programme in a lived experience role spoke about the personal and professional benefits of engagement17. Across all reports of lived experience participation in the programme it is clear those in lived experience roles valued the supportive programme infrastructure that allowed open sharing, discussion and problem solving, which facilitated their roles.

"Having the opportunity to offer feedback and inform service design from a user perspective and to be able to contribute on how to make services more accessible and effective felt very empowering to carry this out on behalf of our lived experience community. To know that these experiences along with those of my peers were informing the various work projects within Time for Change felt transformational in terms of involvement and the potential for new culturally responsive and trauma informed services to take shape. It was a space where I was able to represent the voice of many of my peers who I engage with on a day-to-day basis in several other lived experience roles and I felt the responsibility in ensuring their experiences and ideas were put forward and acted upon."

"The experience of being involved in Te Hurihanga Time for Change has further affirmed to me that here is a growing recognition of the valuable contribution of lived experience expertise as agents of change within the mental health and addiction system and services. My experience as a co-designer, researcher and facilitator in Te Hurihanga Time for Change has been incredibly positive and whilst challenges were identified along the way, these were worked through with stakeholders in a collaborative and transparent process where our ideas and concerns were respected, explored and solutions sought. Our ability to make autonomous informed decisions was encouraged and the Time for Change programme leaders were supportive and enthusiastic of our participation whilst focusing on

outcomes that would be transformational for those using the services within Southern."

One person contrasted their experience with the programme with other projects they had been involved in. For this individual of the experience in Time for Change – Te Hurihanga had been very positive. In other experiences, the role of the person with lived experience was always limited to advice, rather than involvement and engagement in decision making.

While the engagement of people with lived experience as a principle of the programme was seen as a strength of the programme, the practical aspects of engagement across projects was not without challenges. One of the major challenges is that currently there is a very small lived experience workforce in the Southern region, and the region lacks a district-wide network of people with lived experience. This meant that there was limited diversity in co-design groups and a reliance on a small number of people. In some instances, co-design workshops did not always achieve the desired representation across a range of roles.

Those individuals working in a lived experience role in the programme also reported some challenges in fulfilling their role in group meetings. For example, one person noted that conversations with the Cross Sector Group tended to privilege service providers and the 'clinician voice.' More work may need to be done to build capacity and capability across all parts of the mental health and addiction sector to better engage with those with lived experience.

7. Challenges in Implementation

Stakeholders who work with people experiencing mental health challenges were enthusiastic about the potential of the Programme. As noted earlier, the principles and recommendations of the Review were welcomed.

The philosophy and language aligned with national priorities and reflective of the extensive consultations that had occurred to produce the document.

Findings from the survey and from interviews indicated that stakeholders reported that the programme of work had been implemented well. However, in a complex health environment with multiple stakeholders, there will also be challenges that influence the effectiveness of implementation.

The challenges to implementation highlighted in this section reflect perspectives shared by stakeholders through the programme survey or in interviews. They also reflect feedback from interviews with members of the programme team. Some of these challenges are outside the control of the programme team. However, they are potentially critical in progressing the vision of Te Hurihanga Time and Change and are presented as points of reflection to inform planning going forward.

The implementation challenges outlined here include:

- A lack of genuine of co-design in child and youth
- Limited engagement of Iwi Māori
- Perceived rigidity of contracting processes
- Variable skills of local groups in collaborative ways of working, and
- Perceived limited influence of the Cross Sector Group

A lack of genuine co-design in child and youth

Support for children and young people with mental health and addictions challenges was a priority identified in the Review. The Review called for a holistic and person-centred approach and an integrated, seamless pathway for those needing support.

Co-design was seen as a valuable mechanism for developing priorities and models of care that were locally relevant, and locally led. While

adopting co-design as an approach to implementation was praised, there was one implementation area where co-design was seen to be inadequate.

The biggest area of concern expressed by those who work within child and youth mental health and addictions services was a perceived lack of genuine co-design.

A synthesis of comments about co-design in child and youth reveals a view that the process was not seen as genuine because of:

- Narrow representation at the co-design meetings. Te Whatu Ora was seen to 'have an agenda' privileging funded services, and limiting participation of groups who work in the prevention and early intervention space with young people.
- Gaps in the comprehensiveness of co-design in child and youth across the region.

Stakeholders who felt excluded from the co-design process, or who felt that the process was not sufficiently comprehensive expressed a lot of dissatisfaction, and frustration about these issues. They were concerned that the recommendations in the Review were being paid lip service through a process engineered to maintain the status quo.

Narrow Representation in Co-design

The child and youth space poses a range of challenges because it requires diverse stakeholders to collaborate to support the young person and their whanau. There needs to be supported opportunities for young people and their families to participate in sharing what is needed and what will best support them.

The Review identified a need to be inclusive of services, community organisations, and other groups that work with children and young people and find ways for these groups to work together with tangata whaiora and their whanau.

Interviewees shared their concern about the continued gaps in support for children and young people, for prevention and early intervention, and for access to services, particularly in rural areas. They identified persistent challenges in workforce capacity and were aware that workforce issues were not going to change quickly. These stakeholders were keen to participate in co-design to identify new ways of working and collaborating.

"By the time our young people get seen by these services, they can be very unwell. We have young people at 13 or 14 years old who cannot access a services and issues become entrenched affecting their ability to engage in school and socially. If we reached them earlier, we could support them better and keep education pathways on track as well. The societal impact of this is massive and contributes to other health issues down the track."

There was a perception by some stakeholders who had been involved in the co-design in child and youth that Te Whatu Ora did not consider the voices of those across the system in the process of co-design.

Stakeholders raised concerns about the representation in co-design groups which raised concerns for them about transparency of the process. They were disappointed that the process of co-design did not appear to be inclusive of the range of people and groups who work with children and youth.

The co-design workshops offered limited opportunities for some groups who worked closely with children and young people and their families (such as NGOs and schools) to actively participate. As an example of their dissatisfaction, some stakeholders noted that while the initial workshop in Dunedin was open to an inclusive group of individuals and groups working with children and youth, the second workshop was limited to services currently funded by Te Whatu Ora.

Some stakeholders felt that limiting engagement to specific groups resulted in narrowing solutions to those which fit well within an existing Te Whatu Ora contracting system. Where for example was there representation from schools and community organisations that work with children and youth? While clinical services may be required for some young people and at particular times in their lives, there is a lot that can be done to provide 'wrap around' tailored support for children and young people through joined-up and integrated ways of working.

There was a view shared by these same stakeholders that some of the meetings tended to be dominated by 'clinical speak' which narrowed the conversation and inhibited the potential to come up with strategies to better address the diverse needs of young people. This was further

evidence to these stakeholders that options were being limited to those that fit within the existing medical model.

Limited diversity of voices in co-design

"Some voices seemed to have more impact than others. There was a perception that services were shoulder tapped and a lack of transparency and trust. I would like to know and be clear about what decision-making matrix is Te Whatu Ora using?"

"There has been no consultation with people at the coalface- re guidance counsellors and little transparency about key partnerships, referral processes and gaps in services. Rangatahi in rural areas also face additional barriers, which seem to be overlooked." (broader stakeholder group)

"I suppose I was kind of asking maybe, in the mental health space, who else needed to be in the room? And those hui in those early initial stages. We still had people very much in the mental health box that were in there with mental health hats on."

"Young people need to be part of the conversation. Where are the young people?"

Limited Comprehensiveness of co-design

Some stakeholders felt co-design for child and youth was left 'a little too late in the piece' in terms of the programme implementation timeline, which resulted in it feeling like a rushed process.

One stakeholder from the Southland district indicated a view that co-design in the district had been initiated as an 'afterthought.' While this individual was aware that the district had prioritised Peer Led services, the lack of co-design in child and youth in this area that was offered in the other districts was not appropriate. This reinforced a view that co-design process was not about thinking strategically about integration and holistic ways of working. In their view the region would not have been left out of initial co-design plans if the intent was to reform and transform the system. They explained,

"Te Whatu Ora wouldn't have come to that conclusion that co-design [in child and youth] was not necessary across every region if they were coming with a whole of area whole system approach. They wouldn't have left Southland out if they were really taking a strategic approach to children and youth. I have always been an advocate for local variance and nuance, but we have to have something that is integrated across the district otherwise we will replicate the faults we have always had."

For the Programme team, it was not up to Te Whatu Ora to prescribe co-design processes in a particular domain if the localities did not prioritise it. However, the dissatisfaction with co-design expressed by this stakeholder points to the importance of clear communication between and across groups and networks in local areas.

One of the mental health and addiction stakeholders indicated that some of the challenges in co-design in child and youth was that the strategic purpose was not clear. This person suggested that a focus was on meeting processes [what would happen in the co-design meetings] rather than stepping back to consider ways of engaging with multiple groups. They stated:

"If it was a more comprehensive co design process then they would have asked, 'How do we engage education? How do we engage Oranga Tamariki? How do we engage schools? How do we engage Māori?' And the engagement might be different…The brief for the codesign process seemed to be more about 'how do we organise ourselves in the meetings?' As opposed to 'how do we look at the Child and Youth system and what do we need to do this work?'

The dissatisfaction with the inclusiveness and comprehensiveness of co-design in child and youth has been identified as a key implementation challenge.

Limited Engagement with Māori

The criteria used to assess project implementation were helpful in developing an understanding of what worked well and what didn't work so well across the programme. The engagement of iwi Māori in projects was rated lowest by both the Cross Sector Group and the broader stakeholder group as highlighted in Figure 12.

While the Figure below shows ratings across criteria of project effectiveness the focus of this sub-section is on the engagement with iwi Māori.

Figure 12: Mean Ratings by stakeholder group

Rank	Cross Sector group - Mean		Broader stakeholder group -Mean	
1	Timely Communication	4.27	Lived Experience Participation	3.12
2	Actions Taken	3.87	Timely Communication	3.06
3	Opportunities for co-design	3.53	Actions Taken	3.00
4	Lived Experience Participation	3.33	Opportunities for co-design	2.94
5[18]	Clarity of Decision Making	2.87	Responsiveness to Community needs	2.71
6	Engagement of Māori	2.60	Engagement of Māori	2.12

The limited engagement or Māori across projects within the programme is associated with two issues.

Firstly, the disestablishment of the iwi governance committee aligned to Southern DHB and the transition to the newly established Te Whatu Ora

[18] Note: '*Clarity of decision making*' was identified as a useful criterion for those involved in projects in the Cross Sector Group. However, in the broader group survey it was agreed that the respondents would be better able to assess a project's 'responsiveness to community need' as they were less engaged in the direct work of the implementation team. All other criteria remained the same in the two surveys.

and Te Aka Whai Ora created significant issues in terms of formal Māori support and mandate to communicate and engage with tribal governance organisations across the Southern region.

A number of vital existing relationships were no longer structurally in place to draw on through the programme. Existing iwi representation had also become unclear as iwi roles changed, and accountabilities shifted.

Secondly, the Māori workforce is relatively lean in the region. In Central Otago there are 12 active members that are working across a number of areas such as justice, health, environment and conservation. This may influence their capacity to actively engage in all aspects of the programme.

The Pou Tātaki provided a te ao Māori opportunity to contribute to the co-design process in terms of presenting relevant Māori, whānau and/or marae-based situations and scenarios to promote an authentic Māori voice and contribution to the co-design process.

Perceived rigidity of Contracting Processes

The New Zealand health system has a long tradition of competitive tendering. While there are benefits for services and for accountability, competitive tendering does not necessarily result in the best balance of services. The Review highlighted the importance of collaboration and integration if improvements to the system were to be realised.

Following the co-design process, and the finalisation of the model of care, the programme team was able to support the development of an RFP process for the service.

Contracting processes are outside the control of the Programme team. However, for some stakeholders the current contracting system within te Whatu Ora was seen as limited in progressing the vision of Time for Change Te Hurihanga.

One of the challenges for some stakeholders in progressing change was that while the sector can nominate ways to work more collaboratively, contracting processes do not often support partnership ways of working. Competitive tendering processes create a situation where service providers are required to compete against others, rather than work collaboratively.

One stakeholder spoke of the Executive Director's vision that contracting within Te Whatu Ora could structurally encourage collaborative service delivery models and collaborative tendering. However, over the course of the implementation timeframe – to July 2023 contracting requirements remained narrow and did not encourage collaboration. The quotes below elaborate this point and offers a call to action.

A call for Collaborative Commissioning

"Where is the opportunity for collaborative bidding processes that reflect the importance of continuity, integration and a life course approach? We know that is what is required. But this means shared communication, shared funding and our health system isn't set up for that. It will require some work about how it will work, but it is work that is worth doing."

"[We need to] devolve the mahi to the community and what they know works well rather than still holding the power and contracts for services tightly within a clinical language speaks and clinical services bio medical model…This requires collaboration across government sectors and across government approach to funding and models of integrated care."

"We haven't really been creative enough. What a shame that we couldn't offer something up that will build on what was working well in the area, rather than setting up a competitive model of funding."

Variable skills in collaborative ways of working of local groups

Te Whatu Ora was committed to implement a programme of actions to improve the mental health and addiction support system. The Programme team wanted local regions to lead the changes required to ensure they addressed local opportunities and needs.

However, local leadership may be compromised if local groups do not have skills in leading change, or in the process skills to work in collaboration. A view was expressed that perhaps the Programme team made the assumption that groups in local areas would have the skills to work collaboratively on change. In this view this was not always the case.

One stakeholder commented,

> "Perhaps there was a tendency [by the programme team] to overestimate the capacity of existing groups or locality groups to manage the process. It takes particular skills including facilitation skills and group management which some groups may not have had. There is a tendency to think that if people are in a room they will collaborate. There may need to be a lot of preparation work for people to share their values, commitments, agendas in an open forum, but this work needs to be done to ensure it truly is co-design. We cannot assume co-design will happen."

Across the networks and groups within the Southern region there may be variable skills in facilitation, in meeting processes and in capability to manage and resolve conflict and tension.

A number of interviewees commented on the impact of local politics and existing conflicts within some of the groups that inhibited collaborative ways of working and trust. To set the groundwork for change groups group needs to be able to work together as expressed in the following quotation. While support to map skills in group process and collaboration was outside the scope of the programme team, this concern may have implications for of the future work of locality groups.

> "I just think that there has to be a whole lot of work that goes on around joint values, building trust, managing conflict and difference. Collaborations don't just develop out of being in a room together. You have to do the hard work to set the scene for effective ways of working together."

The influence of the Cross Sector Group

The mental health and addictions Cross Sector Group was established to provide opportunities for consultation and engagement on implementation priorities, and to provide guidance to the Programme team about emerging gaps and opportunities. It was a convening group, a

group that was able to keep an ear to the ground and advocate for strategies that support the accessibility and integration of services.

The initial representation of the Cross Sector Group included a range of representatives from NGOs, specialist service providers, leaders within MHAIDS, consumers and those involved in localities networks. Most [12/15] of the survey respondents from the Cross Sector Group indicated that they felt their views were valued to some extent or always in group meetings. Three people felt that the views they shared were not valued.

There were four people with lived experience on the Cross Sector Group, but the imbalance in specific knowledge about clinical aspects or services, and a perceived power imbalance meant that sometimes they did not feel they had a voice.

Respondents to the survey valued the network and believe it has contributed to dialogue across groups about what is needed to improve support for people experiencing mental health challenges.

However, there was a view that initially the group appeared to have an unclear purpose and that this had created some confusion. As one stakeholder said, 'the group lost its way." The loss of focus was associated with irregular attendance of some members, a lack of shared purpose for meetings, and local level politics or competition among the membership. The instability of the group's membership and attendance also influenced its capacity and potential to meaningfully shape the programme of work.

These issues resulted in meetings primarily being used for reporting back processes by the implementation team, rather than for engaged discussion of current status and next steps.

There are several possible explanations for the limited influence of the Cross Sector Group. The following reasons were shared by interviewees – within the Programme team, and wider stakeholders interviewed as part of the evaluation.

Meeting interface

Most people got used to using online interfaces for meetings and workshops following the Covid-19 pandemic. Online meetings are particularly convenient for those located in different parts of the region.

While the use of the online interface was a practical means of bringing members together across geographical distance, some people felt that

the online meetings did not allow the group to develop cohesive or trusting relationships.

Given the group size, there was limited opportunities for interaction, and insufficient time for some to share their perspectives or their insights in the group.

Professionally Competitive Relationships

As the group represented a variety of individuals and groups across the sector, it is not surprising that some of the members worked within or for agencies that may be interested in responding to RFPs (requests for proposals) for planned services.

While there was strong commitment to the vision outlined in the Review, some stakeholders reported they were sometimes cautious about what they shared in the group. They were aware that they may be involved in a competitive bidding relationship with others.

Confusion and duplication of effort

The mental health and addiction sector is diverse and covers a wide geographical region. Networks provide an opportunity to bring the sector together to share information and to support collaborative planning. From an implementation support perspective, the networks allowed the team to draw on expertise of people representing multiple parts of the sector. In system-wide change projects this may be required to address complex challenges. The commitment of members was evident by their representation in multiple networks and groups established to improve the accessibility, quality and sustainability of support for people experiencing mental health and addiction.

While the terms of reference provided an overview of role and purpose of each group a small number of stakeholders found the different groups overlapping in membership, and discussion contributed to confusion about the purpose and role of the groups.

Membership of several networks may mean that conversations and information shared are duplicated. This may not be a problem if the intended value of the information is clear but is likely to be frustrating for members of the group who hear repeat messages multiple times, particularly if there is no decision or follow up action.

Looking ahead

“I just think another 12 months will help things to bed down more. There’re no guarantees, but it will help to continue those momentum that we've got. And if neither of those things come off, then I think we're just going to have a collection of organizations that will do their best, but they will do their own thing. And I don't know how well the collaboration will work.”

8. Lessons Learned

"I am very keen to see the work that's begun across Te Hurihanga with Tamariki and Rangatahi to move to completion. Trust and good relationships have been built between the community sector and Te Whatu Ora around this project. The momentum around this should not be under-estimated or destabilised."

Lessons Learned

Communicating the vision is important.

What did Te Hurihanga do well?

- Strong alignment of the priority actions with the recommendations from Time for Change
- Purposeful and deliberate efforts to align implementation with recommendations from the Review.
- Resonance of the recommendations with the sector and a commitment to transformation
- Leadership within Te Whatu Ora championing change alongside local advocates. A strong MH and Addictions voice at the Executive level.

What could Te Hurihanga have done better?

- Cross Sector Group lack of direction and purpose
- Limited influence of the Cross Sector Group
- Variability in group skills in collaborative ways of working

Ensure the programme plan as well as milestones and achievements are accessible to stakeholders and interested persons, regularly.

What did Te Hurihanga do well?

- Effective implementation across most aspects of the programme.
- The programme team was highly regarded for their skills in implementing projects within the broader programme of work.
- Strong Programme team with a commitment to doing what was agreed to do
- Communications Strategy and Plan developed and implemented. Important that dedicated communications expertise was resourced.

What could Te Hurihanga have done better?

- Increased, dedicated, project and subject matter expert resources for co-design in child and youth, and an earlier start in the programme. A deliberate "Southern" approach at the start of the work.
- Consideration of how to increase information flow into the different communities and groups.

Equity first - establish the partnerships and engagement with Māori, so that processes, people and outcomes enhance the mana of Māori and contribute to addressing inequity.

What did Te Hurihanga do well?

- Strong collaboration between the programme manager and the Pou Tataki/Equity lead on all aspects of the programme. Partnership at the very start of the programme and continued throughout.
- Development of the Health Equity for Māori investment framework and Te Titiriti o Waitangi tool to support equity thinking and planning.
- Effective engagement with and support for new providers on te ao Māori approach.

What could Te Hurihanga have done better?

- The usual protocols of engagement with iwi Māori were suspended whilst the DHB structures were replaced with Te Aka Whai Ora. This meant delays, outside of Te Hurihanga control, in re-establishing the correct pathways for engagement with iwi Māori.

Value the voice of lived experience through the whole of the programme

What did Te Hurihanga do well?

- Commitment to co-design as a design feature that included the voice of lived experience throughout the design process.
- Early appointment of an experienced senior project manager with lived experience to the programme team.

What could Te Hurihanga have done better?

- With the exception of the peer support codesign work (which was led by the project manager with lived experience), mistakes and oversights were made during codesign that meant people with lived experience felt excluded or not heard.

Monitor and report on outcomes.

What did Te Hurihanga do well?

- Regular programme monitoring and updates via weekly meetings.
- Contracting of an independent implementation evaluation.

What could Te Hurihanga have done better?

- Māori and lived experience to be included in the design of the evaluation tool and its implementation at the start of the programme.

Innovative commissioning:

What did Te Hurihanga do well?

- Commission the new services not previously available in Southern - peer support, and community intensive support and residential services.

What could Te Hurihanga have done better?

- Early in the programme, explore more fully with Commissioning what mechanisms could be available to fund for services that align with the transformation vision of Te Hurihanga.

9. Recommendations

It is important the learnings from the evaluation be utilised as the recommendations from the Review are transitioned into the new health system.

However, it is equally important for other project teams going forward to draw on what the Time for Change – Te Hurihanga team did well as an example of good practice for co-designing new services with our community, for our community.

Central to this is co-design is engagement of people with lived experience and a commitment to equity first thinking and practice at the start of the process.

10. Conclusion

The Te Hurihanga Time for Change review provided a lens on what is needed in the Southern region to transform the mental health and addiction system. The comprehensive set of recommendations identified practical changes that will make a difference to tangata whaiora.

In a short period of time, under two years, a lot of projects to improve mental health and addictions support have been implemented. The implementation timeframe was time bound, and the team mobilised themselves to progress their agreed plans within this limited timeframe, while at the same time, navigating the uncertainties of the structural changes within the health system.

It is not just the design, development and contracting of services and frameworks to support change that have been achieved, it is the deliberative way the team has worked to progress these changes, underpinned by a commitment to equity first and co-design.

Any written account will not capture the overt and behind the scenes work undertaken by the team within the sector networks and with the wider community. While Implementation of actions was the responsibility of the team, implementation effectiveness is influenced by a range of factors external to the team. Some of these external factors have been profiled in this report.

Both the administrative decision makers and those at the coalface of implementation are to be congratulated for their courage in taking on such a broad-based encompassing set of interventions, and for their persistence in supporting diverse projects.

While the pathway to implementation has revealed some hidden curves and potholes, the work ahead will be to maintain the commitment to the vision. Te Hurihanga has been a key vehicle for change that will benefit tangata whaiora, whanau and our wider communities.