PUBLIC

	AGENDA Held on Wednesday 28 April 2021 **LOCATION: CSSB, Ground Floor, Board Room, Masterton Hospital** Zoom meeting ID: 826 6127 3900 Time: From **1030 to 1330**

3DHB COMBINED DISABILITY SUPPORT ADVISORY COMMITTEE

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1	**PROCEDURAL BUSINESS**			**10**	**1030**	
1.1	Karakia		All members			2
1.2	Apologies	**RECORD**	Chair			
1.3	Continuous Disclosure – Interest Register	**ACCEPT**	Chair			3
1.4	Confirmation of Draft Minutes	**APPROVE**	Chair			5
1.5	Matters Arising	**NOTE**	Chair			10
2	**SERVICE SPOTLIGHT**					
2.1	Update on Wairarapa Initiatives	**PRESENT**	WDHB Executive Leader, Planning and Performance	30	1040	
3	**SYSTEM AND SERVICE PLANNING**					
3.1	3DHB Alcohol and Other Drug (AOD) Model of Care and Priority Investment	**PRESENT** **ENDORSE**	2DHB Director Strategy, Planning and Performance	30	1110	11
3.2	Disability and Mental Health COVID Vaccine Response	**PRESENT**	2DHB Director Strategy, Planning and Performance	30	1140	21
3.3	3DHB Mental Health and Wellbeing Strategies Update	**NOTE**	2DHB Director Strategy, Planning and Performance	30	1210	45
3.4	3DHB Sub-Regional Disability Strategy Update	**NOTE**	2DHB Director Strategy, Planning and Performance	20	1240	53
3.5	3DHB First Draft Annual Plans 2020/21	**ENDORSE**	2DHB Director Strategy, Planning and Performance	20	1300	60
4	**OTHER**			**10**	**1320**	
4.1	General Business	**NOTE**	Chair			

DATE OF NEXT DSAC MEETING: Wednesday 23 June 2021, **Time TBC**,

Location TBC

Karakia

Whakataka te hau ki te uru,

Whakataka te hau ki te tonga.

Kia mākinakina ki uta,

Kia mātaratara ki tai.

E hī ake ana te atākura he tio,

he huka, he hauhū

Tīhei mauri ora!

Translation

Cease the winds from the west

Cease the winds from the south

Let the breeze blow over the land

Let the breeze blow over the ocean

Let the red-tipped dawn come with a sharpened air.

A touch of frost, a promise of a glorious day.

3DHB DSAC Interest Register

06/04/2021

Name	Interest
'Ana Coffey (Chair)	• Father, Director of Office for Disabilities • Brother, employee at Pathways, NGO Project Lead Greater Wellington Collaborative • Shareholder, Rolleston Land Developments Ltd
Prue Lamason	• Councillor, Greater Wellington Regional Council • Chair, Greater Wellington Regional Council Holdings Company • Member, Hutt Valley District Health Board • Daughter is a Lead Maternity Carer in the Hutt
Yvette Grace	• Member, Hutt Valley District Health Board • Member, Wairarapa District Health Board • Husband is a Family Violence Intervention Coordinator at Wairarapa District Health Board • Sister-in-law is a Nurse at Hutt Hospital • Sister-in-law is a Private Physiotherapist in Upper Hutt
Dr Tristram Ingham	• Board Member, Health Quality and Safety Commission • Director, Foundation for Equity & Research New Zealand • Director, Miramar Enterprises Limited (Property Investment Company) • Member, Independent Monitoring Mechanism to the United Nations on the United Nations Convention on the Rights of Persons with Disabilities • Chair, Te Ao Mārama Māori Disability Advisory Group • Co-Chair, Wellington City Council Accessibility Advisory Group • Chairperson, Executive Committee Central Region MDA • National Executive Chair, National Council of the Muscular Dystrophy Association • Trustee, Neuromuscular Research Foundation Trust • Professional Member, Royal Society of New Zealand • Member, Disabled Persons Organisation Coalition • Member, Scientific Advisory Board – Asthma Foundation of NZ • Member, 3DHB Sub-Regional Disability Advisory Group • Member, Institute of Directors • Member, Health Research Council College of Experts • Member, European Respiratory Society • Member, Te Ohu Rata o Aotearoa (Māori medical Practitioners Association) • Senior Research Fellow, University of Otago Wellington • Wife is a Research Fellow at University of Otago Wellington • Co-Chair, My Life My Voice Charitable Trust

	• Member, Capital & Coast District Health Board • Member, DSAC • Member, FRAC
Sue Kedgley	• Member, Capital & Coast District Health Board • Member, Consumer New Zealand Board
John Ryall	• Member, Hutt Union and Community Health Service Board • Member, E tū Union
Naomi Shaw	• Director, Charisma Rentals • Councillor, Hutt City Council • Member, Hutt Valley Sports Awards • Trustee, Hutt City Communities Facility Trust
Vanessa Simpson	• Director, Kanuka Developments Ltd • Executive Director Relationships & Development, Wellington Free Ambulance • Member, Kapiti Health Advisory Group
Jill Pettis	• NIL
Ryan Soriano	• Clinical Services Manager, Health Care New Zealand • Member, Board Trustee for Saint Patrick School Board, Masterton • Wife Employed as Senior Caregiver at Lansdowne Park Aged Care Facility
Jill Stringer	• Director, Touchwood Services Limited • Husband employed by Rigg-Zschokke Ltd • Trustee on Wellington Welfare Guardianship Trust
Jack Rikihana	• Chairman Horo Te Pai Trust • Research Advisory Group – Māori • Kaumātua Advisory Group • Noose Monotony Committee • Chairman RGAM • Partner Secretary ICU Wellington • Daughter Managing Director Anaesthetists NZ
Sue Emirali	• Nil
Bernadette Jones	•
Marama Eddie	• Board member Whaiora Whanui • Sister works for CCDHB • Sister works with the Aged Care at the Kandahar Dementia Unit in Masterton • Trustee of Ngati Kahungunu ki Wairarapa Tamaki Nui a Rua Treaty Settlement Trust • Member of Māori Women's Welfare League

3DHB DSAC MEETING **PUBLIC**

3DHB Disability Support Advisory Committee Meeting - PUBLIC

MINUTES

Held on Friday 18 December
Pilmuir House Boardroom, Hutt Hospital, Lower Hutt
Zoom link: **858 – 1247 - 3720**
Time: 12.30pm – 3pm

Members	Attendance	Membership
'Ana Coffey - Chair	Present	CCDHB
Sue Kedgley	Present	CCDHB
Yvette Grace	Present	WrDHB & HVDHB
Tristram Ingham	Present	CCDHB
John Ryall	Present	HVDHB
Naomi Shaw	Present	HVDHB
Vanessa Simpson	Present	CCDHB
Jill Pettis	Present	WrDHB
Ryan Soriano	Present	WrDHB
Jill Stringer	Present	WrDHB
Sue Emirali	Apologies	Sub Regional Disability Support Advisory Group Rep.
Marama Taatu	Present	Chair of Kaunihera Whaikaha
Bernadette Jones	Apologies	Sub Regional Disability Support Advisory Group Rep.
Jack Rikihana	Present	CCDHB Māori Partnership Board Rep.

DHB Staff name	Attendance	DHB	Role
Dale Oliff	Apologies	WrDHB[1]	Chief Executive Officer
Fionnagh Dougan		2DHB[1]	Chief Executive Officer
Kadeen Williams	Apologies	WrDHB	Executive Assistant
Sandra Williams	Present	WrDHB	Executive Leader Planning and Performance
Arawhetu Gray	Apologies	CCDHB[1]	Director Māori Health Services
Rachel Haggerty	Present	2DHB	Director Strategy Innovation & Performance
Amber Igasia	Present	2DHB	Board Liaison Officer
Rachel Noble	Present	3DHB[1]	General Manager Disability Strategy, Innovation and Performance
Nigel Fairley	Present	3DHB	General Manager Mental Health Addictions and Intellectual Disability Services
Matt Fribbens	Staff Guest	WrDHB	
Chris Nolan	Staff Guest	2DHB	
Alison Masters	Staff Guest	3DHB	
Guests			
Peter Barnett, Evelyn Bose, Adele Stevenson			

[1] 2DHB – HVDHB and CCDHB, WrDHB – Wairarapa DHB, CCDHB – Capital & Coast DHB, 3DHB – WrDHB, HVDHB and CCDHB.

Members of the Public
Paul Douglas, Bridie Witton

1 PROCEDURAL BUSINESS

1.1 KARAKIA

Tristram Ingham opened the meeting with a karakia following which the Chair welcomed everyone to the meeting.

1.2 APOLOGIES

As noted above.

Moved	**Seconded**
'Ana Coffey	Ryan Soriano

1.3 CONTINUOUS DISCLOSURE

It was **noted** as current and any changes to be sent to the Board Liaison Officer via email.

1.4 MINUTES OF PREVIOUS CONCURRENT MEETING

The Committee **approved** the minutes of the previous 3DHB DSAC Meeting held on 24 June 2020.

- Amendments to the attendees list

Moved	**Seconded**
'Ana Coffey	Ryan Soriano

1.5 MATTERS ARISING FROM PREVIOUS MEETINGS

All complete.

1.6 DSAC WORK PLAN 2020

The work plan was received and further feedback is to be sent to the Board Liaison Officer.

2 PRESENTATION

2.1 ACUTE MENTAL HEALTH INTEGRATED SERVICE RESPONSE

Presenter: Manager Regional Mental Health Services, Chris Nolan

Acute Care Continuum

3 DISCUSS

3.1 ACUTE MENTAL HEALTH INTEGRATED SERVICE RESPONSE

Presenter: 2DHB Director Strategy, Planning and Performance – Rachel Haggerty

WrDHB Executive Leader, Planning and Performance - Sandra Williams

3DHB General Manager, Mental Health, Addictions and Intellectual Disability Service - Nigel Fairley

3DHB Disability Support Advisory Committee note:

(a) Services providing acute and intensive psychiatric and mental health care are under pressure, with a consistent picture of high and increasing demand for services.

(b) There are significant points of stress in the system including over utilisation of inpatient beds, high volume in crisis response services, poor engagement with NGO services resulting in underutilisation of support care, and fragmentation of the acute response system.

(c) The acute care continuum model of care defines core services which require investment and development to create an improved and better coordinated acute care system response.

(d) Investment approved by the Board in November 2019 has been progressed, following COVID-19 delays, with a core tranche of contracted service improvements in train pending Health System Committee chair authorisation.

(e) Further 3DHB investment including potential additional inpatient capacity will be considered through the redesign and development of Te Whare Ahuru, the Hutt Valley DHB inpatient unit, and establishment of a Kaupapa Māori crisis respite service.

(f) A forum of leaders of clinical and NGO acute care tasked with the responsibility for coordination of acute service response and eliminating fragmentation has been established. This collective forum is a core part of implementation of the model of care.

NOTE:

It was noted this is a HVDHB and CCDHB paper, there are different commissioning processes between the two DHBs and the Wairarapa. A question was raised about whether there will be more beds for the service and management indicated that if there were they would be in the acute side of the service. There is a lot of work underway and this is just the start.

The Committee was encouraged to read about the lived experience group and feel confident about the track the DHBs are on.

ACTION: Management to come back to DSAC in routine reporting with the reporting mechanisms and how progress will be measured and kept track of.

The Committee raised concerns that none of the presenters were Māori and asked what is being done in the Kaupapa Māori space. It was noted the collective forum has a Kaupapa Māori provider and there are links with Māori services across Wellington. There is a Te Ao Māori strategy for the presenting provider's workforce and while they may be the first door they also refer onwards.

Moved	**Seconded**
'Ana Coffey	Jill Stringer

3.2 MENTAL HEALTH SERVICES AND PEOPLE WITH DISABILITY

Director Strategy Planning and Performance and GM Disability presented.

The Disability Services Advisory Committee note:

(a) The 3DHB Disability Group commissioned a report on mental health services for disabled people.

(b) This report identified a combination of barriers, namely cost, limited availability of services, inaccessible environments and communication, and inadequate skills and knowledge of health workers, prevent disabled people from accessing appropriate mental health care.

(c) Capital Coast and Hutt Valley DHBs will be developing a Disability-Equity Mental Health service model that ensures that disabled people have their mental health needs met alongside any comorbidity they may have.

NOTES:

Management took the time to acknowledge the work completed by the GM Disability and this sentinel report. GM Disability noted that life has gotten faster and faster and people with disability have been left behind.

The Committee asked if there will be a plan created and management noted this will come through in the planning work across the DHBs. It was also advised that this work has identified a clear need for disability mental health. The Committee requested any future developments in this space to come back as much as possible.

The Committee asked what was happening across the country in this space and management noted Auckland has a deaf mental health service that supports workers going out into the community but nothing else.

3.3 TRANSPORT AND ACCESSING HEALTH SERVICES FOR PEOPLE WITH DISABILITY

GM Disability presented.

Disability Services Advisory Committee note:

(a) International research demonstrates a clear link between transportation barriers and poor health outcomes. Disabled people, in particular, are disproportionately affected by transport barriers.

(b) These barriers directly impact upon disabled people's access to healthcare services and lead to health inequalities.

(c) Focusing on the relationship between transport barriers and health is important for addressing disabled people's over-representation in poor health outcome statistics.

(d) The Disability Team will work with the Regional Council, District Health Board and the disability community to find solutions to the issues raised by disabled people in relation to accessing public transport to attend health services

Disability Services Advisory Committee endorsed:

(a) The approach of the Disability Team to work with the Regional Council, District Health Board and the disability community to find solutions to the issues raised about accessing public transport to attend health services.

NOTES:

The Committee commended both these reports in using the DHB as the lever for other organisations. They recognised the ability for those with disabilities to lead a good life and all the things that contribute to having a healthy wellbeing. The Committee requested clear timelines for action plans to go to the Board regarding this topic. There is hope this work will impact Did Not Attend (NDA) rates.

Moved	**Seconded**
'Ana Coffey	Jill Pettis

1:48pm Yvette returned

4 REPORTING

4.1 SUB-REGIONAL DISABILITY STRATEGY 2017 – 2022 UPDATE

Presenter: 3DHB General Manager Disability – Rachel Noble

The Disability Support Advisory Committee noted:

(a) Progress in key activities related to the implementation of the Disability Strategy implementation.

ACTION: An Accessibility Charter signing ceremony and have the charter framed and displayed.

5 OTHER

5.1 GENERAL BUSINESS

The Committee thanked all the staff who worked on the papers and presentations brought to the meeting.

Meeting closed 2:05pm.

6 NEXT MEETING

Wednesday, 31 March 2021. 1-30pm-4pm. Location to be confirmed.

CONFIRMED that these minutes constitute a true and correct record of the proceedings of the meeting.

DATED this day of 2020

'Ana Coffey
DSAC CHAIR

DSAC ACTION LOG

Action Number	Date of meeting	Due Date	Date Completed	Status	Assigned	Agenda Item #	Agenda Item title	Description of Action to be taken	How Action to be completed
DSAC2020-07	18-Dec-20	31-Mar-21	7-Apr-21	NEW - Complete	Board Secretary	4.1	SuB-REGIONAL DISABILITY STRATEGY 2017 – 2022 uPDATE	Requested a formal signing ceremony for the Accessibility Charter. Also if it could be framed and displayed.	
DSAC2020-08	18-Dec-20	31-Mar-21	28-Apr-21	NEW - Closed	Director Strategy, Planning and Performance	3.1		Management to come back to DSAC in routine reporting with the reporting mechanisms and how progress will be measured and kept track of.	Closed - will be part of regular reporting to DSAC

Disability Support Advisory Committee

28 April 2021

3DHB Alcohol and Other Drug (AOD) Model of Care and Priority Investment

Action Required

It is recommended that the 3DHB Disability Support Advisory Committee endorse:

(a) The Capital & Coast, Hutt Valley and Wairarapa Alcohol and Other Drug Model of Care (the Model of Care) and its five direction-setting, key components for implementation:

- Driving equity of access and outcomes
- Privileging the voice and contribution of those with lived experience
- Growing a whole of population approach
- Building a recovery-focused system of care
- Working collaboratively.

It is recommended that the 3DHB Disability Support Advisory Committee note:

(a) The Model of Care was collaboratively developed by a Steering Group made up of a diverse group of stakeholders from across the subregion and adopted a robust process and methodology to build the evidence-base for the development of the Model of Care.

(b) The Model of Care project found a failing alcohol and other drug (AOD) system of care in the subregion, and the picture of an invisible, disconnected sector, unmet need and inequitable access, particularly for young people, has been updated and confirmed.

(c) The Model of Care is aligned to, and can be a key enabler in the subregion, for the Government's plan to transform mental health and addiction care nationally, and for implementing the subregion's health strategies, that identify people with mental health and addiction issues as a priority major service user group.

(d) Hutt Valley and Capital & Coast DHBs submitted an investment proposal to the Ministry of Health, at its request, to increase access to primary and community AOD services and supports and the Ministry is supporting the proposal with approximately $3m investment over 3 years.

(e) The Ministry's investment will provide a significant and well-timed boost for implementing the Model of Care, enabling investment in AOD sector capacity and capability with the establishment of:

- Enhanced kaupapa Māori and Pacific counselling services delivered close to home.
- Innovative peer support network and coordination to support wellbeing and recovery.
- An AOD provider collaborative to drive an integrated approach to access, outcomes and service development.
- Mental Health and Addiction funded project management resource to enable the implementation of the Model of Care.

(f) The Model of Care provides a commissioning framework for the additional investment that is necessary for its successful implementation and the investment priorities will be developed as part of implementation planning.

(g) The Mental Health and Addictions Team is in the process of detailed project planning with a priority to establish the AOD provider collaborative and will regularly update the Board on progress.

Strategic Alignment	CCDHB Health System Plan 2030 Subregion Living Life Well A strategy for mental health and addiction 2019-2025
Authors	Catherine Inder, Principal Advisor, Strategy, Planning and Performance (SPP) Chris Nolan, General Manager, Mental Health and Addiction, SPP
Endorsed by	Fionnagh Dougan, Chief Executive, 2DHBs
Presented by	Rachel Haggerty, Director, SPP
Purpose	This paper seeks the Board's endorsement of the subregion's Alcohol and Other Drug Model of Care and outlines the plan for implementing the Model of Care supported by new investment from the Ministry of Health
Contributors	Mark Nash, Senior System Development Manager, SPP Nathan Brown, Senior Health Insights Analyst, SPP
Consultation	3DHB AOD Model of Care Steering Group

Executive Summary

The Capital & Coast, Hutt Valley and Wairarapa Alcohol and Other Drug (AOD) Model of Care (Model of Care) project was established in response to a system of care that is failing. If endorsed by our Boards, the Model of Care will support the redevelopment of the AOD sector enabling improved service integration and increased ability to organise to redress inequities for Māori, and our priority populations: Pacific people and people with disabilities.

The Model of Care has five direction-setting key components. The first is 'Driving equity of access and outcomes' and engages the AOD sector in doing everything it can to address inequities, based on our 2DHBs Equity Goal, Definition and Principles.

The second direction is 'Privileging the voice and contribution of lived experience' and aims to grow and strengthen the peer workforces to realise their unique ability to contribute to an effective, and high-functioning AOD sector.

The third direction 'Growing a whole of population approach' recognises the continuum of substance-related harm and need, from none to severe, and commits to building a full continuum of care that responds to the greatest need.

The fourth direction 'Building a recovery-focused system of care' steers the AOD sector towards establishing the system, services, and the connections needed to deliver the person-centred, holistic care required for people to define and achieve their own recovery goals.

The fifth direction 'Working Collaboratively' recognises the attention that needs to be paid to building relationships to increase connectivity across both the continuum and system of care to create a more supported, agile and responsive AOD sector.

The Model of Care will take time to implement but has received a helpful boost from the Ministry of Health in the form of significant investment enabling first steps to be taken in each of the five focus areas. Implementation planning is underway and will quickly gain momentum in response to the new investment.

Strategic Considerations

Service	The Model of Care highlights existing service gaps in the continuum of care including lack of services for people with mild to moderate problems, and recovery support services. The Ministry of Health has agreed to invest in kaupapa Māori and Pacific primary and community counselling services that will go some way to addressing the capacity issues for Māori and Pacific peoples experiencing mild to moderate substance-related harm.
People	The Ministry of Health investment will increase kaupapa Māori and Pacific counselling services by 7 FTE across our DHBs. It will fund a project manager for a fixed term of 12 months to begin implementing the Model of Care. It will also invest in increasing the capacity and capability of the subregion's peer support workforce.
Financial	The Model of Care signals the need for immediate and further investment and signals that existing services may be reconfigured and/or decommissioned.
Governance	The AOD Steering Group provided governance for the development of the Model of Care and will form the backbone for the AOD collaborative to be established as a key part of the Model of Care. In the future, governance will be provided by the to be established Mental Health and Addiction Commissioning Board (committed to in *Living Life Well a strategy for mental health and addiction 2019-2025*).

Engagement/Consultation

Patient/Family	The AOD Model of Care Steering Group includes members with lived experience of addiction. The Model of Care project consulted extensively with people with lived experience.
Clinician/Staff	The AOD Model of Care Steering Group includes AOD health professionals from DHB, PHO and NGO services including Kaupapa Māori NGO providers. The Model of Care project consulted extensively with AOD providers and health professionals.
Community	N/A

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
1.	Lack of an appropriately constituted steering group which results in poor project focus and prioritisation	System Development Manager	Steering Group has recommenced with planned forums	High	Low
2.	Broad and undefined scope of provider delivery resulting in poor or inappropriate targeting of need	System Development Manager	Establish and lead a collaborative to ensure match of capacity and capability to delivery	High	Low
3.	Lack of integration with adjacent services contributing to service delivery fragmentation	System Development Manager	Establish and lead a collaborative which	Very High	Low

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
			commits to service integration		
4.	Poor location, service coverage and type of provider resulting in low utilisation of service, evidenced by a high DNA rate.	System Development Manager	Review of current service provision against the goals described in the MOC	High	Medium

Attachment

1. The Capital & Coast, Hutt Valley and Wairarapa Alcohol and Other Drug (AOD) Model of Care.

Purpose

1. The purpose of this paper is twofold, it:
    - seeks the Boards' endorsement of the 3DHB (Wairarapa, Hutt Valley and Capital & Coast) Alcohol and Other Drug (AOD) Model of Care (the Model of Care); and
    - describes the plan for implementing the Model of Care, supported by a recent commitment from the Ministry of Health to invest in enhanced primary and community AOD services in our two DHBs, in an approach that is well-aligned to the Model of Care.
2. Model of Care progress reports were provided to the Board on 6 May and 10 September 2019 as part of the *Living Life Well* updates. The Model of Care project was scheduled for completion in February 2020 but was delayed due to COVID-19 and staff turnover.

Background

Addiction and harmful substance use are common and contribute to health and other losses

3. In 2020, 3931 individuals experiencing harm from a wide range of substances accessed alcohol and other drug (AOD) treatment services across the subregion. Hazardous and harmful use of alcohol and other drugs is one of the greatest risks to health and wellbeing – affecting individuals, families, whānau, communities and society. Harmful consumption contributes to health and social inequalities and is among the foremost underlying causes of disease including mental health issues, injury, family violence, fetal harm, disability and premature death.
4. These harms exist on a continuum from no harm to severe addiction. Some people use substances recreationally with none or only minor harms resulting. At the other end of the continuum is severe dependence that exacts a heavy toll on individual health, wellbeing and life-expectancy. The 'prevention paradox' is that the majority of substance-related harm occurs in populations who consume only small amount of substances (mostly alcohol).
5. Both mental health and/or addiction (MHA) challenges are common in New Zealand, and anyone can experience them. New Zealand wide data tells us that:
    - 50–80% of New Zealanders will experience MHA challenges their lifetime. There are some indications that prevalence appears to be increasing.
    - Around one in five people will experience MHA challenges in any given year.
    - Unmet need is difficult to predict due to both the lack of recent New Zealand prevalence data and because a proportion of people with AOD issues will recover without AOD services and supports. However, there is an estimated 50,000 people nationally wanting help with their severe substance-use problems but not receiving it.
    - Over 70% of people who attend addiction services have co-existing mental health conditions and over 50% of mental health service users are estimated to have co-existing substance abuse problems.
    - One in five (19%) New Zealanders aged 15 years or more who drank alcohol in the past year has a potentially hazardous drinking pattern that could result in significant harm to them and their families and whānau.

The negative health and social consequences fall inequitably

6. Māori experience the highest levels of MHA of any ethnic group in New Zealand. Pacific peoples also experience MHA at higher rates than others with 25 percent in a given year experiencing MHA compared to 20 percent overall.

- Nationally, 6% of Māori and 3.2% of Pacific peoples experience AOD issues than the general population (3%). This rate is even higher for Māori young people aged between 16 and 25 years at 9.6%.
- Alcohol involvement in youth emergency department presentations is similar in Māori and non-Māori, but hospitalisations wholly attributable to alcohol are higher in Māori adults than non-Māori adults.
- The proportion of frequent methamphetamine users who are Māori increased from 22 percent in 2006 to 32 percent in 2014.
- People in prison have the highest prevalence of MHA issues of any group and this is more significant when ethnicity is also taken into account. Nine out of ten people in prison have a lifetime diagnosis of a mental health or substance use disorder. Māori make up the largest proportion of the prison population, in relation to their proportion of the whole population.

7. The harm is more common for Māori and Pacific peoples and people facing socio-economic disadvantage because these groups have less access to support, are more likely to live in poverty, and to be disabled. The intergenerational effects of colonisation including loss of land, language and culture and the ongoing experience of institutional racism and ableism perpetuate disadvantage and poor health and other outcomes for Māori, Pacific people and people with disabilities. Many people come from more than one disadvantaged group compounding their health burdens

There is unmet need

8. Addiction treatment services have been primarily focused on those with moderate to severe problems. If untreated, mild problems can progress to the point where they are much harder to address. This is often attributable to the devastating personal losses sustained along the way: the consequence of growing reliance on substance-use, and increased tolerance of the ill-effects.
9. Chapter Two of *He Ara Oranga The Report of the Government Inquiry into Mental Health and Addiction*[1] is titled 'What we heard – the voices of the people.'

   We were told that addiction is the opposite of connection, a taniwha that isolates users and holds them in its grip. They spoke of the high social costs of not addressing addictions: harm to families, children and communities. People saw an urgent need to prevent harmful addictions and provide pathways to recovery.

   When a person is ready to change the treatment needs to be available then. Not one hundred placements down the line. (Self-identified service user and provider)

   We were told that our largely punitive criminal justice response to drug use fails to acknowledge the root causes of drug addiction (trauma, abuse, anxiety and isolation) or the frequent connection between intergenerational abuse, addiction, mental distress, unemployment, poverty and homelessness…

   It's not a war on drugs it's a war on very sick people and it needs to stop. Addicts need to be treated as addicts not criminals. (Family member of service user).

10. These experiences were confirmed by those with lived experience of addiction in our DHBs during the development of the Model of Care (see paragraph 14 below).

[1] New Zealand Government (2018). *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington.

The system of care in the subregion is failing

11. The subregion's DHBs recognised that the AOD system of care was invisible and disconnected and that investment had been inadequate, inconsistent and poorly planned. The project to develop the Model of Care began in early 2019 with the bringing together of a diverse group of stakeholders from across the subregion to form a Steering Group for the project.
12. The collaborative AOD Model of Care project employed a mix of methods to understand need, demand, service use and best-practice combining a literature review, a service stock-take (both funded and voluntary), and locality-based integrated data-modelling utilising both New Zealand[2] (2006) and Australian[3] (2019) population prevalence studies.
13. The service stock-take and locality-based integrated data modelling showed:
    - unmet demand for AOD services for people in the 0-14 and 15-24 age group across all localities
    - high unmet demand for AOD services across all age groups in North Porirua and in the 25-44-year-old age group in Wellington
    - inequitable access to AOD services across the subregion, and within each DHB area – services run out of main centres cannot adequately cover the subregion
    - in some areas service utilisation rates exceed predicted treatment demand – however these are assessments in the main for people in the criminal justice system
    - limited AOD focussed services for youth with no residential beds
    - social detox and AOD respite facilities in the Wairarapa only
    - limited access to services specifically for family and whānau
    - no access to a funded AOD service for Pacific peoples in both HVDHB and WDHB
    - large variation in the number of FTEs in Kaupapa Māori AOD services
    - AOD services are funded to respond to mild to severe presentations with little funding for either early intervention or post-treatment recovery, including maintenance
    - a mix of clinical and non-clinical AOD counselling roles and inconsistent staff remuneration within each DHB and across the subregion
    - no funded AOD peer workforce and a limited AOD specialist workforce
    - investment in AOD treatment accounts for only around 11 percent of the subregion's mental health and addiction budget.
14. Extensive stakeholder engagement included over 80 people with lived experience of addiction who stated that they had experienced access barriers including: waitlists, stigma, difficulty finding help or finding the right service, no information or support while waiting, and no after-hours support.
15. Engagement with AOD providers confirmed these findings and identified other challenges:

[2] MA Oakley Browne, JE Wells, KM Scott. 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.
[3] A Ritter, J Chalmers, M Gomez. 2019. Measuring Unmet Demand for Alcohol and Other Drug Treatment: The Application of an Australian Population-Based Planning Model. *Journal of Studies on Alcohol and Drugs, Supplement 2019*: s18, 42-50.

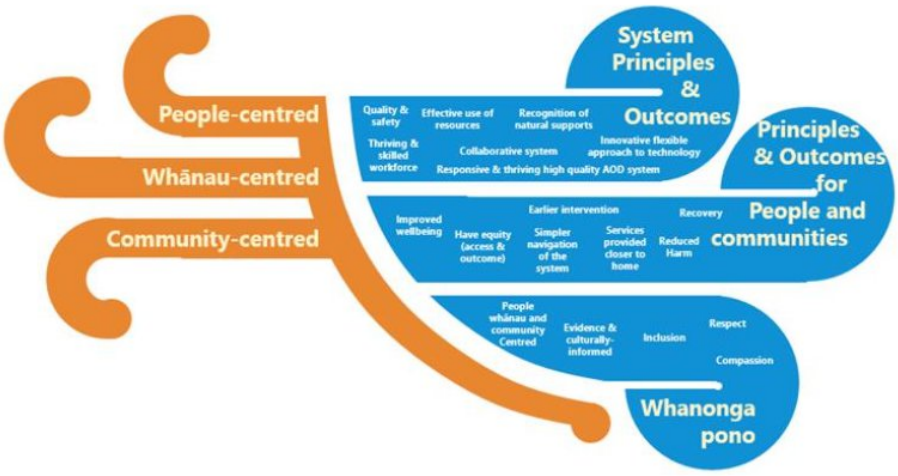
- limited access to secondary services for both youth and adults
- apart from CCDHB, there is limited AOD clinical governance in secondary services when compared to mental health services
- no clear pathway for people exiting compulsory treatment under the Substance Addiction and Compulsory Assessment and Treatment Act 2017
- challenges transitioning people to NGO providers
- gap in the provision of services for coexisting mental health and AOD needs (coexisting issues)
- little available resource for step-down and support services to meet the ongoing needs of people with enduring AOD issues or coexisting issues.

The unmet need is ongoing

16. The locality-based integrated data modelling was refreshed for the 2019 and 2020 calendar years for HVDHB and CCDHB confirming the picture of unmet need, particularly for young people, and for adults in North Porirua, Lower Hutt and Wellington.
17. The data also shows a pattern of access to single services, either a DHB specialist service, or a single NGO provider. This suggests that people may not be accessing AOD services and supports in the most helpful setting or at the right level of intensity. Recovery from addiction nearly always involves setbacks, and sometimes relapse, and the most appropriate service on the care continuum needs to engage or reengage.

The 3DHB Alcohol and Other Drug Model of Care

18. The resulting, collaboratively developed Model of Care is attached to this paper as Appendix One. The Model of Care document describes the development process; the evidence-base; the extensive stakeholder engagement; and the synergies with both the Government's and the subregion's strategies. The document concludes with a high-level implementation plan.
19. The Model of Care proposes a whole-of-population approach to reducing substance-related harm, by enabling early intervention in places that work for the people experiencing and exposed to the harms. The graphic incorporates the subregion's prevailing wind, waves and sea. At the heart of the Model of Care are people, whānau and communities.



20. The Model of Care itself has 5 direction-setting and overlapping components:
    - Driving equity of access and outcomes
    - Privileging the voice and contribution of those with lived experience
    - Growing a whole of population approach
    - Building a recovery-focused system of care
    - Working collaboratively.
21. The Model of Care also has 5, currently draft, priority pathways for main groups of AOD service users. The priority pathways are 'maps' designed to ensure that the system of care responds early to those with the greatest needs. The priority pathways will help AOD health professionals tailor services and supports that respond to the needs, aspirations and cultural frame of reference of people presenting from one (or more) of these five groups:
    - Māori
    - Pacific people
    - Young people
    - People living rurally and/or remotely
    - People with severe problems.
22. The Model of Care was collaboratively developed by the AOD Model of Care Steering Group throughout 2019 and was endorsed at its meeting on 12 March 2021. This paper now seeks the Board's endorsement of the 3DHB AOD Model of Care.

Implementation and investment

23. The Model of Care is aspirational and requires a significant shift in how the AOD sector is strategically positioned, resourced and funded. The Ministry of Health (MOH) has delivered our DHBs with a significant and well-timed boost for the implementation of the Model of Care by agreeing to fund $3m over three years to be invested in primary and community AOD services and supports.
24. The Model of Care and the priority pathways provide a commissioning framework for our DHBs' investment in AOD services and supports; and review of existing contracts and service pathways, which will enable services to be reconfigured. More investment is needed to support both early intervention and enhanced support for recovery, while maintaining existing primary and secondary services.
25. The purpose of the *Enhanced primary and community supports for people experiencing substance-related harm initiative*, (the Initiative) is to enhance our DHBs' existing AOD services, in line with the Model of Care. The Initiative will enable earlier intervention with mild to moderate AOD issues through the increased provision of culturally responsive, accessible counselling and peer support targeted to Māori and Pacific people.
26. The Initiative has three components:
    1. **Enhanced kaupapa Māori and Pacific counselling services** – 7 FTE counselling roles to deliver outreach services and supports in key localities. Services and supports will be targeted to people presenting with harmful or hazardous substance use, who have not previously sought support for their substance use and/or would not meet the threshold for DHB funded addiction treatment services

2. **Innovative peer support network and coordination** – 1 FTE coordinator/educator to develop and grow an exemplar AOD specific, peer support network and a training and support package.

   Providers chosen to deliver the enhanced kaupapa Māori and Pacific counselling services will also develop a network of peer support roles and offer peer support as an ongoing resource for people once clinical input has ended.

3. **Project management to support implementation of the primary and community AOD services** – a 1 FTE project manager for 12 months with responsibility for implementing the initiative and establishing an AOD Collaborative.

   The **AOD Collaborative** is key to addressing the subregion's existing fragmented AOD system of care and enabling a coordinated approach to the implementation of additional services. The goal of the AOD Collaborative is to build the necessary relationships to implement the 5 priority pathways that will drive improved access and outcomes.

27. The service expansion will link closely with adjacent existing services to reduce overlap and ensure that a seamless, integrated approach is taken to service provision. Key service linkages that will be developed in the initial stages of implementation are:

    - Wellbeing and access and choice primary mental health and addiction PHO teams
    - YOSS Services – 'Youth Quake' in Porirua currently in the codesign and establishment phase
    - Piki primary care youth services
    - Existing NGO AOD providers
    - Peer Support Networks.

28. The key milestones and deliverables set out in the Table below assume an early April 2021 drawdown of funds:

Milestones	Deliverable	Timeline
Recruit project manager	Contract of employment signed	Completed
Implementation plan outline	Outline to MOH for discussion	30 April 2021
Establish the AOD Collaborative	First meeting, draft TORS	30 April 2021
Draft project plan/implementation plan	Plan to MOH for confirmation	30 May 2021
Recruit peer support coordinator	Contract of employment signed	30 April 2021
Design enhanced peer support network programme	Report to Steering Group	Mid-May 2021
Phased contracting for counselling services underway	Procurement plan signed	June 2021

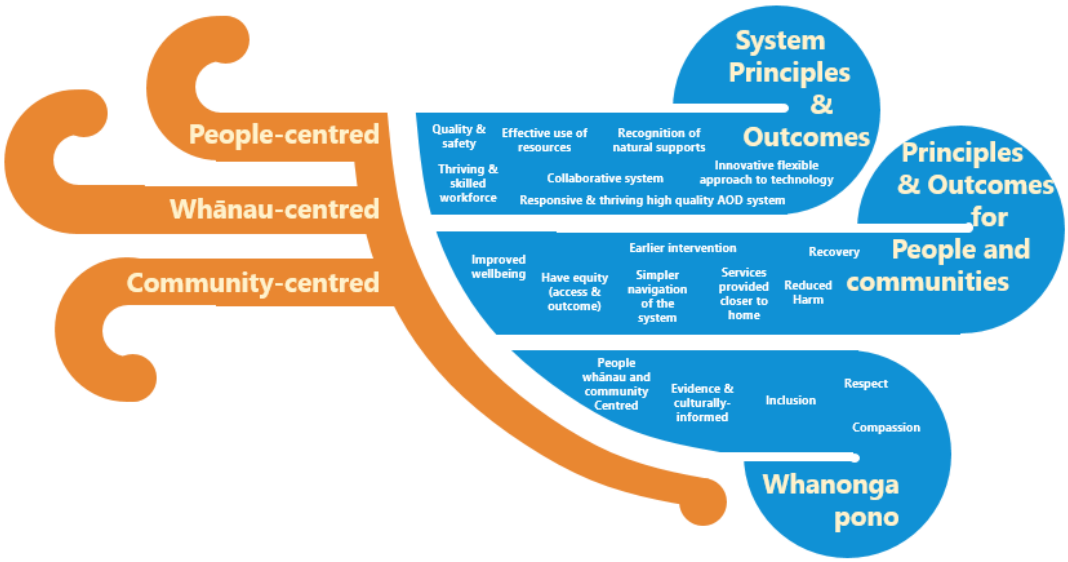
29. The Mental Health and Addictions team is in the process of detailed implementation planning to make the Model of Care a reality across the subregion. The priority is implementing the Initiative, and this will dominate the next few months, and increasing capacity and capability across the continuum of care for Māori, and for Pacific people.

30. A second priority is to develop a detailed Model of Care implementation plan for 2022 and beyond. The work to refine the priority pathways (refer paragraph 21. above) will inform the implementation plan and the investment priorities for 2021-2022. The Mental Health and Addictions team will keep the Board informed of progress.

Capital and Coast, Hutt Valley and Wairarapa Alcohol and Other Drug Model of Care

He aha te mea nui o te ao

He tangata he tangata he tangata



Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Contents

The Development of the 3DHB Alcohol and Other Drug Model of Care

Introduction

The purpose of this document is to present the 3 DHB (Hutt Valley, Wairarapa and Capital & Coast) Alcohol and Other Drug (AOD) Model of Care (the Model of Care) for implementation across the Wellington subregion. It also describes the development of the Model of Care and the synergies with both the government's and the subregion's strategies. Finally, it identifies the implementation priorities.

The process

The project to develop the Model of Care began in early 2019 with the bringing together of a diverse group of stakeholders from across the subregion to be the Steering Group for the project. The Steering Group included representation from those with lived experience of addiction, a Primary Health Care Organisation (PHO), Regional Public Health, NGO AOD providers, DHB mental health and addiction clinicians and operational managers, Kaupapa Māori AOD providers and a Pacifica AOD provider.

The process followed was robust

The Model of Care project employed a mix of methods in order to understand need, demand, service use and best-practice combining a literature review, a service stock-take (both funded and voluntary), and locality-based integrated data-modelling utilising both New Zealand[1] (2006) and Australian[2] (2019) population prevalence studies.

There was extensive stakeholder engagement

The AOD sector was asked, via a survey and over 30 interviews with providers, to give information about gaps in service delivery and opportunities for future investment.

Over 80 individuals with lived experience of addiction were consulted over the lifetime of the Model of Care project. They identified barriers and challenges that impacted their recovery and also provided significant positive comment about their experiences of services. Appendix Two is a 'Stakeholder Engagement Map'.

The findings – the system of care is failing

The Model of Care project found that the AOD system of care, while providing a range of specialist and NGO based counselling services for a significant part of the population across the subregion, is invisible, disconnected and inadequately resourced to meet the needs of the people it serves.

Unmet need is difficult to predict due to both the lack of recent New Zealand prevalence data and because a proportion of people with AOD issues will recover naturally, meaning that they will address their problems without AOD services and supports.

The Model of Care project reviewed the demographic mix in each locality and the deprivation index to mesh block level within localities. This information was matched to other information such as access rates to services with prevalence data to better understand unmet need at locality level and

[1] MA Oakley Browne, JE Wells, KM Scott. 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.

[2] A Ritter, J Chalmers, M Gomez. 2019. Measuring Unmet Demand for Alcohol and Other Drug Treatment: The Application of an Australian Population-Based Planning Model. *Journal of Studies on Alcohol and Drugs, Supplement 2019*: s18, 42-50.

across the subregion. The Model of Care project was also informed by stakeholder and provider reports on waiting lists for services.

The locality-based integrated data-modelling showed unmet need and the qualitative information provided by AOD service providers, particularly from the kaupapa Māori and Pacific providers, confirmed the findings.

The stock-take and locality-based integrated data modelling showed there is:

- unmet demand for AOD services for people in the 0-14 and 15-24 age group across all localities
- high unmet demand for AOD services across all age groups in North Porirua and in the 25-44-year-old age group in Wellington
- inequitable access to AOD services across the subregion, and within each DHB area – services run out of main centres cannot adequately cover the subregion
- in some areas service utilisation rates exceed predicted treatment demand — however these rates included streamed referrals (single point of referral assessments) in the main for people in the criminal justice system
- limited AOD focussed services for youth with no youth specific residential beds
- social detox and AOD respite facilities in the Wairarapa only
- limited access to services specifically for family and whānau
- no access to a funded AOD service for Pacific peoples in both HVDHB and WDHB
- large variation in the number of FTEs in Kaupapa Māori AOD services
- AOD services are funded to respond to moderate to severe presentations with little funding for either early intervention or post-treatment recovery, including harm reduction for severe problems
- a mix of clinical and non-clinical AOD counselling roles and inconsistent staff remuneration within each DHB and across the subregion
- no funded AOD peer workforce and a limited AOD specialist workforce
- investment in AOD treatment accounts for only around 11 percent of the subregion's mental health and addiction budget.

People with lived experience stated that they had experienced access barriers including waitlists, stigma, difficulty finding help or finding the right service, no information or support while waiting, and no after-hours support.

Engagement with AOD providers confirmed these findings and identified other challenges:

- limited access to secondary services for both youth and adults
- with the exception of CCDHB, there is limited AOD clinical governance in secondary services when compared to mental health services
- no clear pathway for people exiting compulsory treatment under the Substance Addiction and Compulsory Assessment and Treatment Act 2017
- challenges transitioning people to NGO providers
- gap in the provision of services for coexisting mental health and AOD needs (coexisting issues)

- little available resource for step-down and post-treatment support services to meet the ongoing needs of people with enduring AOD issues or coexisting issues.

Current state

The locality-based integrated data modelling was refreshed for the 2019 and 2020 calendar years for HVDHB and CCDHB confirming the picture of unmet need particularly for young people, and for adults in North Porirua, Lower Hutt and Wellington.

The data also shows a pattern of access to single services, either a DHB specialist service, or one NGO provider, suggesting that people may not be accessing AOD services and supports in the most helpful setting and/or at the right level of intensity. Recovery from addiction nearly always involves setbacks, sometimes relapse, and the appropriate services on the continuum and system of care need to engage or reengage.

Strategic alignment

Government

The Model of Care is aligned to and can be a key enabler for implementing the Government's plan to transform mental health and addiction care nationally.

Taking Mental Health Seriously - He Ara Oranga, the Report of the Government Inquiry into Mental Health and Addiction[3] confirmed that a new approach to mental health and addiction in New Zealand is needed with an increased emphasis on wellbeing and community, more prevention and early intervention, expanded access to services, more treatment options, treatment closer to home, whānau and community-based responses and intersectoral action.

Through Budget 2019, the Government is providing significant investment for a wide range of health and social sector initiatives to support the transformation of the mental health and addiction system. The Model of Care will enable the subregion to make the best use of existing and new investment (see page 16, Implementing the Model of Care).

The *Health and Disability System Review – Final Report – Purongo Whakamutunga*[4] emphasises the importance of maintaining health and wellbeing rather than treating illness and signals that the health system needs to take a more collaborative, cooperative approach and that changes in both attitude and culture are necessary. The four key themes are:

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

The Government has accepted the direction of travel outlined in the Review and has established an implementation team to lead the policy and design work.

[3] New Zealand Government (2018). *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington.

[4] Health and Disability System Review (2020). *Health and Disability System Review – Final Report – Pūrongo Whakamutunga*. Wellington.

The Subregion

The Model of Care is a key enabler for implementing the subregion's health strategies that taken together aim to eliminate health inequities in the subregion.

Living Life Well A strategy for mental health and addiction 2019-2025 (*Living Life Well*) sets the direction for mental health and addiction care in the subregion committing the 3DHBs to moving towards a consistent, coordinated and integrated whole of system model of care. *Living Life Well* has two service directions – life-course care and people-based care, supported by three enabling directions – information intelligence, quality and safety, and commissioning.

The subregion's other population-based strategies identify people with mental health and addiction issues as a priority major service user group for whom the system needs to work better:

- *Health System Plan 2030* (CCDHB) – will undertake people-centred service design for people with enduring mental health and addiction and to achieving health equity by 2030
- *Our Vision for Change 2017-2027* (HVDHB) – people experiencing mental health and addiction illnesses are a priority population
- *Te Pae Amorangi, Māori Health Strategy 2018-2027* (HVDHB) – focus area 4 is mental health and addictions
- *Toe timata le upega – Pacific Action Plan 2017-2020* (subregion) – supporting Pacific people to better access mental health and addiction services is a priority
- *Taurite Ora Māori Health Strategy 2019-2030* (CCDHB) – service focus area 2 is mental health and addiction
- *Our Wellbeing Plan 2018 A Thriving Hutt Valley* (HVDHB) - recognises mental wellbeing as critical to overall wellbeing and aims to support and strengthen mental wellbeing
- Mental health and addiction care for people with disabilities is embedded into the *Sub-Regional Disability Strategy 2017-2022 Enabling Partnerships: collaboration for effective access to health services.*

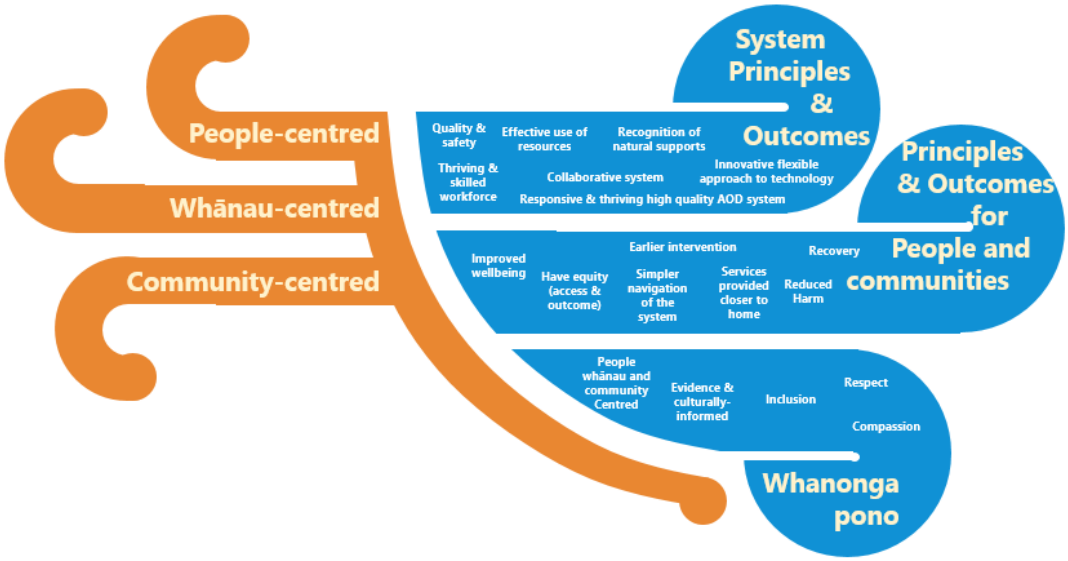
The Alcohol and Other Drug Model of Care

Overview

Hazardous and harmful use of alcohol and other drugs is one of the greatest risks to health and wellbeing – affecting individuals, families, whānau, communities and society. Harmful consumption contributes to health and social inequalities and is among the foremost underlying causes of disease including mental health issues, injury, family violence, fetal harm, disability and premature death. The 'prevention paradox' is that the majority of substance-related harm occurs in populations who consume only small amount of substances (mostly alcohol).

The collaboratively developed Model of Care proposes a whole-of-population approach to reducing substance-related harm, by enabling early intervention in places that work for the people experiencing and exposed to the harms.

The graphic incorporates the subregion's prevailing wind, waves and sea. At the heart of the Model of Care are people, whānau and communities.



Te Tiriti o Waitangi

Te Tiriti is a statement of individual and collective rights, a charter for New Zealand as a whole, and a reminder to Government, and its agencies of their collective obligations in respect of the Tāngata Whenua of New Zealand. Our DHBs have obligations to the mana whenua of the subregion to:

- ensure that health outcomes for Māori are equal to those of non-Māori
- provide for Māori self-determination and mana motuhake in the development, design, delivery and monitoring of health services
- provide for and properly resource kaupapa Māori health services, offering kaupapa Māori services and supports first to those who identify as Māori to ensure choice
- ensure that all health services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care

- work in partnership with Māori, including Māori with lived experience of addiction, and Māori AOD providers, indecision-making, development, design, delivery and monitoring of health and disability services.

Principles

The Model of Care recognises the following principles:

- People, whānau and communities with substantially improved wellbeing through equity of access and outcomes, for those with the greatest need.
- Sector partners working inclusively and respectfully to create a person, whānau and community-centred system of a care using integrated and collaborative approaches.
- A system of care that is visible, easy to navigate, accessible earlier, and closer to home.
- Effective use of resources, with an innovative approach to technology-use.
- High quality, safe services based equally on evidence and culturally informed best practice.
- A thriving and skilled workforce.[5]

Scope

The Model of Care takes a life-course approach and includes those exposed to and experiencing substance-use harm 'from the womb to the tomb' recognising that the nature and degree of substance-use harm varies considerably across the life-course and requires evidence-based, tailored services and supports.

The Model of Care takes a whole of population approach and responds to the full continuum of substance-use harm from people who are not currently experiencing harm through to the services and supports for people with severe substance use disorders.

The Model of Care promotes a systems approach to service delivery emphasising integration (service connectedness and collaboration) across the whole continuum of care to achieve better outcomes for both people and their families and whānau; individual services; and the AOD system of care.

The Model of Care does not include services and supports for those experiencing solely gambling-related harms, or other behavioural addictions. The Model of Care is however recovery-focused emphasising a holistic approach and the importance of working collaboratively with all relevant services and supports including other organisations providing these services.

Implementing the Model of Care will require new investment and reinvestment in reconfigured services to increase the AOD sector's capacity and capability. The Model of Care recognises that service reconfiguration includes the decommissioning of services.

Definitions

Evidence includes non-traditional evidence including the ways of knowing, doing and understanding the world of Māori (mātauranga Māori), Pacific peoples and those with lived experience of AOD issues.

A **peer** is someone who has had similar experience to another person or people, such as **a lived experience of addiction** that has had a significant impact on a person's life.

[5] Agreed by the AOD Model of Care Steering Group at their meeting on 18 April, 2019.

The service user, consumer and **peer workforce** include all people with openly identified lived experience of mental distress or addiction and recovery. They can be in paid or unpaid employment and use their experience to benefit others with mental distress or addiction in the work they do.

Recovery is a process of change in which people improve their health and wellness, regain control over their choices, live happy lives, and reach their full potential.

Specialist services are services that provide AOD care that cannot be provided in primary care settings.

The Model of Care defines **substance-use harm** as any pattern of substance use (including alcohol use) that causes harm to individuals, whānau and communities and recognises all harms including those that are subjectively identified by people, whānau and communities.

Key Components of the Model of Care

The Model of Care has five direction-setting and overlapping components:

1. Driving equity of access and outcomes
2. Privileging the voice and contribution of those with lived experience
3. Growing a whole of population approach
4. Building a recovery-focused system of care
5. Working collaboratively.

1. Driving equity of access and outcomes

Equity is a human right that is embedded in the legislative frameworks of health, specifically the New Zealand Public Health and Disability Act 2000. Establishing equity is a core commitment for all three of the subregion's DHBs.

Māori experience the highest levels of mental illness and addiction (MHA) of any ethnic group in New Zealand. Pacific peoples also experience MHA at higher rates than others with 25 percent experiencing MHA in a given year compared to 20 percent overall. The harm is more common for Māori and Pacific peoples and people facing socio-economic disadvantage because these groups have less access to support, are more likely to live in poverty, and to be disabled.

The intergenerational effects of colonisation including loss of land, language and culture and the ongoing experience of institutional racism and ableism perpetuate disadvantage and poor health and other outcomes for Māori, Pacific people and people with disabilities – the priority populations. Many people identify with more than one disadvantaged group compounding their health burdens.

Overview: Equity Goal, Definition and Principles

The Hutt Valley DHB and Capital & Coast DHB Board have endorsed an **Equity Definition**, an **Equity Goal** and **Equity Principles** in response to the breadth of inequities experienced by Māori, and our priority populations: Pacific peoples and people with disabilities.

These Equity fundamentals were developed by a Steering Group and are the product of extensive engagement with partner and stakeholder groups.[6]

The Equity Definition, Equity Goal and Equity Principles provide a framework for action and will be supported by a policy framework, an education and communication strategy, and ongoing monitoring and review.

[6] The Māori Partnership Board, the Sub-Regional Pacific Strategic Advisory Group, the Sub-Regional Disability Advisory Group and the Citizens' Health Council.

Equity Definition

In the Hutt Valley and Capital and Coast districts, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

Equity Goal

To achieve health equity by 2030, as measured by:

- consumer input, access, quality, experience and direct results.
- influence on fundamental causes and social determinants.

Equity Principles

1. Privilege their Voice	**Amplify and value the voice of individuals and whānau from priority groups. Put them at the centre**. Seek out and give favourable treatment to their views. Ensure these sit at the heart of information gathering and decision making – in strategy, policy, process, service design and delivery.
2. Focus on Whānau	**Expand the focus from individuals to include the family unit**. Design and deliver services that are oriented not just to individuals – but also to their whānau and household realities and circumstances. Explore and design so as to mitigate confounding factors to good health in the whānau environment.
3. Empower Consumers (Rangatiratanga)	Actively work to **empower individuals, whānau and communities to take control of their health, and become agents of their own change**. Foster their mana motuhake (autonomy, independence, self-management). Share power, influence and decision-making over the design, delivery and governance of health services.
4. Prioritise Access	Prioritise service access, quality and experience - by adapting service strategy, policy, process, design and delivery to ensure key services for individuals and whānau from priority groups are available, accessible, affordable, acceptable and appropriate.
5. Offer Kaupapa Māori (and equivalent) Options	**Transform health services by developing and fostering Kaupapa Maori services** alongside generic service models - to enable choice for Māori, Pacific, Disability, other priority group consumers. Kaupapa services cover models of care and services designed and delivered by Māori, Pacific, Disability and other priority groups for all. Equally, hold general healthcare models and services accountable for transforming and prioritising culturally safe care that caters for Māori and other indigenous traditions and worldviews, and disability worldviews, in ways that address disadvantage in care access or quality.
6. Invest Proportionately	**Intensify care for those who have less resources and experience the greatest levels of avoidable poor health**. Deploy reasonable additional resources where required, proportionate to address the inequities that exist.
7. Challenge Discrimination	Advance an environment of open communication, supported inquiry, learning and development around discrimination in all forms, including racism, ableism and bias. Support employees and partners in the conversation. Call out conscious and unconscious discrimination on all levels - personal, institutional and structural.

The Model of Care requires that all AOD workforces including managers, clinicians, support-workers and health commissioners adopt a pro-equity approach to their work. Being pro-equity means actively challenging the status quo at every step, and committing to redistributing resources (for

example, budgets, services and supports, networks) that are within each team and worker's control or sphere of influence in order to achieve health equity.

The Model of Care includes the development of 5 Priority Pathways to facilitate commitment and action to redressing inequities (see page 15, The Priority Pathways, and Appendix One). The Māori and Pacific priority pathways are maps for designing, producing and delivering culturally responsive and safe services and supports.

2. Privileging the voice and contribution of those with lived experience

Peer work benefits the people who use services, the peer worker and the organisation. Peer support worker roles can provide effective acute care and help maintain recovery. The contribution of those with lived experience comes in many forms including consumer advisors who provide strategic and operational advice to design, develop and improve services, educators, researchers, evaluators, auditors and peer supervisors.

This second component of the Model of Care, 'Privileging the voice and contribution of those with lived experience', is an enabler for the first component 'Driving equity of access and outcomes' in particular Equity Principle 3. 'Empower Consumers'. The voice and contribution of our priority populations: Māori, Pacific people and people with disabilities with lived experience of addiction is needed in all parts of both the evolving continuum of care and the system of care.

The Model of Care recognises the need to grow the peer workforce and create flexible access pathways to increase individual and family and whānau access to peer support. The Model of Care also recognises the importance of developing sustainable, funded peer services with equitable pay and conditions of employment.

The Model of Care privileges the voice of Māori whānau recognising the interdependence and interconnectedness of whānau is central to wellbeing, both individually and collectively, and supporting whānau well-being is essential for recovery. Listening to the voice of whānau, means valuing and prioritising both the autonomy and the collective wellbeing of whānau.

The Model of Care will help drive whānau ora approaches recognising that it is the right way to deliver holistic care and is closely aligned to a whole of population response to need. Whānau Ora encompasses the diverse needs of all population groups, particularly, developmentally specific needs across the life course.

Together the voices of those with lived experience and whānau, communicated using codesign principles, will inform how services are developed within the Model of Care and define the investment and planning priorities.

3. Growing a whole of population approach

The harms that result from AOD use exist on a continuum from no harm to severe addiction. Some people use substances recreationally with none or only minor harms resulting. At the other end of the continuum is severe dependence that exacts a heavy toll on individual health, wellbeing and life-expectancy as well as family, whānau and community wellbeing and functioning.

Addiction treatment services have been primarily focused on those with moderate to severe problems. This means that mild problems can progress to the point where they are much harder to address, in part because of the sometimes-devastating personal losses sustained along the way - the consequence of growing reliance on substance-use and increased tolerance of the ill-effects.

The Model of Care takes a whole-of-population approach recognising the continuum from no harm to severe harm and aims to grow a system of care that responds to the greatest need across the continuum.

The Model of Care recognises the need for innovative harm minimisation approaches across the continuum of care; and the importance of establishing an evidence-base (that recognises both traditional and non-traditional forms of evidence) for new and reconfigured services.

The whole of population approach requires our DHBs to commit to investment in a full range of evidence-based approaches, including tailored programmes for priority groups, as follows:

- programmes to influence the social determinants of health and support the creation of healthy environments
- health promotion activities to educate and increase awareness to reduce AOD harm
- primary and community care
- specialist services.

Whole of population: addressing the social determinants

Addiction is a complex and challenging condition with many contributing factors. Successful behaviour change depends on consideration of the physical and social environments in which people live, work, and play.

The person's exposure to longstanding psychosocial stressors and their physiological response to their environment has a big influence on treatment outcomes. It is essential that immediate needs such as housing, mental and physical health, and income support are addressed in parallel to treatment for AOD problems. Interaction with the criminal and family justice system can be important to support people with legal problems including addressing family violence (both perpetration and victimisation).

The Model of Care promotes the strategic alliances and collaborative approaches that are needed to underpin the services and supports that can improve access to the determinants of health.

Whole of population: health promotion prevention and education

The Model of Care requires an increased focus on collaboration with existing national, regional, and local health promotion and education programmes to raise awareness of harms and harm reduction supports and services. It is important that these activities are tailored for those groups experiencing the greatest harms.

Whole of population: primary and community care

The Model of Care requires increased capacity and capability for screening and brief advice to intervene early in health, criminal justice and social service settings to prevent substance-related harms.

A range of primary and community services are needed to effectively meet the needs of the whole of population with a particular focus on Māori, Pacific people, young people, people living rurally and/or remotely and to meet the broader health care needs of people with severe addiction.

The Model of Care focuses attention on developing effective working relationships with primary and community health services and building strategic alliances to provide timely and seamless access to AOD services and supports.

Whole of population: specialist services

The Model of Care recognises the broad array of accessible, high-quality specialist services that are needed to undertake responsibility for the care of those at greatest risk.

The specialist service part of the continuum is located mainly in community treatment settings, with programmes focused on recovery, support for safe withdrawal, intensive outreach, social detoxification, whānau support, and access to inpatient or residential treatment.

The programmes delivered by specialist services target prioritised parts of the community, for instance services for young people, co-existing problems and Kaupapa Māori programmes of care including support for whānau.

Whole of population: visual

The concentric circles visual has people at the centre surrounded by their main sources of support: families and whānau and support networks.

Next, community and primary services provide an early response in places close to where people live. Then, the priority pathways of care layer (for Māori, Pacific people, young people, people living rurally/remotely and people with severe problems) are maps that recognise inequities of access and outcomes and support the AOD sector to integrate to provide the necessary services and supports for Māori and the priority populations.

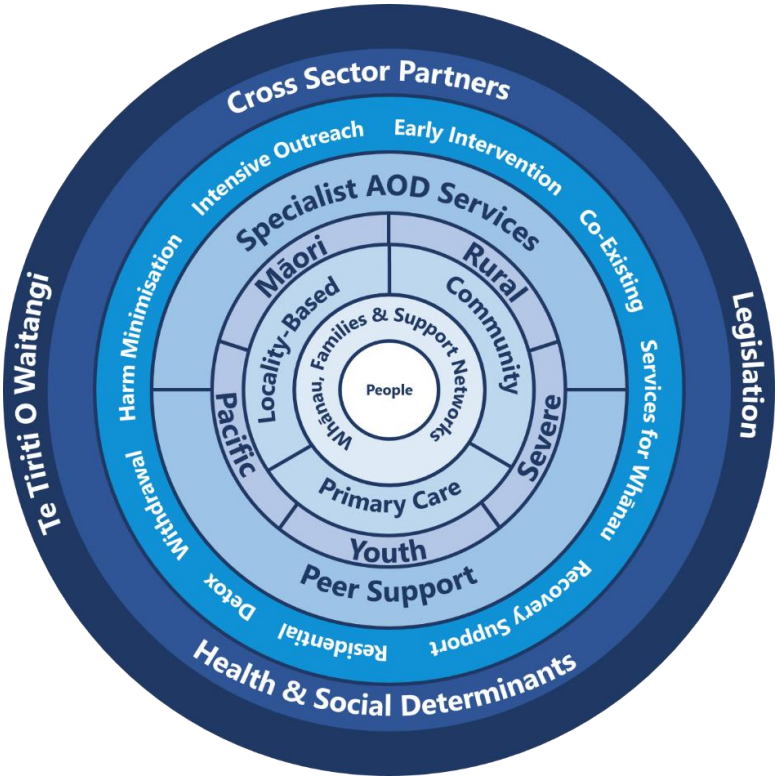
The next two layers depict the integrated AOD sector − specialist secondary, specialist community and peer-based services. The integrated AOD sector has the capacity and capability to deliver a range and choice of interventions and resources (including harm minimisation and recovery support) in a holistic response to the unique needs of the person in recovery.

The penultimate circle recognises the importance of cross-sector partners in preventing harm and supporting recovery and wellbeing.

The outer circle signals the AOD sector's obligations to mana whenua under the Treaty of Waitangi and the broader legislative framework within which the sector operates.

The ever-widening circles can also symbolise the dynamics of substance-use, the continuum of substance-use related-harms and the fluidity needed in the service response.

Finally, the visual references the ripple effects of the recovery journey that first improves the life of the person in recovery, and next the lives of their families and whānau and support networks, and then, rippling outwards. ultimately contributes to the wellbeing and functioning of the whole.



4. Building a recovery-focused system of care

Addiction treatment services provide acute treatment and care for people with moderate to severe problems in times of crisis, and ongoing management including continuing treatment for a small group of people with the most severe problems.

Clinical interventions that treat, stabilise and minimise the harmful effects of substance use are an important part of the recovery journey but cannot restore social losses, or address the factors that reinforce substance dependence creating vulnerability to relapse such as unstable relationships, housing need, unemployment and involvement in crime.

There are multiple pathways to wellness and the Model of Care signals a shift away from an exclusive focus on clinical interventions towards addressing the long-term supports that will support people to concentrate on their recovery, reduce substance-related harm and build meaningful lives.

The Model of Care emphasises that a focus on recovery is important on every part of the continuum of care. Services and supports are there to empower people to define what recovery means for them and to assist them to achieve their recovery goals while addressing both the determinants of health and continuing care needs.

A recovery-focus is holistic and consistent with Māori health and wellbeing frameworks including Te Whare Tapa Whā and Whānau Ora that recognise the relationship between mana, whānau and whanaungatanga and their vital connection to individual, whānau and community wellbeing.

The Model of Care needs to build innovative systems and services that support activities that exist outside of the traditional remit of treatment and build the evidence-base for what works. This will include:

- a network of peer support including peer-led recovery groups
- engaging the wider community to reduce stigma against people who have experienced substance misuse problems
- drawing on the assets and resources that exist within communities to grow these communities and build the self-esteem of the people in them.

Recovery capital

The concept of 'recovery capital' is helpful for understanding the process of recovery. Recovery capital is the extent and quality of resources that can support an individual through the initiation and maintenance of their recovery. Resources can be both internal (such as family support, or a skill or occupation) and external (such as access to secure accommodation and transport). The role of AOD services and supports is then to promote individual resilience, increase intrinsic and extrinsic resources and minimise external risk factors.

Relapse and harm minimisation

The Model of Care understands the value of relapse because of the role it can play in strengthening an individual's resolve to change as both they, and their family and whānau, gain familiarity with triggers and experience in dealing with setbacks. Relapse can however result in people giving up on their recovery journey.

Services and supports in the Model of Care emphasise the learning opportunity presented by the relapse and recovery cycle, and when there are setbacks provide timely access to both formal and informal supports, to reduce their duration and severity.

The Model of Care understands that for some people harm minimisation is a stage on the recovery journey and for others it is a recovery goal. Self-defined milestones and goals can and often will change. For example, long-term opioid substitution treatment provides a platform of stability and safety that enables many people to live meaningful lives. Other people will use short-term treatment as a springboard for a managed reduction and eventual withdrawal.

Peer support

The Model of Care recognises that the peer workforce is uniquely equipped to provide ongoing, recovery-focused support that is complementary to treatment. Peer support workers are role models for a life in recovery, and the experience of supporting the recovery of others can provide hope and motivation for sustaining their own recovery.

Peer support has many benefits for people in recovery. It can improve relationships with providers and social supports, increase satisfaction with the treatment experience, reduce rates of relapse, and increase retention in treatment.

5. Working collaboratively

The importance of working collaboratively both within health and across community, social and justice services is a strong emphasis in all the Model of Care components but, especially in 3. 'Growing a whole of population approach' and 4. 'Building a recovery-focused system of care'.

People's needs can include housing, employment, education and training as well as liaison with the criminal and family justice system. Unmet psychosocial needs can be a barrier to recovery and compounding barriers can make accessing services and supports impossible for people, especially when they are socially and economically marginalised.

The Model of Care recognises that services and supports are fragmented and disconnected and vertical and horizontal integration across AOD services, the wider health sector as well as integration with other agencies are key enablers for implementation. This includes ensuring a shared philosophy of treatment and commitment to sharing resources to meet population need.

Establishing a mechanism for collaboration between AOD providers is essential to supporting the Model of Care's ambition to take a whole of population approach and ensure that priority pathways for targeted populations are fully integrated.

The collaboration of the AOD sector will ensure there is awareness of the range of interventions and available, clear pathways for transition between services as well as people-centred services that understand where people have come from and help them seamlessly transition on towards recovery.

The Priority Pathways

The five priority pathways for main groups of AOD service users complement the Model of Care. They are designed to ensure that we are responding to those with the greatest needs and providing early intervention both in the life-course and in the life of the problem. The five priority pathways are still draft and are included as an Appendix to the Model of Care.

The priority pathways are essentially maps for AOD health professionals so they can see at a glance key considerations that will help them to tailor services and supports that respond to the needs, aspirations and cultural frame of reference for people presenting from one (or more) of these five groups:

1. Māori
2. Pacific people
3. Young people
4. People living rurally and/or remotely
5. People with severe problems.

The priority pathways are being developed with the communities they are designed to serve using co-design principles and the data and insights that informed the Model of Care project.

Common themes

Each priority pathway links to all the other priority pathways.

People have a choice of priority pathway or can use more than one pathway.

All the priority pathways identify the social, cultural and economic determinants of health that contribute to people needing help and the health, social and other partners and agencies that are part of the wider system of care.

All the priority pathways recognise that there are both workforce and technology enablers that are needed for the pathway to work effectively.

Next steps

The priority pathways require further testing with the AOD sector, development and refinement and this will occur as part of the implementation plan for the Model of Care.

Implementing the Model of Care

The Model of Care Steering Group identified the following system and service development priorities:

- the need for collaboration and partnership across the system of care
- the need for an improved ability to evidence impact of interventions
- the need for both flexible funding and service access criteria
- the importance of taking a life course approach to addiction needs
- the importance of both clinically and culturally informed best practice
- the need for increased visibility of the AOD system of care.

These key sector development areas will form the areas of focus for the implementation of the model of care

The AOD Collaborative

A first step is to establish an 'AOD collaborative', as a key enabler for the successful implementation of the Model of Care including the further development of the five priority pathways.

The proposed AOD Collaborative is a provider-led platform to enable the AOD sector to work together to implement the key recommendations in the Model of Care. The collaborative will coordinate developmental activity and integrate the system of service delivery as well as address the challenges and opportunities, including:

- further develop and increase the viability, and equity of access of the Priority Pathways inclusive of outreach and enhanced access locations such as Marae based service provision
- address system of care visibility issues by mapping services along the continuum and providing this to the sector and wider community
- building locality-based service design and delivery aligned to the Model of Care grounded in clinically and culturally informed best practice
- creating a collective workforce plan to address resource and workforce developmental gaps
- developing relationships that enable improved care coordination and service integration
- developing and implementing an alcohol and drug outcomes framework and setting key indicators to measure improved health status when implementing the Model of Care.

The aim of the AOD collaborative is to develop a collective provider response which more effectively meet the needs of people with AOD issues in an integrated approach to service development.

An aligned and second implementation step (step two) will be to identify opportunity for investment and implement proposals as funding becomes available. The following investment has been proposed in response to initiatives from the Ministry of Health.

The enhanced primary and community AOD supports initiative

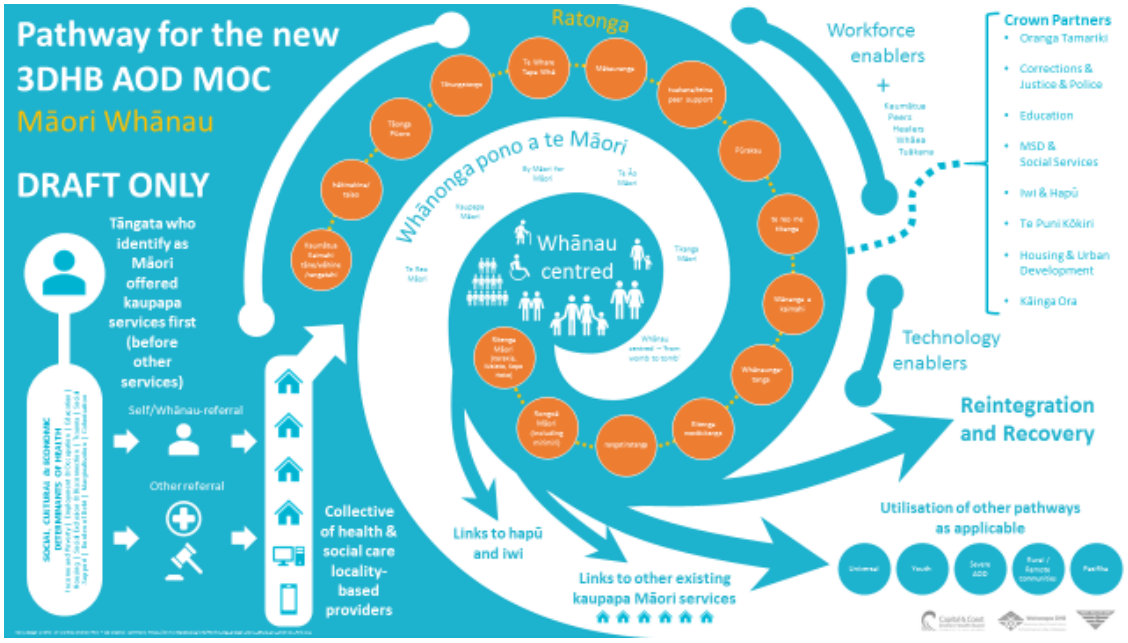
The Ministry of Health invited CCDHB and HVDHB to submit a proposal for investment in order to increase access to primary and community AOD services and supports. The Ministry is supporting the proposal with $3m of investment over three years to establish:

- **Enhanced kaupapa Māori and Pacific counselling services** –accessible, culturally responsive counselling services and supports to address substance-related harm targeted to Māori and Pacific communities and delivered close to home
- **Innovative peer support network and coordination** – providers chosen to deliver the counselling services will also offer the enhanced peer support component to aid wellbeing and recovery. The initiative includes: a peer support coordinator role, the establishment of an AOD peer network, and training and supervision for the peer workers
- **Project management** – to support implementation of the primary and community AOD services and implementation of the AOD Collaborative (see the section above).

This proposal if successful, the new services and supports will be aligned with the Model of Care beginning with establishment of the AOD Collaborative.

Appendix One – Priority Pathways

Draft Priority Pathway 1 – Māori



The pathway is presented as a koru – an unfurling fern frond. The circular shape suggests perpetual movement and the inward coil, a return to the point of origin – in this case whānau. The koru symbolises the way in which life can change, but also how it stays the same. The arrows emerging from the unfurling koru show that recovery is possible at any point on the pathway.

The values that underpin the framework are whanonga pono a te Māori and are shown in the white centre of the koru. The services (Ratonga) that could form part of the services and support are listed in the orange circles. The workforce for this pathway will include kaumātua (elders), peers, healers, whāea (Aunties) and tuākana (elder siblings, senior members of a whānau).

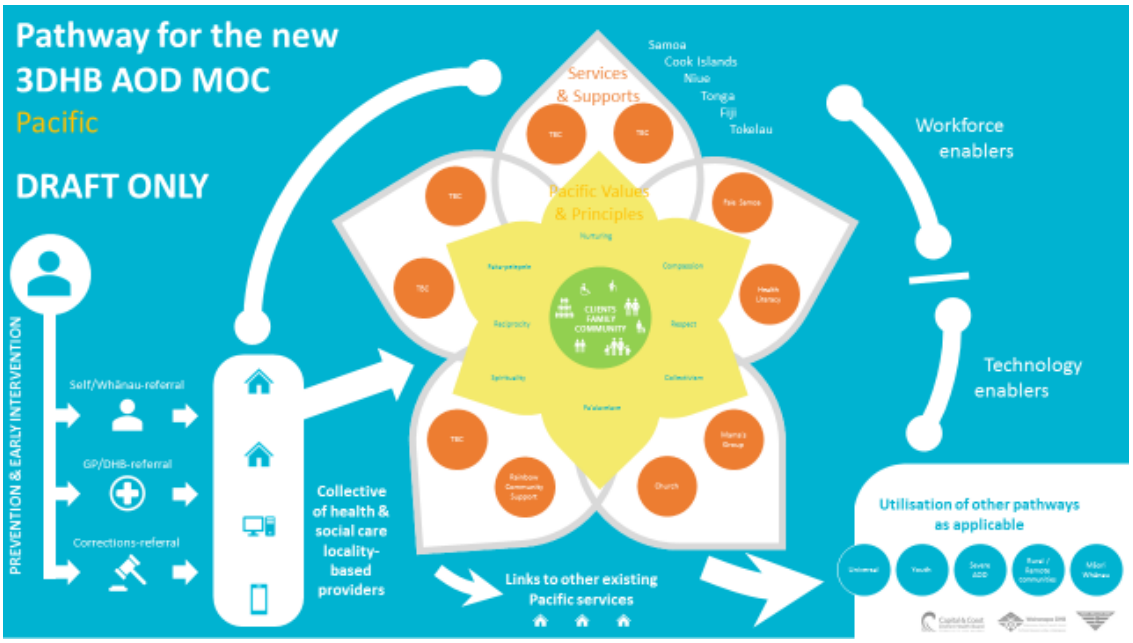
The pathway is whānau centred and offers services and supports across the life course. The pathway emphasises the importance of offering kaupapa Māori services and supports to those who identify as Māori, before offering mainstream services and supports.

Services and supports offered must be provided by kaupapa services who are governed and embedded in te ao Māori. There are also links to hapū and iwi and other kaupapa services.

Anyone can refer to kaupapa services including the person seeking services and whānau. Services and supports are offered via a collective of kaupapa health and social care providers in a community or locality.

For this pathway to function it is vital that it is visible to whānau and community. All doorways into services and supports and workforces will need to understand the requirement to offer kaupapa services and how to support access to them.

Draft Priority Pathway 2 – Pacific people



Pacific peoples is an umbrella term used to describe a population made up of 16 distinct and diverse cultures of peoples from Melanesia, Polynesia and Micronesia. In the subregion the seven largest ethnic groups are Samoan, Tongan, Cook Island Maori, Niuean, Fijian, Tokelauan and Tuvaluan.

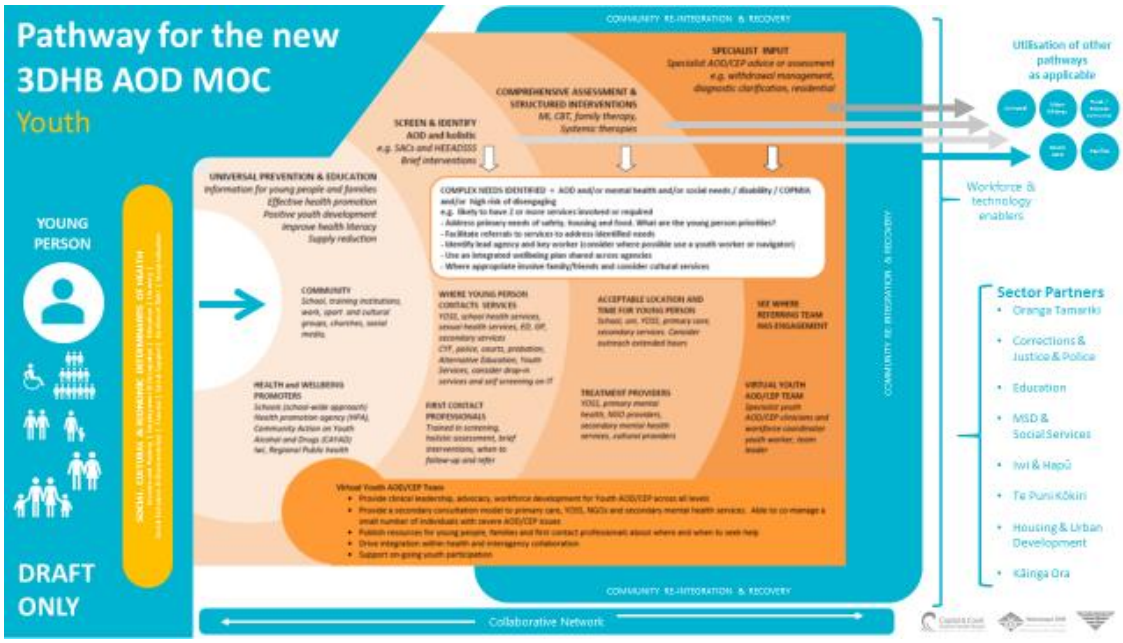
While each of these countries and cultures have their own languages and customs, this pathway attempts to show values and principles that are similar across the Pacific in the yellow centre of the flower and Pacific services and supports are in the orange circles.

The pathway has clients, families and communities at the centre and offers services and supports across the life course. The pathway emphasises the importance of offering Pacific services and supports to those who identify as Pacific, before offering mainstream services and supports.

Anyone can refer to Pacific services including the person seeking services and their family. Services and supports are offered via a collective of Pacific people health and social care providers in a community or locality, by services who focus on Pacific communities.

For this pathway to function it is vital that it is visible to Pacific people. All doorways into services and supports and workforces will need to understand the requirement to offer Pacific services and how to support access to them.

Draft Priority Pathway 3 – Young people



The Youth AOD/Coexisting Problems (CEP) Model of Care was collaboratively developed in 2016 and has been partially implemented.

The young person, their family, whānau and their peers are at the centre of a population-based model that emphasises the importance of universal preventive interventions for all young people.

Young people use alcohol and drugs in potentially harmful ways as part of developmentally appropriate risk-taking and this takes place within a social context that normalises and even celebrates excessive AOD use.

Young people use substances very differently from adults:

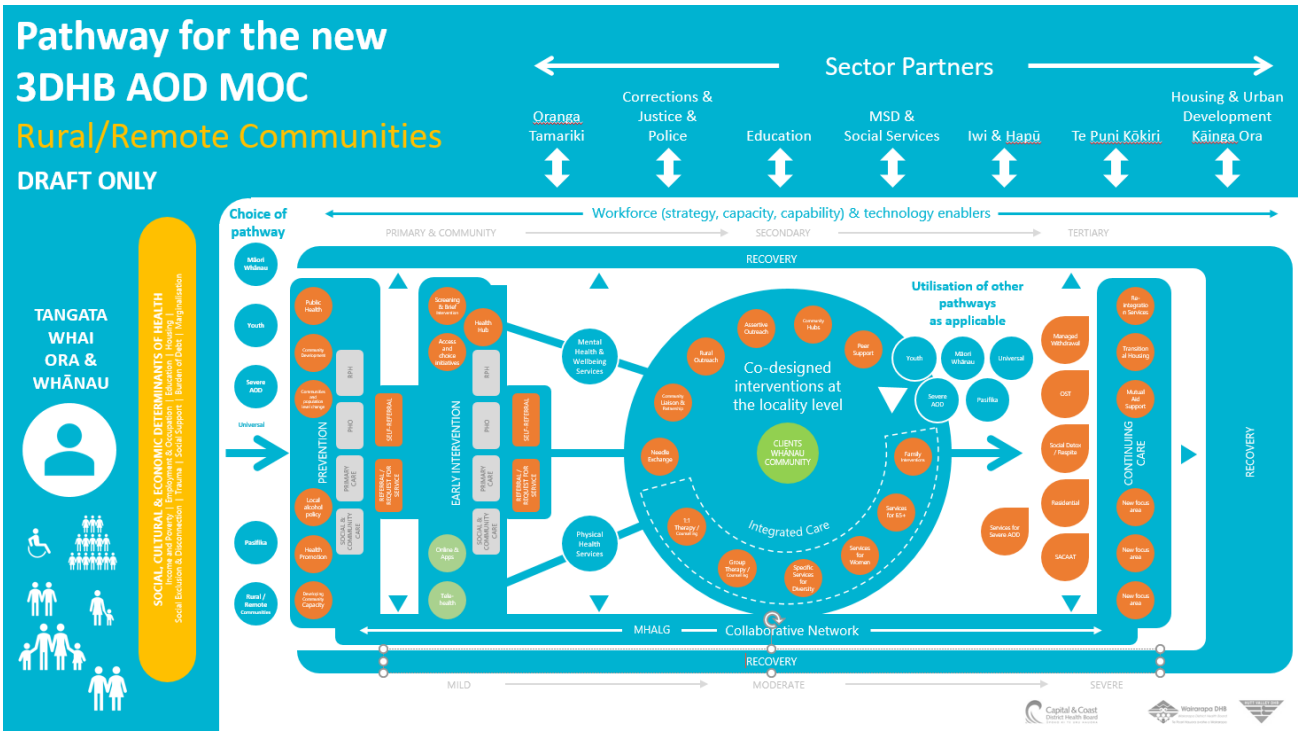
- it is very rare for young people to be substance dependent however, the harms that result from substance use can be higher
- young people will often not understand that their substance use is problematic
- interventions need to be appropriate to the developmental stage of the young person and this does not necessarily correlate with their chronological age
- nearly all young people live within some form of family unit or whānau so it important that services and supports can include family and/ or whānau.

The model draws attention to those young people with complex problems to highlight the limitations of a one-dimensional, severity-based, stepped-care model.

The model recognises that the level of need in young people often fluctuates and the importance of ensuring they can move seamlessly between services.

The model emphasises the importance of the specialist youth AOD/CEP team providing clinical leadership, driving integration and workforce development and ensuring youth participation across all levels of the model.

Draft Priority Pathway 4 – People living rurally and/or remotely

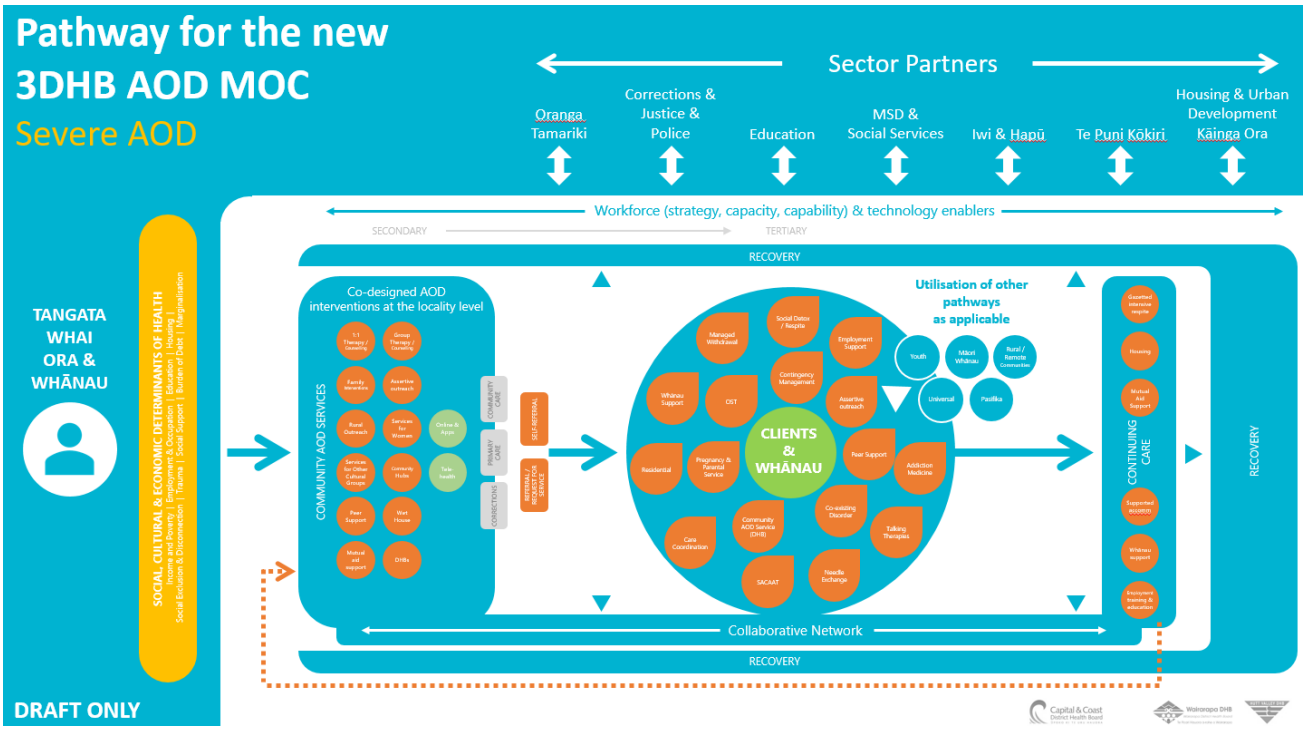


Wairarapa is a rural region and includes some very remote areas and as a result service delivery can be significantly different from the services and supports offered in our other two DHB areas. Assertive out-reach and mobile services are essential and described in the model as rural outreach.

Wairarapa is unique in that all AOD services and supports are provided by two NGO providers: a kaupapa Māori provider, and a mainstream provider (also the only NGO provider of opioid substitution treatment services in New Zealand). These small NGO providers need to cater to diverse groups in terms of both age and ethnicity. The model describes this as integrated care.

Wairarapa providers and providers in other rural areas need to work closely with other health providers and other sectors to utilise places where people already go to access support. For example, services and supports can be provided from GP clinics, community services or churches. The model describes this as community liaison and partnership.

Draft Priority Pathway 5 – People with severe problems



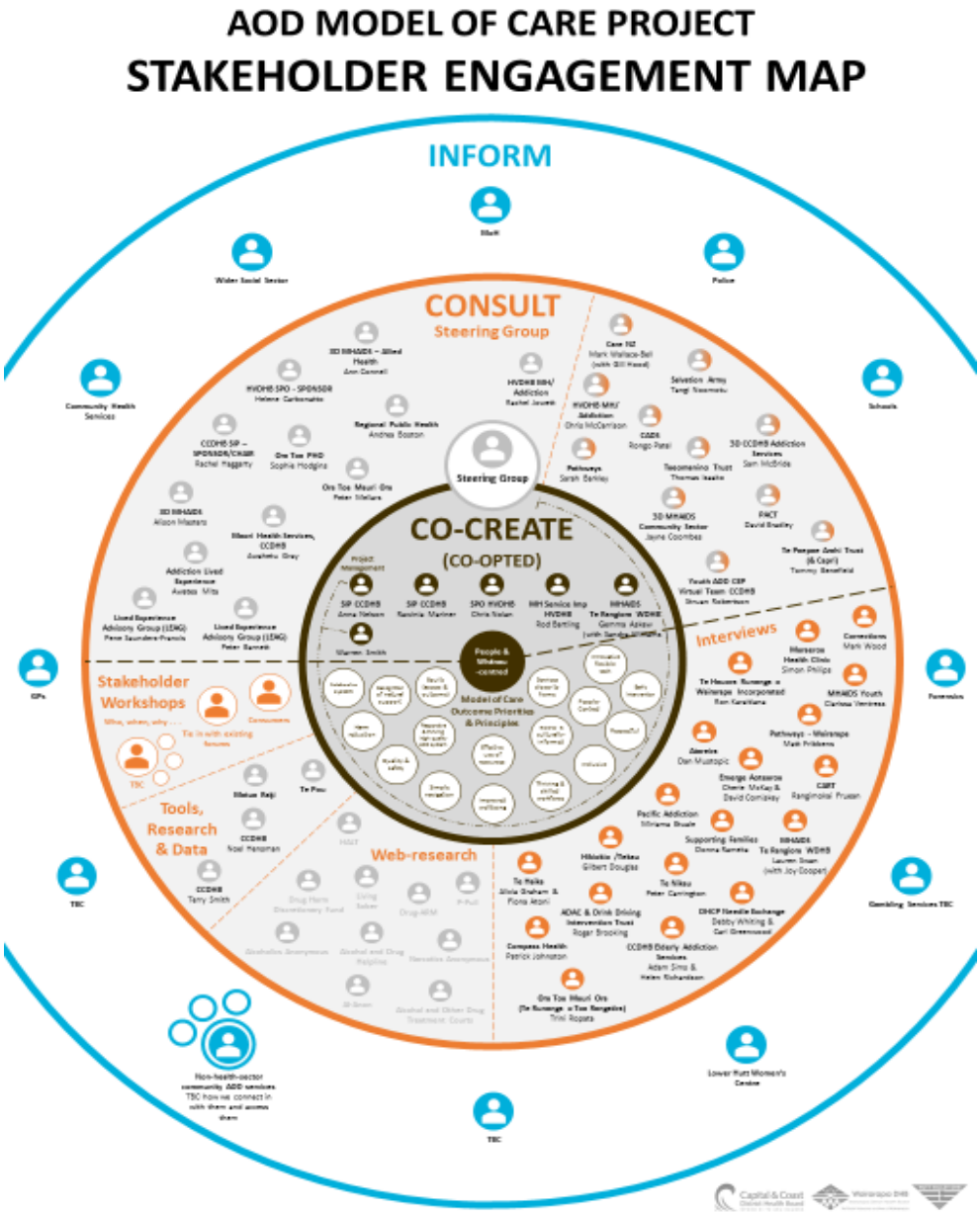
Services for people with a severe addiction or substance use disorder are very limited across the subregion. The new Substance Addiction (Compulsory Assessment and Treatment) Act 2017 enables people to be committed for addiction treatment to a Canterbury treatment centre. There are very few housing or support options for housing or support for the high needs group of people returning to the subregion following release from compulsory treatment.

Recent investment in AOD treatment services has been in primary and community services. Most people with severe addictions are supported by secondary services in DHBs and additional investment in these services is needed to support this group.

The priority pathway model shows the services and supports that this group needs and the system of care. Crucial to the effectiveness of this pathway is the availability of supported housing options and a gazetted intensive respite service. Unique to this pathway are the following services and supports:

- outreach and innovative approaches of care
- residential treatment services
- addiction medicine
- neuropsychological assessment
- specialist psychological therapies (for example, Motivational Interviewing, Cognitive Behavioural Therapy, Dialectical Behaviour Therapy)
- contingency management
- managed withdrawal.

Appendix Two – Stakeholder Engagement Map



Disability Support Advisory Committee

28 April 2021

3DHB – Mental Health and Wellbeing Strategies Update

Action Required

3DHB Disability Support Advisory Committee note:

(a) The subregion's *Suicide Prevention and Postvention Action Plan* has been refreshed to align it with the Government's *He Tapu te Oranga o ia Tāngata: Every Life Matters – Suicide Prevention Action Plan 2019-2029* and the subregion's Māori Health and Pacific Health strategies.

(b) The Suicide Prevention and Postvention Action Plan governance group has endorsed the *Suicide Prevention and Postvention Action Plan* and the Plan will be presented to DSAC for endorsement at its May 2021 meeting.

(c) The good progress implementing a broad range of initiatives under *Living Life Well A strategy for mental health and addiction 2019-2025* in three service domains: whole of population; primary care; secondary specialist services; and in both the subregion and central region.

(d) The collaborative, networked approach to implementing the subregion's refreshed *Suicide Prevention Action Plan* in four service domains: health promotion; prevention; intervention; and, postvention.

(e) The roll out of COVID 19 vaccination to mental health and addiction clients partnering with our NGO and other lead providers.

Strategic Alignment	*Health System Plan 2030* *Living Life Well A strategy for mental health and addiction 2019-2025* *Taurite Ora Māori Health Strategy 2019-2030* *Te Pae Amorangi Maori Health Strategy 2018 -2027* *Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025* *He Tapu te Oranga o ia Tāngata: Every Life Matters – Suicide Prevention Strategy 2019–2029* *Suicide Prevention and Postvention Action Plan*
Authors	Chris Nolan, Acting General Manager Commissioning, Mental Health & Addictions Catherine Inder, Principal Advisor, Strategy, Planning and Performance
Endorsed by	Rachel Haggerty, Director SPP Fionnagh Dougan, Chief Executive
Presented by	Chris Nolan, Acting General Manager Commissioning, Mental Health & Addictions Sandra Williams, Executive Leader Planning & Performance, Wairarapa DHB NGO partners and AOD partner clinical staff
Purpose	This paper provides brief updates on the implementation of our DHBs' mental health and wellbeing strategies: *Living Life Well* and the *Suicide Prevention and Postvention Action Plan*.
Contributors	Emma Fursman, Suicide Prevention, Mental Health and Addictions, SPP

	Kate Stewart, Project Manager, Mental Health & Addictions, SPP Nathan Brown, Senior Health Insights Analyst, Analytics, SPP
Consultation	N/A

Executive Summary

Living Life Well and the *Suicide Prevention and Postvention Action Plan* together set the direction for the subregion's mental health, and addiction services to improve outcomes and address inequities for people experiencing these significant challenges to their wellbeing. The *Suicide Prevention and Postvention Action Plan* has been refreshed to align it to the Government's *He Tapu te Oranga o ia Tāngata: Every Life Matters – Suicide Prevention Strategy 2019–2029* and the subregion's Māori Health and Pacific Health strategies and *Living Life Well*.

Both *Living Life Well* and the *Suicide Prevention and Postvention Action Plan* take a whole of population approach to implementing change and include initiatives that span the continuum of need including health promotion, prevention, primary care and secondary specialist services. Both plans take a collaborative, networked approach working closely with partners, communities, other health and social services and people with lived experience and their families and whānau.

Highlights in this report include significant progress developing:

- primary care liaison services including funding to increase access to primary health care
- the Access and Choice primary mental health service with 16 additional FTE supporting people with their mental wellbeing
- the Acute Care Continuum with enhanced respite services including a tailored respite option for older-aged people in crisis
- capacity and capability in Emergency Departments (also part of the Acute Care Continuum) responding to people in acute distress, with plans to expand this to other settings
- a step-down forensic kaupapa Māori service located in Porirua
- a proposal for investment to funding resources in crisis resolution services for people with a hearing disability.

Strategic Considerations

Service	Mental Health, Addiction and Suicide Prevention and Postvention services
People	The resourcing schedule is part of the operating budget for 2020/21.
Financial	The resourcing schedule is part of the operating budget for 2021/2022.
Governance	The Governance of this work is supported by SPP and MHAIDS.

Engagement/Consultation

Patient/Family	Lived Experience Advisory Group
Clinician/Staff	A wide range of clinicians are engaged in developing models of care and service delivery.
Community	Engagement with community providers via the Collective Forum

Identified Risks - None as this is an update.

Attachments - None.

Introduction

Purpose

1. This paper provides brief updates on the implementation of our DHBs' mental health and wellbeing strategies:
    - *Living Life Well a strategy for mental health and addiction 2019-2025* (*Living Life Well*).
    - *Suicide Prevention and Postvention Action Plan*.

Context

2. This Disability System Advisory Committee (DSAC) paper is complementary to the accompanying *Alcohol and Other Drug (AOD) Model of Care and Priority Investment* paper dated 28 April 2021. DSAC received the in-depth paper, *Acute Mental Health Integrated Service Response*, about the Acute Care Continuum in our 3DHBs (subregion) on 18 December 2020.
3. These recent papers provide detailed, contextualising information about the people who experience mental health and addiction (MHA) challenges.

Our Mental Health and Wellbeing Strategies

4. *Living Life Well* aims to transform the MHA system to one that can intervene earlier, both in the life course and when issues arise. Meeting needs earlier will create a positive feedback loop where reduced demand on secondary specialist MHA services will enable us to focus on improving access for first-time service users, and increase efforts towards prevention, early intervention and population wellbeing.
5. The subregion's *Suicide Prevention and Postvention Action Plan* (the *Action Plan*) has been through a process of alignment with the goals of the Government's *He Tapu te Oranga, Every Life Matters – Suicide Prevention Strategy 2019–2029* and the subregion's Māori and Pacific People's strategies. The Suicide Prevention and Postvention governance group endorsed the refreshed *Action Plan* in February 2021. The *Action Plan* will be shared with DSAC for endorsement at a later date.
6. The *Action Plan* aims to coordinate with existing agencies and services to develop:
    - a programmed and networked response to preventing suicide and addressing harms
    - activities and partnerships that provide a system of consistent interventions to relieve the distress and trauma for significant others, and whānau.

Living Life Well – population based initiatives

7. *Living Life Well* takes a whole of population approach to service development and aims to improve the physical and mental health and wellbeing of a defined population (local, regional or national) and reduce inequities. A population based approach includes actions that reduce the incidence of ill health; deliver appropriate health and care services; and address the social determinants of health. Implementing a population based approach means working closely with partners, communities and both inter and cross-sector.

Population Outcomes Framework

8. On 27 August 2019, DSAC endorsed an indicative population outcomes framework (the Outcomes Framework) to support *Living Life Well*. The Outcomes Framework includes an indicator set designed to capture shifts from a medical model to a holistic, person-centred

approach responsive to the social determinants of health. The Outcome Framework is based on three key result areas:

- Mauri ora / health status
- Whanau ora / social wellness
- Wai ora / healthy living.

9. The team has developed an integrated reporting framework to monitor the community health networks' 2021 focus areas: people accessing primary care (all-ages); young people; Māori and Pacific people; and, people with ongoing MHA issues, while the Outcome Framework is being developed.
10. The MHA team will provide you with more information regarding the implementation of the Outcome Framework in future updates.

Living Life Well - primary care initiatives

Primary Care Liaison Service

11. The primary care liaison service is a new initiative to address a service gap for people with moderate to severe mental health issues who mostly present in primary care settings. The services aim to create an effective and productive relationship between secondary specialist and primary care services to better meet the needs of the moderate to severe group. These primary care liaison services are an essential enabler for the national Access and Choice primary mental health service (Access and Choice) (see paragraphs 15-16 below).
12. The plan is to grow and strengthen an integrated approach to primary care liaison across both CCDHB and HVDHB (2DHBs) through investment in these services and supports:
    - Mental Health and Addiction and Intellectual Disability Service (MHAIDS) has allocated a full time consultant psychiatrist role to the Wellington primary care liaison service. This is additional to the two existing specialist clinical nursing roles in that service.
    - The MHA team is establishing two specialist nursing roles in HVDHB, based in MHAIDS, to match the existing CCDHB roles. The specialist clinical nurses will work with the primary care liaison consultant psychiatrist to grow the capability and capacity necessary for a 2DHB primary care liaison service.
    - There is additional funding to subsidise primary care access for people who have enduring experience of mental health problems, and who may not be able to afford access to general practice.
13. The enhanced secondary specialist support for primary care is to:
    - Support primary care to grow the competence and expertise and the behaviour changes necessary to manage people with moderate to severe needs, in partnership with Access and Choice.
    - Increase capacity and capability to develop and support shared care and transition management plans for people who are more stable.
    - Offer incentives for example, subsidised joint appointments that provide a "warm handover" from specialist services to primary care.
14. For people with MHA issues, the primary care liaison services enable them to build rapport and trust with their primary care provider, as a partner in their care, potentially alongside their family, carers and whānau. It also helps them gain a better understanding of their health

condition and identify the triggers and risk factors for inclusion in a management plan that enables early intervention when there are set-backs.

Access and Choice primary mental health service

15. The MHA team is planning a further expansion of Access and Choice with investment planned for both 2021-2022 and 2022-2023. In its first 6 months, Access and Choice has served 127 people across the subregion including 38 (30%) Māori and 15 Pacific (12%). Porirua residents have utilised Access and Choice at twice the rate of people in other localities in the subregion.

16. Currently the 2DHB investment in Access and Choice will ultimately fund 40 FTE split with 20 Health Improvement Professionals and 20 health coaches. Investment in 2021-2022 will fund an additional 16 FTE evenly split between these two workforces. It will also fund the implementation team supporting all 2DHB primary care mental health teams.

Roll out of vaccination services

17. The MHA team is working with the 2DHB vaccination team on a plan to provide the earliest possible access to COVID-19 vaccination for MHA clients in residential and other services. Plans are well underway to engage with our NGO providers and ensure that a coordinated process enables protection against COVID-19 in line with national priorities.

Living Life Well - secondary specialist service initiatives

Acute Care Continuum services

18. The Acute Care Continuum services provide care to about 1200 people across the 3DHB area. The Acute Care Continuum model of care defines core services which require investment and development to create an improved and better coordinated acute care system response.

19. The programme of work aims to reduce pressures on Te Whare Ahuru and Te Whare Maitairangi, the acute inpatient units that frequently operate at 110% inpatient bed occupancy, by providing alternatives to inpatient care. Acute care continuum services also aim to improve access for people in crisis by developing services which are better aligned to support recovery.

Collective Forum

20. The Collective Forum is designed to create a collaborative approach to service development and integration. The forum includes secondary specialist services, NGO and lived experience leadership. It meets monthly and has made progress across four services: crisis respite; mobile after-hours; older person's crisis respite; and, the inpatient unit (see paragraphs 21-26 below).

Crisis Respite

21. Crisis Respite across the subregion serves 875 people a year, including 178 Māori (20%) and 59 Pacific people (7%). Young people aged 10-24 years, 33% of whom are Māori, make up 15% of people using Crisis Respite services. One NGO provider has purchased a facility to convert to an improved six bed crisis respite facility and the other NGO provider has employed a dedicated project manager to source a facility. Any additional crisis respite developments to respond to locality-based pressures are subject to investment bids.

Mobile after-hours

22. All three large NGO providers are collaborating to provide an improved home support service partnering with specialist clinical services. Mobile after-hours services currently serve 262 people across the 3DHBs, including 71 Māori (27%) and 17 Pacific (7%). Māori and Pacific people from Lower Hutt and Masterton have the highest utilisation rates of the service.

23. The HVDHB population served by the mobile after-hours service is 137 and 37 (27%) are Māori. In HVDHB, NGO providers have developed common pathways and agreements that enable the

service to operate seven days per week to 10 pm and provide follow up to avoid hospitalisation in Te Whare Ahuru. The service is a significant enhancement of small existing services and the number of clients is expected to grow.

Older Persons Crisis Respite

24. In 2020, Crisis Respite services across the subregion served 16 people aged over 65, only one of whom was Māori. Current Crisis Respite providers are not equipped to handle the complex needs of older people and referrals are declined. The HVDHB older people's MHA service has already identified additional clients under their care who would benefit from access to an age-appropriate respite bed.

25. A provider has agreed to develop a prototype crisis respite model of care for older people who are experiencing a deterioration in their mental health, with the aim of preventing any further decline. This is a new service and it is anticipated service numbers will grow post-establishment. We anticipate that access to these beds will enable earlier discharge for those needing lower intensity support before return home.

Inpatient unit

26. The inpatient units across the subregion serve 764 people, including 242 Māori (32%) and 73 Pacific people (10%). The MHA team is supporting investment in a new inpatient unit in HVDHB which will include additional capacity for flexible management of inpatient demand.

Mental Health and Addiction Crisis Support (MHACS)

27. This new project, integrated within the Acute Care Continuum services initiative, aims to develop clinical pathways for people in crisis and their families and whānau to support the delivery of responsive, compassionate and safe crisis care. This project also links closely with the Suicide Prevention and Postvention Programme (see paragraphs 37-41 below).

28. Many people in crisis have contact with both Emergency Departments and the integrated police, mental health, and ambulance service (a mobile response for people in crisis who contact the police). A review of current Emergency Department service issues and gaps (as well as other locations where people present in acute distress) is nearing completion. The project has established two clinical roles in Emergency Departments and is developing links with other crisis service partners.

29. The 2DHB Acute Care Continuum governing group is providing oversight and is responsible for leading the improvement of acute care capability, capacity and outcomes. A working group with broad representation, and a partnership with Maori Health providers, is facilitating the co-design of enhanced acute care clinical pathways and clinical role development. The group meets every two weeks and has finalised a project plan.

Sub-acute transitional places

30. The MHA team is planning to increase investment to support the rehabilitation of people with longer term MHA issues and complex needs. A sub-acute transitional service provider with four beds in HVDHB is keen to offer recovery support and housing. The MHA team is aligning the approach to the Crisis Respite service (see paragraph 14 above) with the provision of double staffing and clinical oversight.

Kaupapa Maori forensic step down service

31. In 2020, the MHA team initiated the procurement of a Kaupapa Maori Forensic 'step down' facility. This facility will provide support for Māori people in forensic inpatient units to transition to lower levels of care. In 2020, secure inpatient units across the subregion served 106 people, 62 (59%) individuals are Māori.

32. A provider has now been contracted to provide this service and a small working party established to progress the service. A full-time, dedicated project manager is assisting the provider to help manage the significant barriers to finding and securing a suitable property.

Proposal for services for deaf people

33. The MHA team is working with the Disability team to put in place MHA services for deaf people as an addition to our investment in mental health services for people with disabilities. The purpose is to re-establish resources able to provide improved communication for people with a hearing disability at the initial point of contact. The proposal for investment will start with funding resources in crisis resolution services.

Living Life Well- subregion and central region initiatives

Wairarapa DHB

34. Wairarapa DHB is implementing recommendations from its review of MHA services within an affordability envelope. It is working with its own, well-established Collective Forum to implement the continuum approach to coordinating acute care and has a plan to redevelop the Crisis Respite service elements such as mobile support.

Regional Mental Health and Addiction Services

35. The Central Region includes Capital Coast (central Wellington), Hutt Valley, Wairarapa, Whanganui, MidCentral (Palmerston North) and Hawkes Bay DHBs. A programme of work to establish a regional system of care for specialist MHA services is underway. The phased work programme aims to support greater equity (particularly for Māori) of access and to improve outcomes across the Central Region.

36. Francis Health Limited have been contracted in the first phase of the work programme and to date have interviewed over 50 stakeholders, including service users and both DHB and NGO providers. The final report due in June 2021 will:

    a. review existing regional service level agreements and funding models for these services

    b. analyse the performance and equity of access and outcomes across the region

    c. identify service delivery improvement opportunities.

Suicide Prevention and Postvention Action Plan

Promotion and Prevention

37. The Suicide Prevention and Postvention (SPP programme) team is taking a locality based approach to health promotion connecting with the key communities and groups within each area, including social sector agencies. The SPP team is working alongside partner services to deliver, promote and support suicide prevention tools, resources and key messages.

38. Prevention is a combination of recognising early signs of distress and having person-centred, culturally appropriate, flexible and wide-ranging support options to meet diverse needs. The SPP programme team will deliver suicide prevention education to support early intervention for a distressed person and whānau. In house prevention programmes will be developed for a diverse range of areas including workplaces, prisons, and education and training settings.

39. Workplace based prevention initiatives will prioritise first responder organisations (Police, Fire, and Ambulance) and health and wellbeing services to encourage the development of greater awareness to drive both informed responses at the point of contact with bereaved whanau and significant others and to develop organisational health and wellbeing.

Intervention and Postvention

40. The SPP programme team approach is guided by people who have experienced suicidal distress. The SPP programme team will work with agencies, services and people with lived experience, Māori, first responders and frontline staff to develop, implement and share best practice and innovation.

41. The SPP programme team aims to strengthen systems to support whānau, families, friends and communities following a suicide to support resilience and reduce the risk of contagion or other suicidal behaviour.

Disability Support Advisory Committee

28 April 2021

3DHB Sub Regional Disability Strategy 2017 – 2022

Action Required

3DHB Disability Support Advisory Committee note:

(a) This report provides DSAC with an update on the implementation of the Sub Regional Disability Strategy 2017 – 2022.

Strategic Alignment	Health System Plan 2030 Living Life Well A strategy for mental health and addiction 2019-2025 (Living Life Well) Taurite Ora Māori Health Strategy 2019-2030 Te Pae Amorangi Maori Health Strategy 2018 -2027 Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025
Authors	Rachel Noble, General Manager Disability
Endorsed by	Rachel Haggerty, Executive Director Strategy, Planning & Performance
Presented by	Rachel Noble, General Manager Disability
Purpose	This paper provides brief updates on the implementation of our Sub Regional Disability Strategy 2017 – 2022.
Contributors	The Disability Team
Consultation	N/A

Background

The Disability Strategy and Performance team supports 3DHB initiatives to provide accessible and inclusive healthcare services to disabled people and their whanau by identifying and addressing inequalities within the DHBs.

The team provides advice across the 3DHBs on policies, strategies and initiatives. It also promotes quality accessible services, reasonable accommodation measures, co-design while also raising awareness through a range of education initiatives. The team also promotes accountability through data and monitoring initiatives.

The key areas of activity are outlined the in the Sub Regional Disability Strategy 2017 – 2022 and includes our responses to the recommendations from the Sub Regional Disability Forum.

Focus Area One: Leadership

Disability Team

At the end of 2020 the Team was sorry to lose David Darling, Senior Systems Development Lead who made the decision to move north. On March 15, we welcomed Moko Mataa into the role. Moko's strengths are in change management so will assist with embedding disability equity practices within DHB practices.

Regional Forums

Planning is underway to hold locality Forums in Kāpiti, Porirua, Wairarapa, Hutt Valley and Wellington. SRDAG members will act as the host for these meetings.

On request from the Sub Regional Disability Advisory Group the focus will be to review the actions requested during the 2019 Sub Regional Forum and to report back on progress so far and expected actions going forward.

Regional Hui and Fono

We are implementing a process to evaluate progress from the perspective of our Maori and Pacific disability communities. The Disability team is working closely with the Maori Directorate and the Pacific Directorate on this evaluation.

Kaunihera Whaikaha are holding a Hui, with an independent facilitator, to review the requests made by tāngata whaikaha at the 2014 and 2019 Sub Regional Disability Forums in Silverstream. In each conference the tāngata whaikaha community raised issues around accessibility to health services. This discussion will determine where progress has been made, where it is stalled and what actions need to be taken and by whom. This discussion will also enable Kaunihera Whaikaha to create a strategy which is likely to form the foundation of the 2022 – 2027 Disability Strategy.

With the Pacific Fono a different approach is being taken. We have engaged with the Oasis Porirua Pacific Disability Group, where we agreed to appoint an independent contractor to review the material collated in earlier Forums, where members of the Pacific Disability Community made calls to improve their access to health services. This will form the benchmark to review actions taken by the DHB to date in response to these calls, and to identify gaps that still need attention.

World of Difference Programme

Following extensive community consultation in 2020, the Disability Strategy Team are working closely with People & Capability to progress the learning design for the 3DHB World of Difference education programme. This programme is a bespoke, organisation-wide education programme designed to shift attitudes, reduce discrimination and improve equity in healthcare for disabled people.

A request for proposal (RFP) is being developed to contract an external learning design agency to develop a comprehensive solution for programme delivery. As the programme needs to be appropriate, accessible and valuable for all DHB staff, the learning design will comprise multiple delivery and content solutions, including face to face and digital options.

The Disability Strategy Team will continue regular consultation and feedback processes with the community regarding programme content and delivery design, and maintain close working relationships with Māori Health, Pacific Health, People & Capability, and Quality, Improvement &

Patient Safety to ensure the end result is a comprehensive, engaging and accessible programme for all DHB staff.

Upon completion of the learning design, a reference group of staff members (the target audience for the education programme) will be established to provide guidance and feedback as delivery moves forward. Initially the programme will be embedded into orientation processes for new staff, and rolled out progressively to groups of existing staff.

Monitoring mechanisms for feedback from staff who have completed the programme and people interacting with those staff will be implemented alongside rollout in order to measure progress and impact.

Because the Disability Strategy Team is a 3DHB team working to the Sub Regional Disability Strategy, this programme is being developed with the intention of delivery across the CCDHB, HVDHB, and WDHB, including PHOs, Allied Health, and Regional Public Health.

Focus Area Two: Inclusion and Support

Data

With the endorsement of the Executive Leadership Team the Disability Strategy team is working to develop a standardised disability question for use in all data collection mechanisms and patient information entry points, so that anyone interacting with the healthcare system can self-report their disability status. This will be a ground-breaking step toward the visibility of disabled people in healthcare. The ability to collect comprehensive data on disability is vital in order to plan, fund, and improve our healthcare services to achieve equity and better outcomes for the disability community.

In order to make sure the question and follow-up process is robust, comprehensive and fit for purpose, a working group is being established to ensure representation from a diverse range of DHB staff, departments and services, and the perspectives of disabled people, their family/whānau, and disability community groups.

Once the wording is determined, the standardised disability question will be mandatory in patient information collection, at all points of entry, and recorded within a patient's electronic file alongside other demographic information.

The lack of access to disability data is a complex, nationwide problem, as discussed and confirmed in the 20DHB data discussion in late 2020. Our Team is showing national leadership in this space, continuing discussions with the Ministry of Health about the potential to include disability status as key demographic information in the NHI system. Very recently the Ministry of Health has advanced the concept of disaggregating NHI data by disability and to develop a patient profile system. We provided advice and continue to be closely engaged with this development.

Alerts

The current Disability Alerts system is very limited, and ineffective as both a data collection tool and method of communicating access needs. The establishment of a standardised disability question and comprehensive data collection will enable the development of a more robust Disability Alerts tool.

If a person self-identifies as having a disability or impairment, a secondary follow-up process to collect more information will be triggered, in order to determine:

- Whether the self-reported disability is related to the primary reason for referral
- What the person's access needs are

- What reasonable accommodations DHB services and departments can provide

The Disability Strategy Team is currently working with 3DHB ICT to explore options for collecting, using and accessing this information so that healthcare staff and services receive information about what a person needs in their own words, and can provide reasonable accommodations.

Initially this process of collecting and communicating access needs information will be embedded into the development of the new e-referrals system; so information will be collected at PHO level when a patient is referred to other services. 3DHB ICT is also committed to finding or creating better tools for accessing and displaying the alert information for both service users and healthcare staff.

As the discussion about national solutions (including NHI system) progresses, the Disability Strategy Team hopes to lead the development of nationally available tools and systems for collecting and displaying alert information. Again, we are working alongside the Ministry of Health to advise on the development of this national resource.

Accessible Public Health Campaigns

The Disability Strategy Team's work to date in designing born-accessible public health campaigns has had a significant impact on the CCDHB approach to planning campaigns. Alongside existing work on the Bowel Screening and Measles Immunisation programmes, the Disability Strategy Team has been involved in planning for the Influenza Immunisation campaign, and the COVID-19 Vaccination rollout.

The Disability Strategy Team is now working to consolidate this work and develop a framework and guidelines for building accessible public health campaigns that can be easily applied to all future campaigns and programmes at the planning stages.

After a series of informal connections with the Regional Public Health team we are now jointly planning a strategy session so we can align our work to create an accessible and inclusive public health service across our region.

Bowel Screening

Further feedback from the Ministry of Health about the Equity plan presented in October 2020 calls it "excellent" and "extremely high quality", with special mention of the inclusion of Disability as a priority group.

Dates for the CCDHB Bowel Screening programme rollout have not been finalised as yet, but work continues to ensure that the Equity plan is implemented effectively when rollout begins. This includes the production of alternate format translations of essential documents, data gathering about frequent complaints and queries received by the national call centre that might indicate common access difficulties, and more focus on outreach and access for disabled Māori and Pacific people.

Measles Immunisation

The Ministry of Health have acknowledged the guidance and leadership of the CCDHB in building accessible public health campaigns. As a direct result of conversations with the Disability Strategy Team, the Ministry of Health have now produced alternate format translations of key MMR Immunisation Campaign materials for use nationwide.

The CCDHB Measles Immunisation campaign team continue to work closely with the Disability Strategy team to ensure their work is accessible and prioritises Disability as a key Equity group. The video produced by the campaign team included NZ Sign Language and audio description transcript.

Influenza Immunisation

Disability Strategy Team representatives are part of a newly established working group looking to secure Ministry of Health funding for Māori-specific immunization outreach and delivery. This funding includes both MMR and Influenza vaccinations, and was used effectively by CCDHB & HVDHB in 2020. The working group intends to incorporate the accessible public health campaign guidance already established by the Disability Strategy Team and increase immunization uptake in two Equity population groups by focusing on outreach, access and inclusion for Māori people with disabilities.

COVID-19 Vaccination

The Disability Strategy Team have been involved from the outset in planning for the rollout of COVID-19 vaccinations in order to ensure an equitable vaccination program for all three equity groups. Good working relationships have been established with other key managers and directors, including the Māori and Pacific Health Directorates, and guidance about accessibility, inclusion and equity for disabled people is being directly sought to inform the planning process.

A COVID Vaccination pack is now ready for our 3 DHBs and also with all 20 DHBs. We are closely engaged with the Ministry of Health however we expect to take on a national leadership role.

Health Passport

My Health Passport (including the express version) is being promoted by our hospital volunteers and Nurse Champions across DHBs. The Nurse Champions network is proving useful, their role initially is simply to promote the use of My Health Passport in their clinical area and to provide us with feedback any disability related issues. They are also in a position to promote the newly launched e-learning module on Disability Equity.

My Health Passport community training rollout has started. Meetings have been initiated with a number of disability organisations and support agencies to train them around what the My Health Passport is and how best to encourage people to use it. A PowerPoint presentation has been prepare for these training that includes information in Easy Read.

Planning is also underway to take the My Health Passport to PHOs.

Focus Area Three: Access

The Accessibility Charter was signed by CC&HV DHB Boards

On April 8 the Accessibility Charter was signed by our Board chair David Smol, deputy chair Wayne Guppy, Fionnagh Dougan Chief Executive, communications and engagement director Helen Mexted, and our chief digital officer Tracy Voice on behalf of both DHBs. We are the first DHB to sign the Charter, and I am very proud of that. It shows how serious we are about making health services accessible and inclusive, so all people are safe and comfortable.

We recognise that by signing the Accessibility Charter we give all our staff the mandate to work toward an accessible environment, both for the people who use our services, and for each other. Our Disability Team has been driving the implementation of the Charter across both DHBs and is working closely with the Communications and ICT teams to bring about a culture of accessibility, so we actively look for ways we can improve.

Our website was audited last year and already we have taken steps to improve our accessibility by addressing some of the issues identified. But there is more work to do. We are also building our skills

and networks so we can provide communications accessible to all – our measles campaign and Te Wao Nui videos are excellent examples of accessible communications in action.

Accessible Information

The most significant activity in this area was to dedicate some resources (hours) to one staff member to produce Easy Read information. This has involved participating in a training programme. The first focus area is the text of the Disability team website page (to be updated).

Children's Hospital

We continue to engage with the Children's Hospital Project team on a number of different focus areas as we are mindful that the majority of the children attending hospital are disabled children and their whanau.

Wayfinding Signage – as wayfinding is a significant accessibility challenge we appreciated the opportunity to bring in members of the disability community to provide feedback on the proposed signs. More than half of the participants were those with low vision. The user experience feedback received was invaluable, and more useful than following guidelines. We appreciated the changes already made by the designers and look forward to seeing the feedback incorporated into the final design.

Branding Launch

As the launch of the brand and the kaitiaki characters is a significant moment we endeavoured to ensure the information was available for the disability community also. With the launch date being March 4, we were able to facilitate the provision of information in the following formats:

- Captions on the video
- NZSL
- Audio description (in text)
- Easy Read

Kaitiaki Name Signs

We workshopped with members of the Deaf Community to develop 'name signs' for the new Children's Hospital in advance of the launch of its name and forest characters. NZ Sign Language is one of NZ's three official languages, Deaf children and adults will access the hospital along with many other children who use NZSL. More and more children are learning NZSL in schools today. We included our Maori Disability Adviser to help us make sure we understood the Maori concept being conveyed when creating individual signs.

To create name signs we had to consider the role and context of the characters and their appearance. I was particularly proud of the sign we collectively created for the new name of the hospital itself – one that totally encompasses all that the children's hospital is to be.

Built Environment

We are currently involved in a number of building projects in a consultative way.

There is a new procedure suite being built as part of the Plastics Unit at Hutt Hospital. We are working closely with the Project Manager and architect to ensure that this unit is built as accessible as possible.

Hutt Hospital is also looking to redesign the Women's Health Service Facility and we are currently in the early stages of working with the design team on this project.

We were also asked to support Kenepuru Hospital in their bid to obtain funding to install a new accessible walkway from Kenepuru Drive up Ambulance Drive to the hospital. There is currently no accessible route to the hospital from the train station.

There are also initiatives underway to address issues around the visibility of the doors to Wellington Regional Hospital. A dangerous pole will be painted so it can be seen by people with low vision.

Focus Area Four: Health

E-Learning Modules

After extensive delays through the development process we are thrilled to say the resource has now been launched. The programme is called 'Disability Equity' and the modules are

1. Disability explained
2. Engaging with disabled people
3. Working with disabled people

Presentations are being made at Nurses Ground Round progressively across all Hospital sites which will provided us with an opportunity to launch the resource and to ensure we communicate the core messages widely across 3DHBs encouraging people to refresh their disability awareness/responsiveness by doing the new modules. Having the Maori Disability Adviser in the team meant we were able to spotlight Tāngata Whaikaha.

Health TV

There is interest in information coming from the disability space so we want profile building blocks and key messages articulating what an inclusive and accessible healthcare service looks like. Health TVs are based in waiting rooms. The Wellington Regional Hospital Outpatients Department recently connected their TVs so we are submitting a variety of slides. It is intended to offer the same slides to the Hutt and Wairarapa DHBs also and more widely including the PHO space.

Disability Toolkit

As the 3DHB's are committed to promoting a human rights-based health care service that is inclusive and accessible so all people feel safe and comfortable the disability team has created a variety of resources for different purposes.

The focus has been on developing the e-learning material therefore it is time now for us to create a Disability Toolkit resource both as a desktop resource and on the intranet (internal for staff).

The intention is to pool our resources into one location that can then be accessed by staff as required. It will also provide directions for accessing appropriate equipment or services as requested by individuals requiring reasonable accommodation.

The resource will reinforce the learnings from the e-learning modules thus providing practice applications.

This idea is based on the Tikanga developed by Cheryl Goodyear and the Maori Cultural Team. It is handed to those who attend Tikanga training plus others as required. The resource is a small flip chart which sits on a desk.

Disability Support Advisory Committee

28 April 2021

3DHB First Draft Annual Plans 2021/22	
Action Required Disability Support Advisory Committee (DSAC) to provide feedback on the CCDHB, HVDHB, and WrDHB first draft annual plans 2021/22 by the end of April 2021.	
Strategic Alignment	The draft annual plans are aligned with the CCDHB Health System Plan 2030 and HVDHB's Vision for Change, the 11 2DHB strategic priorities, and WrDHB's eight strategic objectives.
Presented by	Rachel Haggerty, Director Strategy, Planning & Performance CCDHB and HVDHB
Purpose	Outline the actions planned in 2021/22 to improve mental wellbeing and improve the health outcomes of disabled people.
Contributors	Peter Guthrie, Manager Planning & Performance, Strategy, Planning & Performance CCDHB and HVDHB Nathan Clark, Manager Strategy and Planning, Strategy, Planning & Performance CCDHB and HVDHB
Consultation	DHBs received planning guidance from the Ministry late December 2020 and were required to send their first draft annual plans to the Ministry by 5 March 2021. Now that the advisory groups have arranged their meeting schedules for 2021, consultation with the advisory groups will occur between now and May 2021. The final draft plans are due to be submitted to the Ministry in mid-June.

Executive Summary

1. Each DHB has a statutory responsibility to prepare an annual plan for approval by the Minister of Health. The annual plan is an important part of the Ministry of Health's Monitoring Framework.
2. CCDHB and HVDHB have run a single 2DHB process to develop the first draft 2021/22 annual plans. The CCDHB and HVDHB annual plans are aligned but not identical, as our populations have unique characteristics and needs. We have also worked closely with Wairarapa DHB to ensure 3DHB alignment across our plans.
3. Our first draft annual plans reflect our 2DHB strategic priorities and the Government's planning priorities for health. Our Pro-Equity Approach is incorporated across all our 2DHB strategic priorities. We are currently establishing specific work programmes, budgets, and governance arrangements for 2021/22 to support implementation of our strategic priorities.
4. The plans use the template supplied by the Ministry of Health. Section 2, Delivering on Priorities, includes sections on 'Health Outcomes for Disabled People' and 'Improving Mental Wellbeing'.

Health Outcomes for Disabled People

5. For the 'Health Outcomes for Disabled People' section of annual plan, the Ministry has asked DHBs to include at least one action:
    a) to support COVID-19 recovery and/or embed key learnings from its COVID-19 response
    b) focused on our Māori populations
    c) focused on our Pacific populations.

6. Our draft plans include the following 3DHB actions for 2021/22 to improve health outcomes for disabled people:

    a) Collaborate with the Ministry, DHB staff, community stakeholders and disabled people in each region to develop new Sub Regional Disability Strategy for 2023 – 2028, which will include a specific focus on embedding the learnings from COVID-19. Development of the revised strategy will include targeted engagement with Māori disabled people and Pacific disabled people to advise and help develop tailored actions to achieve equable outcomes.

    b) Implement a process to collect information (eg standardised disability question) from people with disabilities that enables health services to respond to people with disabilities and be culturally responsive to Māori and Pacific people.

    c) Deliver core disability responsive education with the newly completed e-learning programme of three modules that all staff must complete. This programme will ensure that all staff have foundational knowledge about disability; the rights based approach; the importance of attitude and how to make reasonable accommodations building on the gap identified during the COVID response.

Improving Mental Wellbeing

7. For the 'Improving Mental Wellbeing' section of annual plan, the Ministry has asked DHBs to include at least one action:

    a) to support the psychosocial response to and recovery from COVID-19
    b) improving the integration of primary and specialist mental health and addiction services
    c) focused on improving our cultural response, focussed on Māori and Pacific populations
    d) improving follow-up within seven days post-discharge.

8. Our draft plans include the following 2DHB and 3DHB actions for 2021/22 to improve mental wellbeing:

    a) MHAIDS will review its plans and protocols established during the COVID-19 lockdown and ensure currency of interventions should there be a re-emergence of COVID-19. This review will also include reviewing the protocols and agreements with all providers involved in the collective provider and stakeholder forum that was implemented to respond to the COVID 19 and lockdown early in 2020. Access to psychosocial support (increased resource to support access to primary mental health care) and social welfare services will be part of the collective plan to reinforce our COVID response. (3DHB)

    b) Implement an integrated community mental health and wellbeing hub model that will provide a timely response at a local community level to those who present in distress. In 2021/22 we will to use a co-design approach to design a service model and the completion of an investment business case to implement the model. The proposal is to target a collaborative approach with a strong kaupapa Māori focus and high needs areas. The current priority localities are Porirua and Naenae. (2DHB)

    c) Develop a 2DHB Māori and Pacific Service Providers' Collaborative and engage in strategic planning with the collaborative to meet the needs of Māori and Pacifica populations. We will partner with the collaborative on the development of common goals to achieve equity, service development targeting high needs populations, and the development of common goals agreed with inter-sectoral partners. (2DHB)

    d) We will streamline our data and implement more robust processes to improve our rates of timely follow-up after a patient is discharged from an inpatient mental health unit. (3DHB)

9. WrDHB's draft annual plan includes the following additional actions for 2021/22 to improve mental wellbeing:

    (1) Principles 4,6 and 7 of *COVID – 19: Kia Kaha, Kia Maia, Kia ora Aotearoa (2020)* supports the strategy of engaging with local community groups, agencies and stakeholders in developing a framework for activity within an accountable shared space. Wairarapa DHB will:
        a. Reform and redesign the local MH&A advisory group into a steering group / collaborative, with clinical and operational leadership with PHO, local governmental / social agencies. A co-design approach will be used
        b. The redesigned local MH&A group will be responsible for:
            i. Activity contributing to governance of service delivery across the Wairarapa
            ii. Providing point of co-ordination for strategic development of psychosocial response process / protocols, and synchronized service delivery during any state of emergency, including pandemic such as COVID – 19
            iii. Links with other non-provider agencies as a wider reference network

    (2) Establishment of the MoH funded MHAC (Mental Health and Addiction Crisis Support) role within the Emergency Department, based at Wairarapa Hospital

    (3) Support development of Nurse Specialist role within NGO based addiction service to improve local governance and service delivery.

    (4) The Wairarapa has the highest per capita population of older people in New Zealand and to recognize the increasing need for MH services for this age group, complete a review of current service provision. Using a co-design process, create recommendation for future development of service delivery across all providers and develop an implementation strategy

    (5) In the Wairarapa, there is a dearth of available and dedicated consumer / peer support for service development and delivery. Complete assessment of the need for development of formal consumer advisor activity and develop a strategy for supporting any recommendations made from this.

    (6) Work with local community and key stakeholders to review existing provision of acute / crisis respite care and out of hours service provision, in line with the MHAIDS Acute Care review, and recommendations from review completed in 2020 within WrDHB.

    (7) Using co-design, develop a model of service delivery that refocused initial MH&A engagement and assessment from a principally clinical orientation, to an appropriate collaborative model of holistic assessment, informed by Māori model of health care.

    (8) Over the last 5 years (Jul 2015 to June 2020), 35% of all those admitted to acute MH facilities from the Wairarapa are Māori, with a community population base of 17%. Other ethnic groups make up 80% of the local population but comprise just over 60% of all admissions. This over representation is compounded by Māori people being discharged under a CTO (community treatment order – Mental Health Act, 1992) just over five times more likely than non Māori. The reason for this is not clear.
        a. Using a project focus aligned with the MHAIDS and NGO local services, develop an assessment of the issues driving this disparity in service delivery, and consider recommendations regarding service development to address any identified gaps, model of care issues, or resource shortfall.

Other areas of interest

10. There are actions under other planning priorities in our draft annual plans that are also expected to improve mental wellbeing and/or improve the health and wellebing of disabled people. The following 2DHB actions are incorporated under the 'Whakamaua: Māori Health Action Plan 2020-2021' planning priority:

    - Develop a 2DHB pro-equity approach to recruitment and onboarding, designed to attract an increased diversity of candidates (e.g. Māori, Pacific, disabled) and ensure a positive candidate experience for all.
    - CCDHB and HVDHB will explore opportunities to extend school based services for Māori and Pacific
    - Implement the Disability Equity E-learning module to strengthen cultural competency within the 3DHBs.
    - Improve access to sex and gender diverse healthcare, the integration of youth services in Porirua and any other pieces of work discussed at the 2DHB Youth Integrated Care Collaborative.
    - Students will continue to have access to telehealth and other forms of virtual consultations/ appointments in decile 1-5 secondary schools, teen parent units and alternative education facilities.

11. Under the 'Family Violence and Sexual Violence' planning priority:

    - Develop a joint 2DHB Family Violence Strategic Work Programme to re-design the way the 2DHBs respond to people experiencing family violence so we can reduce its impact, improve outcomes, and support safer communities. This work will focus on DHB responses for Māori and Pacific whanau/families.
    - Increase Violence Intervention Programme (VIP) training rates by adopting 2DHB approaches to refine and deliver the training to DHB clinicians (medical, nursing and allied health) in designated services (Emergency Department, Women's Health, Children's Health, Community Mental Health Teams and Addictions Services).

12. Under the 'Acute Demand' planning priority:

    - MHAIDS, in partnership with Hospital Flow Services, will improve performance of services to provide timely assessments for priority populations (i.e. Mental Health, Maori, and Pasifika).

13. Under the 'Long-Term Conditions' planning priority:

    - Review access to after/hours services across the region with a particular focus on access for Māori and Pacific and people with disabilities.

Outcomes and Impacts

14. Each DHB has a statutory responsibility to prepare a Statement of Performance Expectations (SPE), providing financial accountability to Parliament and the public annually. The SPE enables the Minister to participate in the process of setting annual performance expectations, to inform the House of Representatives and to provide a base against which annual performance can be assessed. The SPE will be audited by Audit NZ and DHBs are required to report against the measures in the Annual Report.

15. The following indicators are used in our SPEs to demonstrate the success of our mental health, addictions and wellbeing services:

    - Access to mental health services / number of mental health services
    - % of clients with a transition (discharge) plan
    - % of clients with a wellness plan

- % of population accessing community mental health services
- % of population accessing secondary mental health services / addiction treatment services
- % of patients 0-19 referred to non-urgent child & adolescent services that were seen within eight weeks within mental health services and within addiction treatment services
- % of people admitted to an acute mental health inpatient service that were seen by mental health community team 7 days prior to the day of admission and 7 days following the day of discharge
- Rate of Māori under the Mental Health Act: Section 29 community treatment orders.

16. The following indicators are used in our SPEs to demonstrate the success of our disability support services:

    - Number of sub-regional Disability Forums
    - % of hospital staff that have completed the Disability Responsiveness eLearning Module
    - Number of people with a Disability Alert
    - % of the CCDHB domiciled population with a Disability Alert who are Māori or Pacific.

17. All indicators will be reported on by ethnicity where possible. In the last couple of years we have tried to move some of the indicators from a focus on Outputs (i.e. activity) towards Outcomes (i.e. how well did we do it) and Impact (i.e. what difference did we make). However, this has proved particularly challenging in relation to disability services, as there is limited data captured in relation to disability outcomes and impacts.

18. We are currently exploring options to improve the way we measure disability outcomes, including working with the Ministry on national mechanisms. Our long-term goal is to report all indicators by ethnicity and by disability status.

Next Steps

19. DSAC is asked to provide feedback on the first draft Annual Plans 2021/22 by the end of April 2021.

20. Further work on the Annual Plans will be done as we receive feedback and further guidance from the Ministry. We will continue to work across the three DHBs to ensure alignment where possible. We will also present the draft Annual Plans to the Māori, Pacific, and Consumer advisory groups and incorporate the feedback we receive.

21. The Boards will be asked to approve the final drafts annual plans in May or June 2021. The final draft annual plans 2021/22 are due with the Ministry of Health mid-June 2021.

Attachment/s

1. First draft 2021/22 CCDHB annual plan including Statement of Performance Expectations
2. First draft 2021/22 HVDHB annual plan including Statement of Performance Expectations
3. First draft 2021/22 WrDHB annual plan including Statement of Performance Expectations